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Ask me, listen to me, treat me well and I shall tell: a qualitative study of Swedish youths' experiences of systematic assessment of sexual health and risk-taking (SEXIT)

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Abstract: *Sexual ill health among young people, in terms of sexually transmitted infections (STIs), unintended pregnancy, transactional sex and sexual violence, is a global public health concern. To that end, the SEXual health Identification Tool (SEXIT) was developed. The purpose of this study was to explore the visitors' experiences of a youth clinic visit when SEXIT was used. A purposively selected sample of 20 participants (16–24 years of age) was recruited from three Swedish youth clinics using SEXIT. Participants were interviewed individually in March and April 2016, and data were analysed using inductive qualitative content analysis. The analysis resulted in four main categories describing the participants' experiences of using SEXIT: "Issues of concern" includes descriptions of the items in SEXIT as important; "Enabling disclosure" describes how SEXIT serves as an invitation to talk and facilitates disclosure of negative experiences; "Road to change" captures experiences of the conversation with the healthcare professional; and "Managing power imbalance" describes experiences regarding the response and attitudes of the healthcare professional as well as the participants' fears of being judged. The categories are connected by the overarching theme "Ask me, listen to me, treat me well and I shall tell". This study contributes knowledge on young people's experiences of a tool-supported dialogue on sexual health and risk-taking initiated by the healthcare professional. Structured questions in a written format, as a basis for dialogue, are appreciated and experienced as a functioning way of addressing sexual ill health and risk-taking at Swedish youth clinics.*
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Introduction

Sexual and reproductive ill health among young people, in terms of sexually transmitted infections (STIs), unintended pregnancy, transactional sex and sexual violence, is a global public health concern.[1] Different manifestations of

sexual and reproductive ill health tend to be interrelated and share many associated factors. Examples of groups identified as disproportionately burdened are lesbian, gay, bisexual and transgender (LGBT) youth and young people in secure state care.[2,3]

Both Swedish and international research suggest that young people seldom raise sexual and reproductive health (SRH) concerns,[4] or disclose experiences of sexual violence or transactional sex to professionals of their own accord.[5–7] Thus, when in contact with the healthcare system, systematic identification of individuals exposed to or at risk of sexual and reproductive ill health is crucial, not only for effective prevention and care but also for equitable sexual health care. However, research suggests that this is seldom the case. A recent study conducted in the USA concluded that healthcare providers appear to address SRH topics both infrequently and inconsistently during encounters with young people, and called for targeted interventions to strengthen the regularity and depth of clinicians' SRH conversations.[8]

In Sweden, a recent research project at youth clinics has addressed the problem and demonstrated that the systematic use of the SEXual health Identification Tool (SEXIT) may facilitate raising important questions on sexual risk-taking and sexual ill health with youth clinic visitors.[9] The tool was also found to be feasible and valuable from the perspective of the healthcare professionals, by ensuring consistency and quality in assessing visitors.[10,11]

Other Swedish studies have suggested that youth clinic visitors react positively to routine enquiry about violence and alcohol consumption[12] and that women (23–29 years of age) are supportive of healthcare professionals asking questions on sexual coercion.[13]

International studies have concluded that adolescents would like healthcare providers to address sexuality issues, and that they prefer to discuss sensitive topics directly.[4,14,15]

However, young people's experiences of being asked about sexual risk-taking and sexual ill health, in a context of systematic assessment within health care, have not, to our knowledge, been previously investigated. The aim of this study was therefore to explore youth clinic visitors' experiences of systematic assessment of sexual ill health and risk-taking using SEXIT, and specifically of filling out the SEXIT questionnaire.

Methods

Study design

A qualitative explorative design was chosen as it can provide insight into a research area that has not previously been investigated. Semi-structured interviews provide a rich understanding of participants' experiences of the world, expressed in their own words.[16] Other approaches, such as focus group discussions, were considered less appropriate due to the potentially sensitive topics to be discussed. Qualitative content analysis was used for analysing the data, being a suitable method for describing and exploring something new. The epistemological basis for this method of analysis is that data and interpretations are co-created between the interviewee and the interviewer, and interpretations during analysis are co-creations between the researchers and the text.[17] These assumptions underpin this study, and also imply that reality can be interpreted in various ways and that the understanding is dependent on subjective interpretation.[18]

Setting

In Sweden, youth clinics are highly accessible primary care facilities for adolescents and young adults, 13–25 years of age. In most cases the visits are free of charge, with some exceptions for people above 20 years of age. Youth clinics can be found throughout Sweden and visits can be either booked or drop-in. Services offered range from counselling on SRH to a wide range of psychosocial health concerns. The clinics also offer testing for STIs and provide subsidised condoms and other contraceptives. The staffing varies but generally midwives, social workers and physicians are available. If other professions are needed referrals can be made to other healthcare facilities as well as to the social services. The visitors at the clinics are heterogeneous in age and purpose of visit; in terms of gender, approximately 85% are female. In 2005–2006, 23% of 16- to 26-year-old women in Sweden reported having attended a youth clinic in the previous three months. The corresponding number in young men was 4%[19]. The most common reason for visiting a youth clinic relates to STI, contraceptives and counselling.[20]

The sexual health identification tool

SEXIT is an assessment tool for staff at Swedish youth clinics, developed to facilitate identification of young people exposed to or at risk of sexual ill

health. [9] It is a 16-item questionnaire informed by literature on risk factors and predictors of sexual ill health. The items are: age, gender identity, sexual orientation, living situation, alcohol use, cannabis use, other drug use, age of sexual debut, first-date-sex, number of sexual partners, previous chlamydia, unintended pregnancy, transactional sex, sex against own will and having persuaded/forced someone to have sex (see supplemental material). The questionnaire serves as a conversation starter to initiate a dialogue on the included items, and to alert the staff to possible risks or ill health. The questionnaire together with associated training and guidance for healthcare professionals, forms the SEXIT toolkit. Visitors to the youth clinics are informed about SEXIT and the procedure of asking questions on sexual health and risk-taking on posters in the waiting room. When they enter the consultation room, they receive verbal information about SEXIT and are invited to complete the SEXIT questionnaire on their own. The healthcare professional then reviews the answers together with the visitor and poses follow-up questions. Based on SEXIT, the subsequent conversation, and the full patient history, the professional then makes the risk assessment.

Table 1. Characteristics of the participants

Characteristic	Participants ($N = 20$)
Gender identity	
Male	4
Female	14
Other*	2
Age	
16–17	5
18–20	7
21–24	8
Type of youth clinic	
Large urban clinic	10
Small countryside clinic	5
Regional specialist clinic	5
Main language (mother tongue)	
Non-Swedish	2
Swedish	18
Youth clinic experience	
Visited a youth clinic before	19
First time visiting a youth clinic	1

*Transgender, non-binary or other.

Procedures and participants

Participants were recruited from an ongoing multicentre research project in western Sweden during the spring of 2016. [9] The project investigated the feasibility and effect of introducing the SEXIT toolkit at youth clinics to facilitate identification of young people exposed to or at risk of sexual ill health.

Three youth clinics participated in the project, one small rural clinic (the only clinic in a city with 23,000 inhabitants), one urban city clinic (one out of six clinics in Gothenburg, a city with 600,000 inhabitants) and one regional clinic specialised in sexual health of vulnerable and risk-taking youth, often referred from alcohol and drug use services. The clinics were chosen to represent a diversity of visitors and clinics.

Inclusion criteria for this study were visitors aged 15–24 years consulting one of the participating youth clinics and who had answered the SEXIT assessment tool during that visit.

A purposive sample of 20 adolescents and young adults representing the client base of youth clinics was chosen to ensure maximum variation in gender, age and type of clinic visited. [16] Characteristics of the study population are presented in Table 1. At the clinic, visitors who answered the SEXIT questionnaire were invited to participate in a follow-up interview. Among them, half provided contact details (phone and/or e-mail), and 37 were contacted by the first author (SH) within four weeks to receive verbal information about the study. Of the 37 contacted youths, 26 participants initially agreed to an interview. In the end, 20 participants met in person, received written and oral information about the study, and subsequently provided written consent. The remaining six participants were either

too young (<15years) or unable to perform the interview for circumstantial reasons (school exams, travels, etc.). After 20 interviews had been completed, it was decided that additional interviews were unlikely to add to the understanding of the research question.

Data collection

Data were collected in March and April 2016 by means of individual semi-structured interviews, conducted within a month after the youth clinic visit guided by the SEXIT questionnaire. An interview guide was developed, focusing on experiences of the visit, the assessment tool, the provided care and the healthcare professionals' attitudes. The questions were open-ended and the order in which they were asked varied. Elaborating follow-up questions, "probes", were used to get richer answers.[21] The interview guide was tested in two pilot interviews (not included in the study), which resulted in minor revisions, including one additional probe to more thoroughly explore the visitors' experience of answering the assessment tool (i.e. SEXIT), and minor linguistic alterations to make the interview flow more naturally and relaxed.

Seven key questions were used in the final interviews:

- What is your overall experience of your last visit to the clinic?
- Can you describe what it was like to fill out the assessment tool?
- What is your view on the specific questions?
- Can you describe what it was like to discuss your answers with a healthcare professional?
- How was the attitude and response of the healthcare professional?
- Can you reflect on the care or support you received?
- How did the assessment tool affect the information the clinic received about you?

All the interviews were conducted by the first author (SH) who had no professional or personal relation to the participants. The interviews took place at a private and secluded venue located separately from the youth clinics. The interviews were held in Swedish, although two participants sometimes switched between English and Swedish to be able to express themselves better.

The interviews lasted for approximately 30–40 minutes and were audiotaped digitally. The interviewer gathered field notes from every interview to better reflect on the data gathering and on details that might have interfered with the data quality or that might affect later interpretations.[21] The recordings were transcribed verbatim by a transcribing service, and the first author (SH) listened to the recordings and verified the transcripts. The participants received compensation for travel expenses as well as a movie ticket.

Data analysis

Interview data were analysed using inductive qualitative content analysis, as described by Graneheim and Lundman.[22] The analysis focused on both the manifest content, i.e. the description of the explicit and obvious content, and the latent content, i.e. an interpretation of the underlying meaning(s) of the text. The inductive analysis began with immersion in the specifics of the text (i.e. the participants' own stories) to discover patterns, themes and interrelationships.[16] The analysis moved from the data to a theoretical understanding – from the concrete and specific to the abstract and general.[22] The first author performed the analysis in close collaboration with the remaining five authors.

First, all transcripts were read thoroughly several times to achieve a sense of the whole. Each transcribed interview was considered a separate unit of analysis. The texts were divided into meaning units, i.e. several words, sentences or paragraphs that related to each other and addressed the research questions. Each meaning unit was condensed and labelled with a code. Two interviews were coded separately by three authors (SH, ML and SB), and compared to achieve consensus. Two content areas were discovered, answering separate parts of the research question: (a) experiences of the SEXIT questionnaire and (b) experiences of the youth clinic visit with SEXIT.

The next step was to search for similarities, patterns and relationships within the codes, and to sort them into sub-categories and categories. This process involved moving back and forth between parts of the text and the whole. The categories represent the manifest content. During the analytical process, underlying meanings in the text were identified and formulated into an overarching theme, i.e. the latent content. All authors took part in the creation and naming of categories and themes. In naming codes and categories, concepts close to the text were sought. The process of coding was facilitated by using software NVivo 12.

The first author was a PhD candidate with a master's degree in public health at the time of the research, specialised in SRH within primary care, and with experience of working with youth. Three authors have a background in implementation research or SRH research, with experience of qualitative content analysis (ML, SB, PN), and two authors are midwives working in the youth clinics from which the participants were recruited (JE, EF). Since the first author also was project manager for the development of SEXIT, careful examination of her own bias throughout the process, particularly during data collection and analysis was necessary. This examination was facilitated by the collaboration within the research group.

Quotations are verbatim, except for the repetition of certain words that have been deleted. Quotes are attributed by pseudonymised names and ages. To bring alive the descriptions of the categories, single words or a few words from the participants are sometimes used in plain text using quotation marks. Quotes were translated from Swedish to English during manuscript writing (Table 2).

Ethical considerations

According to the Swedish Ethical Review Act, which concerns the ethical review of research involving humans [23], active consent is not required from parents of adolescents aged 15 years or older. According to this act, adolescents aged 15–17 years should be informed about the study and if they are able to understand what participation entails, they can personally provide their consent. In the present study, this judgement was made first by the youth clinic staff and then by the interviewer. Youth clinic visitors received written and oral information about the study and were informed that participation was voluntary. All participants provided written consent and received contact details for help and support, if the need should arise after participation in the study. The study was approved by the Regional Ethics Review Board in Gothenburg on 27 January 2016 (Reference 935-15).

Results

The participants' experiences are described through 4 main categories and 11 sub-categories, as illustrated in Figure 1. As demonstrated by the figure, experiences of filling out the SEXIT questionnaire itself can be regarded as part of the overall experience of the youth clinic visit with SEXIT. An overarching theme was developed during analysis: "Ask me, listen to me, treat me well and I shall tell". This descriptive theme was conceptualised to capture and describe the connections between the categories and the texts' underlying meaning.

Content area: experiences of completing the SEXIT questionnaire

Issues of concern

In the category "Issues of concern", participants described their experience of the questionnaire as containing questions that were highly relevant and of great concern to them. The category contains two sub-categories "Raising relevant questions" and "Inducing emotions". Together they cover experiences related to the content of the SEXIT questionnaire, i.e. what topics are included and how they are perceived by the participants.

Raising relevant questions

The topics covered in the questionnaire are described as important to all participants, one reason being that they are relevant in the lives of young people, and because that's the reason they attend the clinic, or as one young woman expressed it:

"I'm somehow living these questions right now, in my life situation." (Tina, 24 years)

The participants acknowledged that the questions pinpoint common health problems among young people and that, although it concerns them, many "keep things to themselves" and "are afraid to tell someone".

"*Everything is important really, but it feels like sexuality and the questions on sexual habits are the ones that … at least in my world, they are signs of psychological ill health, if you have an unhealthy view on your sexuality and what you do sexually*." (Kristian, 22 years)

By raising these questions, young people could get help from the youth clinic; "knowing that you're not alone" also gives comfort. It was suggested that the questions should be asked as often "as possible", for example in schools.

Inducing emotions

The SEXIT questionnaire induced contrasting types of emotions. Some participants had no problem answering the questionnaire:

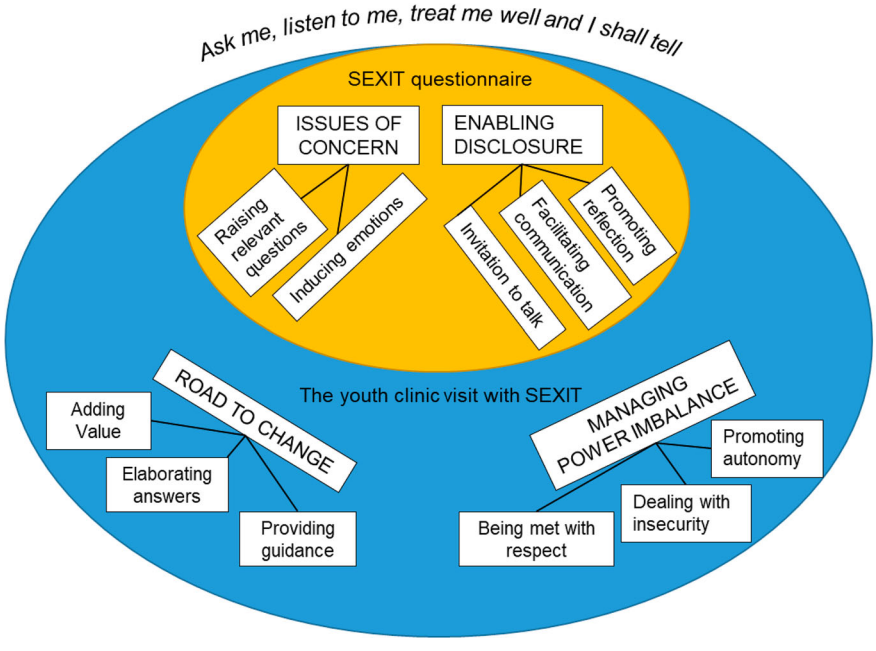
Table 2. Example of meaning units, condensed meaning units, codes, sub-categories and categories

Meaning unit	Condensed meaning unit	Code	Sub-category	Category
I think it's very important, that you acknowledge it, and that you ask people. I think you should ask as often as possible really. It feels reassuring somehow …	Important to acknowledge and ask questions	Important to ask	Raising relevant questions	Issues of concern
Especially sexuality I think, but there were also some questions on drugs and prostitution, and they are all very taboo.	Sexuality, drugs and prostitution are taboo	Sensitive topics	Inducing emotions	Issues of concern
When you write something you also get something to talk about, even when it doesn't seem to be anything to talk about. But still you can … somehow you get something to build [the conversation] on.	A written answer is something to build a conversation on	Door opener to conversation	Invitation to talk	Enabling disclosure
Many of these questions are things I have been forced to ask myself, before, so I have already been reconciled with the thoughts you might have about that.	Been reconciled with own thoughts on the questions	Reconciled with the questions	Promoting reflection	Enabling disclosure
It can be easier to write first, than if someone asks you directly, because it can be too straight forward, and then people might back off.	Easier to answer in writing compared with a direct question	Easier in writing	Facilitating communication	Enabling disclosure
There are a lot of things that you would not open up immediately to them, not say "I did this, I did that" but it was like, indirect questions coming to you from the piece of paper so it's not the person who would ask you. If someone asks you "did you do that" you would be like "why, it's none of your business" but with the piece of paper you feel more comfortable.	Easier to open up and feel comfortable with indirect questions from a piece of paper	Questionnaire facilitates opening up and feeling comfortable	Facilitating communication	Enabling disclosure

"*I didn't find them difficult to respond to … I'm quite honest and open minded, so for me it was no problem at all.*" (Lisa, 17 years)

They pointed out that the questions were unproblematic to them because they had no "problems with their sex life". There were also participants

Figure 1. Experiences of the youth clinic visit with SEXIT, expressed as theme, categories and sub-categories



who experienced the questions as "heavy to answer" because they triggered emotions and memories related to negative experiences from the past. Some wished not to think about what had happened and they described it as "then it came back".

"*… the question on alcohol was a bit sensitive … because it has been a problematic issue for me. And also this one, 'if you have experienced sex against your own will?'*" (Amanda, 19 years)

Regardless of whether the participants found the questions emotional or not, they described the questions as "personal", "taboo" and "sensitive", while at the same time the questionnaire provided them with reassurance that everyone was being asked.

Enabling disclosure

In the category "Enabling disclosure", participants described experiencing the questionnaire as something that enabled them to disclose sensitive experiences that otherwise they would have been unlikely to talk about. The category contains three sub-categories: "Invitation to talk", "Facilitating communication" and "Promoting reflection". Together they cover perceptions related to the method, shape and wordings used in the SEXIT questionnaire, i.e. how the topics are raised and how that manner was experienced by the participants.

Invitation to talk

The importance of asking specific questions to open a conversation, like an "ice-breaker" or "door opener", was raised by the participants, especially in new encounters.

"Obviously it works because, I don't know, maybe she [the midwife] would have brought it up without this [the questionnaire], but more stuff comes up and you are more likely to get help with your specific needs." (Simon, 19 years)

It was expressed that a specific question signals interest and knowledge, and that it is easier to answer compared with the more general question: "Is there anything you'd like to ask?" Participants expressed that the questions in a positive way "forced", "brought out" or "pulled out" answers that they would not otherwise disclose;

other participants described that the questionnaire gave them "the opportunity" to talk and that they "did not have to bring it up" themselves.

"*There are a lot of things that you wouldn't open up immediately to them [healthcare professionals], not say 'I did this, I did that' but it was like … indirect questions coming to you from the paper so it's not the person who would ask you. If someone asks you 'did you do that' you would be like 'why, it's none of your business' but with the paper you feel more comfortable*." (Mohammed, 19 years)

Facilitating communication

Generally, participants described the questionnaire in terms of "clear questions, good response options, quickly answered", and they highlighted that the paper format, with specific questions and fixed response options, facilitated disclosure. Reasons given were that "it is easier to just tick a box" than to formulate and give an oral response to someone directly. On the other hand, some young people mentioned that this could also imply a risk of revealing more than anticipated. They also found the written format "more impersonal" and "more concrete" compared to receiving oral questions. Another aspect that was raised was the advantage of being able to think before having to answer, and not receiving a visible and immediate reaction from the healthcare professional when you answered:

"It's easier to be honest when you don't have to sit and look at someone … I definitely think so. You are more honest on paper, when you can answer on your own and … not get all the expressions and so from the person sitting in front of you." (Ines, 17 years)

The questionnaire was compared to the way one can be more honest when writing on the internet or in a diary. If the questions are asked face to face, they can feel "harsh", "heavy" and "too direct" and may elicit an instinctive negative response because "it's so obvious that one should answer "no" on that question". But with the questionnaire "you feel more comfortable" and "you know what is going to happen". However, other participants thought that it would have been easier to get the questions orally and to be able to explain the answers immediately. Generally, the participants appreciated the non-heteronormative wording and response options used, and that the questionnaire "didn't assume anything" about the person answering.

Promoting reflection

The questionnaire promoted reflection in various ways, sometimes in the form of awareness because the participants had not thought about the topics much or did not know certain experiences existed among young people in Sweden. Sometimes participants explained that they had to "think through how things were", because answering the questionnaire demanded it, for example, the items asking for quantitative measures of alcohol use, because "I haven't exactly counted". Some questions were deliberately formulated in a way that required reflection, which initiated appreciated discussions about sometimes difficult concepts:

"The question: 'have you ever been exposed to anything of the following against your will?' … I think about the word 'will' here, it's so … , I mean, what is even 'will'"? (Alice, 24 years)

Another type of reflection occurred when the participants were reminded of their own previous experiences and thought about them in a different way.

"It became very evident, but I think that's a good thing. Otherwise it's easy to … how do you say … suppress it. No wonder you feel bad now and then. When you think about it it's quite understandable that you do." (Clara, 24 years)

The participants explained that their reflections could both create motivation to change their behaviours and cause adverse feelings.

"It was like a challenge between me and the paper, like okay I need to stop this, I need to do that, I need to change things, I need to keep on doing this type of things. The question is like "You want to be safe or you want to be unsafe?" that's the question." (Mohammed, 19 years)

Content area: experiences of a youth clinic visit with SEXIT

Road to change

The category "Road to change" describes experiences of the youth clinic visit with SEXIT as a whole, and how the use of the SEXIT questionnaire also affected other parts of the visit. The actual process from entering to leaving the consultation room, as well as the participants' experiences of it,

was often perceived as different from previous visits at youth clinics. The category contains three sub-categories: "Adding value", "Elaborating answers" and "Providing guidance".

Adding value

Being invited to answer a questionnaire during the visit surprised a few of the participants but was generally described with words like "completely normal", "nothing special" and "like every other visit". They described that it positively affected their perception of the visit, it felt more serious. Others mentioned that the visit including the SEXIT questionnaire gained their trust, that it created "a feeling of that they wanted to help me".

"It was good, especially during the first visit, because then I got a picture of the person asking the questions and … you develop a more personal contact. And the other way around, that person also got to know more about me, and that feels good because then you almost have a kind of friendship, since you know things about each other." (Ines, 17 years)

Compared with previous youth clinic visits without the questionnaire, the participants described an unusual encounter where more and different topics were covered. This was perhaps most evident for those who visited the clinic regularly for psychosocial counselling.

"A little bit unusual, it's not why I normally visit the clinic, and the topic, sex, is nothing I and my counsellor have talked about before." (Emil, 23 years)

Elaborating answers

The intended routine associated with SEXIT includes that the healthcare professional briefly reviews the answers together with the young person and poses follow-up questions when necessary. The participants described this process and different levels of elaborating their answers in various ways, from some follow-up questions to a conversation or general discussion.

"There were all my answers, I had been honest. I used to do drugs, so we talked about that and how guys treated me and things like that. So, yes, we started talking more after that piece of paper. I wouldn't have opened up otherwise, sure if she would have asked, but I still wouldn't have told as much without that paper. So, we had a conversation, it went well." (Lisa, 17 years)

Reviewing and elaborating the answers with the healthcare professional was described as "comfortable" and "good", making the visitors feel their responses were taken seriously and making them feel safe. At the same time, discussing the answers could also be a nervous moment related to uncertainty as to how the healthcare professional would react, and a reluctance to talk about some of the answers.

"It feels good, but it's a little … like you have to account for it, or that you are going to discuss it. It's easy to tick a box, but then to also talk about it makes it a bit more difficult. But I still like that they ask these questions, because it's only to help you, so, it felt good." (Tina, 24 years)

Not all participants elaborated their answers with the healthcare professional. This could be explained by lack of time when filling out SEXIT during busy drop-in hours, that the answers "were not exactly much to elaborate", or by other unknown factors.

Providing guidance

The participants described mainly positive experiences of the help and support they had received from the youth clinic during their visit. The visit was described as "personal but professional", "competent" and "safe", and the predominant experience was that "you are taken seriously when needed". Having the opportunity to discuss personal matters with a professional was appreciated:

"She can look at things more neutral, so to speak, she can be like this person that comes from behind when you're doing a crossword puzzle and immediately sees the solution, she looks at things from another angle, more clearly. Because she's not as involved as I am, she can more easily find a solution." (Sara, 17 years)

The participants valued straightforward communication and specific suggestions on how to handle problems:

"He was very like … 'You should do this, this and this', very straightforward and no fussing around, 'You need to do this, and you need to do it now'." (Kristian, 22 years)

The only negative experience mentioned was a promised phone call to follow up an STI test result, that never came.

Managing power imbalances

In the category "Managing power imbalances", the participants described emotional experiences and aspects of the visit that affected the power imbalance inherent in the patient-caregiver relationship, and experiences with a significant impact on the young visitors' attitudes towards the visit as a whole. The category contains three sub-categories: "Promoting autonomy", "Dealing with insecurity" and "Being met with respect".

Promoting autonomy

Feelings of being safe and in control of what was happening were instilled by several different parameters described by the participants. One was the knowledge that the questionnaire was routine procedure, offered to everyone, "exactly like we do with everyone else", and not specifically to any individual based on preconceptions about that visitor. Another aspect promoting autonomy was the knowledge that answers were voluntary, with "no pressure" to take part. Knowing what SEXIT was, what topics it covered and why, and lastly how it was to be used, i.e. that the healthcare professional and visitor would review and talk about the answers together, further promoted autonomy.

Feelings of trust and autonomy were stimulated by professional confidentiality, which was described as a precondition for disclosing troubling experiences: "what is said here, stays here". At the same time, some participants commented on the fact that healthcare professionals have a duty to file a report if they suspect that a child (below 18 years of age) is at risk of harm.

"I can understand how they might reason 'this is very serious, we need to report it', but I wish they could ignore that obligation sometimes and focus on building a trustful relationship, because otherwise – next time something bad happens that person won't turn to anyone for help." (Clara, 24 years)

Information about the limits of confidentiality was provided on posters in the waiting room and orally to the visitors, before completing the questionnaire. The information can also be found on the website of the youth clinics.

A sense of control was stimulated by confidence in the healthcare staff's professionalism. Healthcare professionals demonstrating knowledge of transgender and queer identities were described as fostering a safe environment: "it feels like they are fairly updated, so then I have been able to feel quite safe". Participants described being able to influence how the conversation following the questionnaire proceeded, further promoting autonomy.

"*'Is there time to cover this properly, or should we save it for another time, or do we want to talk about this?' … we had this discussion and I felt that it could be done in a good way*." (Sam, 22 years)

Dealing with insecurity

In contrast to the previously described sub-category, participants could also experience a lack of confidence, especially before the visit, and if the healthcare professional was someone they had never met before, "the questions are good, it's just that you fear that … you don't know … it's a new person". Participants told of being nervous about being asked private and sensitive questions and afraid of being poorly treated, "judged" or "put in a box", based on their answers.

"[I want to] feel that no one is trying to pigeonhole me, that they are asking because they want me to think and reflect, that we can discuss things openly, without anyone looking at me with sad dog eyes or … like revealing their own emotions." (Alice, 24 years)

Insecurity was sometimes found to be unwarranted and sometimes confirmed.

"You create a scenario in your head 'what if she asks about awful things or if I have to explain private details … ' and then when I actually got there, she was just a human being, it was more comfortable than in my imagination." (Sara, 17 years)

A feeling that completing the questionnaire was expected, and uncertainty about how the responses were to be used, sometimes triggered adverse feelings. Insecurity negatively affected the honesty in the participants' responses, because "you are afraid of the consequences that may follow".

Being met with respect

Generally, the participants were satisfied with the attitude and response they received from the healthcare professional when they reviewed and elaborated the SEXIT questionnaire together. Examples of words used to describe the professional response are: *confident, nice, respectful,*

helpful, understanding, easy to talk to, takes me seriously, takes responsibility. The participants used words such as "judging/ not judging", which seemed to be a central aspect when assessing the healthcare professionals' response. To be able to reveal personal and socially undesirable behaviours without feeling judged, and to be met with respect and understanding, seemed to be most important for the participants. Being met with respect was closely linked to feeling able to be honest.

"She is easy to talk to, the conversation felt better, more mature and more adult, she takes me more serious and I feel that I can be honest." (Lisa, 17 years)

Healthcare professionals who reacted emotionally impeded talking calmly about the young persons' experiences in a relaxed way, as experienced by Alice:

"I felt she interpreted my answers and thought like 'oh God, how awful' or was worried, and it felt a little exaggerated, so then I had to prove her wrong 'you don't have to be concerned, I'm OK'. I felt so watched I couldn't focus on myself, and had I been able to do that maybe I'd come up with more stuff." (Alice, 24 years)

The participants also described other aspects of a respectful and professional response, such as the healthcare professional remembering them from previous visits and the healthcare professional not manifesting stress despite there being many people in the waiting room. When there were reading or language difficulties, the healthcare professional took time and explained the questions, which was appreciated.

Discussion

This qualitative study adds to the research field by including the voices of young people and describing their experiences of completing the SEXIT questionnaire and of their subsequent youth clinic counselling session. The underlying meaning conceptualised from the results is "Ask me, listen to me, treat me well and I shall tell". Throughout the material runs a sometimes expressed, sometimes underlying, wish to feel able to share matters of the heart, openly and without having to worry about reactions and consequences. Being asked both sensitive and important questions covered in SEXIT, followed by a respectful conversation initiated by the healthcare professional, has the potential to open up a deepened and broadened conversation about the visitor's sexual health. The procedure made the participants feel that they were taken seriously and that questions relevant to them were also important to the youth clinic professionals. Thereby, the use of SEXIT contributed to the circumstances necessary to instil the feeling of trust and confidence that enables disclosure of sensitive experiences.

The participants in this study expressed appreciation for the SEXIT questionnaire. Structured questions in the written format served as an invitation to talk, facilitating communication and disclosure of sensitive experiences that would otherwise have been difficult for the participants to raise by themselves. These overall positive experiences of a youth clinic visit in which SEXIT was used, are supported by quantitative data from the SEXIT pilot implementation, showing that 87% of youth clinic visitors found the questions important, and not uncomfortable (93%) or difficult to answer (92%).[9] The positive experiences are also consistent with Swedish qualitative studies on routine enquiry about violence and alcohol consumption at youth clinics,[12] and on young women's perceptions of being asked questions about sexuality and sexual abuse.[13,24] Those studies also found that questions on sexuality and violence are not only acceptable to, but explicitly requested by, young people when in contact with health care.

The results are also in line with international studies. In an American study, a majority of adolescents deemed provider-adolescent discussions about puberty, STIs, HIV, and birth control as important. Rosenthal et al.[14] found that most adolescents want healthcare providers to address sexuality issues, and that they prefer to discuss sensitive topics directly and within a generally caring context. It has also been reported that drug use and STIs are among the topics adolescents really want to discuss with their physician, but these conversations were rarely initiated by the healthcare provider and the adolescents would not raise their concerns themselves.[4]

That routine inquiry with explicit questions on sexuality and violence, serves as a "door opener" to dialogue with the healthcare professional and facilitates disclosure of negative experiences, is expressed in other studies.[12,24] Other active strategies, such as the Event history calendar

(structuring the conversation through themes, and helping the young person recall events through a timeline), seem to have a similar effect of improving sexual health communication with adolescents.[25,26]

From this study and others,[9,13,24] we know that there will always be some visitors who find questions on sexuality and violence uncomfortable and private. Therefore, it is important in clinical practice to always underscore that answering SEXIT is completely voluntary and done with the purpose of improving care and support to that individual. The power imbalance that is inherent in the patient-caregiver relationship became visible through the use of SEXIT. Being asked to complete the questionnaire both revealed feelings of insecurity about being judged by the healthcare professional, and promoted the participants' autonomy, through having the possibility to discuss issues of concern, knowing which questions were to be asked, and that completing SEXIT was a voluntary routine practice.

An important precondition for dialogue on sexuality and violence, expressed in our study as well as in others, is that healthcare professionals can be trusted not to reveal information to parents or others.[12,24,27] Professional confidentiality and privacy are, together with accessibility and staff characteristics and competency, essential aspects of what is often referred to as youth-friendly SRH services.[28] Swedish youth clinics can provide both privacy and almost complete confidentiality, except for their duty to report to social services if they suspect that a child (below 18 years of age) is at severe risk of harm. No parental consent is needed to access youth clinics, regardless of age. However, in most parts of the world the opportunity for a young person to talk privately with a healthcare professional about sexual health cannot be taken for granted. The lack of both privacy and professional confidentiality, is a major impediment worldwide for young people to disclose sexual health concerns and receive adequate care and support.[27] This barrier for accessing health care is particularly affecting young people in need, ie. those who are taking risks and suffering from psychological distress.[29]

The participants in our study described being met with respect as essential when visiting a youth clinic working according to SEXIT. This indicates that the healthcare professional's response is crucial for the outcome of the visit and is closely linked to the young person feeling able to be honest in their answers. If met with an unprofessional response, health conditions, dangerous situations, and risk-taking may not be disclosed during the visit, and opportunities to prevent or treat ill health might be lost. A Scottish study suggests that within the care system, it is standard practice to share sensitive information about young people's sexual health across team members, even when there are no child protection issues. This information sharing was experienced by the young people themselves as compromising their privacy, and the authors argue that this practice may deter young people from utilising sexual health services.[30]

The desire to be treated with respect by the healthcare professional was also identified in another qualitative Swedish study of young people who had been exposed to family violence.[31] The participants in that study described valuing being treated as an equal, with understanding and respect, "almost like an adult". The authors' interpretation was that young people's expressions of their need for respect and equality are comprehensible in relation to the vulnerable position they are in as a young person in a counselling relationship with an adult, focusing on painful experiences. The complex situation arising when professionals are using SEXIT or in other ways actively addressing sensitive issues with young people, underscores the need for reducing the power inequality inherent in the relationship between a youth clinic visitor and the healthcare professional.

In our study, fear of being judged was predominantly expressed by the participants who had negative or societal non-conforming experiences of sexuality. Although necessary, the classification of needs and experiences of a young visitor may not always be met with gratitude. Hydén and Överlien [32] have in their studies of "troubled girls", identified the dilemma when the girls themselves resist the prospective helpers' efforts to classify their needs and experiences. The authors argue that this dilemma cannot be resolved unless the helper can recognise not only the girl's troubles, but also her overall competence and potential for creating a better life for herself.[33]

With the results of our study and others in mind, providing quality preventive care to young people within the health care context requires routine enquiry on sexuality and violence. Healthcare professionals working with youth need to be competent, respectful and comfortable with

initiating dialogue on sensitive issues. This includes an organisational preparedness to deal with the possible responses in a professional way, and to support young people when ill health is identified. They also must think beyond identification of "people at risk", by recognising and promoting also what is positive and healthy in the lives of the people they meet. By establishing a trustful relationship, the possibility increases for the young person to also be willing to receive care and support or to change behaviours.

Strengths and limitations

Several steps were taken to enhance the trustworthiness of the study.[33] Credibility was striven for by analyst triangulation as researchers conducted the analysis collaboratively, by having codes and categories assessed for relevance by the co-authors during and after completion of the analysis (peer debriefing), and by recruiting participants from three different youth clinics working with SEXIT. Including both regular youth clinics and the specialised clinic, ensured the involvement of young people both with and without negative experiences of sexuality in the sample. Purposeful sampling of participants, ensuring a variation in the sample similar to the client base of youth clinics, further enhances credibility.[16] Finally, credibility is enhanced through the use of supporting quantitative data.[9]

Confirmability was sought by linking category labels closely to the text and by literal quotations linking the findings to the data.[16] Dependability was ensured by describing the process of enquiry as clearly and traceably as possible and by the first author conducting all the interviews during a limited time period.[34]

To enhance transferability, the setting and context have been carefully described. Although the findings are contextual and cannot be generalised, patterns in the findings might be transferable to similar groups in comparable contexts.[33]

A potential limitation of this study is that the experiences of some participants may have received more attention than others. Teenagers and young adults differ in their verbal and reflective abilities. In our attempts to understand and search for informative descriptions, it is possible that experiences from the older participants have received more analytical attention. A limitation of the questionnaire used in this study (SEXIT 1.0) is that it did not include any specific references to sexting or online abuse. However, this shortcoming has been corrected in later versions (SEXIT 2.0 and 3.0).[11,35]

Future studies

We suggest that future studies should focus on the care and support offered to youth clinic visitors identified as at risk of sexual ill health, the clinical effectiveness of the measures, and how they are perceived and valued by the youth clinic visitors themselves. Exploring healthcare professionals' experiences of using the SEXIT tool kit would also contribute important knowledge. Further, it would be desirable to test the feasibility of the SEXIT tool kit in an international context.

Conclusions

This study contributes new knowledge on how the SEXIT tool kit is experienced by young people visiting Swedish youth clinics. The voices of participating youth support our previous findings that SEXIT is a feasible model in the clinical setting. Our study consolidates previous knowledge that young people in general are in favour of dialogue on sexual health and risk-taking initiated by the healthcare professional. The study also adds knowledge by suggesting that systematic and structured questions in the written format, as a basis for counselling, are experienced as an appropriate and functional way of addressing sensitive topics at youth clinics, and of promoting disclosure and dialogue on sexuality and violence. When healthcare professionals actively ask, listen and provide a professional and respectful response, more young people can be expected to disclose their sexual experiences and be open to care and support. The will among young people is there, they are just waiting for the right conditions.

Based on these conclusions, the use of the SEXIT tool kit can be recommended in Swedish youth clinics. By means of protecting the health and wellbeing of young people, the authors would like to emphasise that using SEXIT requires full recognition of young people's SRH and rights,[1] competent and respectful professionals, and private and confidential consultations.

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Data availability

The data that support the findings of this study are available on request from the corresponding author, [SH]. The data are not publicly available due to privacy restrictions.

Authors' contributions

SH, PN, SB and ML conceptualised the study. SH managed data collection. SH, SB and ML conducted analyses, and PN, JE and EF verified the results. SH drafted the manuscript. All authors reviewed, edited and approved the final version submitted for publication.

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Résumé

La mauvaise santé sexuelle chez les jeunes, du point de vue des infections sexuellement transmissibles (IST), des grossesses non désirées, des

Resumen

La mala salud sexual entre jóvenes, en términos de infecciones de transmisión sexual (ITS), embarazo no intencional, sexo transaccional y violencia

rapports sexuels transactionnels et des violences sexuelles, est un problème mondial de santé publique. C'est pourquoi l'outil d'identification de la santé sexuelle SEXIT (SEXual health Identification Tool) a été mis au point. L'objet de cette étude était d'explorer l'expérience des visiteurs d'un centre de santé pour jeunes lorsque le SEXIT était employé. Un échantillon par choix raisonné de 20 participants (âgés de 16 à 24 ans) a été recruté dans trois centres de santé pour jeunes utilisant le SEXIT en Suède. Les participants ont été interrogés individuellement en mars et avril 2016, puis les données ont fait l'objet d'une analyse qualitative du contenu par raisonnement inductif. L'analyse a dégagé quatre principales catégories décrivant l'expérience vécue par les participants utilisant le SEXIT: « Les sujets de préoccupation » comprennent des descriptions des points du SEXIT jugés importants; la catégorie « Permettre la divulgation » décrit comment le SEXIT sert d'invitation à parler et aide à révéler des expériences négatives; « La route vers le changement » englobe les expériences de la conversation avec le professionnel de santé; et la catégorie « Gérer le déséquilibre du pouvoir » décrit les expériences concernant la réponse et les attitudes du professionnel de santé, ainsi que les craintes des participants d'être jugés. Les catégories sont reliées entre elles par le thème global « Demande-moi, écoute-moi, traite-moi bien et je te parlerai ». L'étude enrichit les connaissances sur la pratique par les jeunes d'un dialogue initié par le professionnel de santé et étayé par un outil sur la santé sexuelle et la prise de risque. Les questions structurées sous forme écrite, comme base pour le dialogue, sont appréciées et jugées comme une manière opérante de s'attaquer à la mauvaise santé sexuelle et à la prise de risque dans les centres de santé pour jeunes.

sexual, es un problema de salud pública mundial. Con ese fin, se creó la herramienta para la identificación de salud SEXual (SEXIT, por sus siglas en inglés). El propósito de este estudio era explorar las experiencias de visitantes a una clínica de jóvenes donde se utilizaba SEXIT. Se reclutó una muestra seleccionada intencionalmente de 20 participantes (entre 16 y 24 años) de tres clínicas suecas para jóvenes donde se utiliza SEXIT. Se entrevistó a cada participante individualmente en marzo y abril de 2016, y se analizaron los datos utilizando análisis inductivo de contenido cualitativo. El análisis produjo cuatro principales categorías que describen las experiencias de los participantes con el uso de SEXIT: "Asuntos preocupantes" contiene descripciones de los ítems importantes en SEXIT; "Permitir divulgación" describe cómo SEXIT sirve como invitación para hablar y facilita la divulgación de experiencias negativas; "Camino hacia el cambio" captura las experiencias de la conversación con el profesional de salud; y "Manejo del desequilibrio de poder" describe las experiencias relacionadas con la respuesta y las actitudes del profesional de salud, así como los temores de los participantes de ser juzgados. Las categorías están conectadas por el tema general "Pregúnteme, escúcheme, tráteme bien y le diré". El estudio contribuye conocimientos de las experiencias de la juventud con el diálogo sobre salud sexual apoyado por la herramienta y la toma de riesgos iniciada por el profesional de salud. Las preguntas estructuradas en formato escrito, como base del diálogo, son bien recibidas como una manera funcional de tratar la mala salud sexual y la toma de riesgos en las clínicas para jóvenes.