Adolescent health care in a multi-cultural area: a qualitative study from adolescents’ perspective

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ABSTRACT

Only few studies have investigated adolescents’ own views of health care in relation to socio-economic contexts. This study evaluated the Adolescent Health Service in Angered, a socio-economically disadvantaged, multi-cultural area in Gothenburg, Sweden, to identify factors that may facilitate or impede access to and visits at such services. Data were collected through focus groups with 11 female and 12 male adolescents and thematically analysed according to young peoples’ conceptions of adolescent health services, their needs and experiences thereof, and factors that could facilitate or impede their use of such services. By enhancing competence, concern and respect amongst staff and ensuring acceptable practical arrangements, sufficient information, familiarisation and involvement of adolescents and parents, services can provide accessible and acceptable health care for young people, thus contributing to fulfilment of adolescents’ right to health.

ARTICLE HISTORY

Received 27 November 2015
Accepted 30 December 2015

KEYWORDS

adolescent health; right to health; AAAQ; youth friendly services; focus groups; thematic analysis

Adolescent health services, or youth centres, have been established throughout Sweden with the ambition to exclusively address issues in relation to adolescent health. In this study, we evaluated an adolescent health service in Angered, a district in a large Swedish city facing a combination of challenges and resources on account of high prevalence of different nationalities as well as socio-economic disadvantage, high-risk lifestyles and high rates of ill-health (Healthcare Committee Office of Gothenburg, 2010; Region Västra Götaland, 2012).

The right to health

As outlined by the World Health Organization (WHO) in 1946, ‘health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization, 2009a, p. 1). The right to health is included in various human rights declarations (UN General Assembly, 1948, 1966, 1989). In order to assist the interpretation and implementation of the right to the highest attainable standard of health (UN General Assembly, 1966), the UN Committee on Economic, Social and Cultural Rights (CESCR) published General Comment No. 14 (UN CESCR, 2000). According to this comment, the right to health is based upon four cornerstones: Availability, Accessibility, Acceptability and Quality – usually referred to as the AAAQ framework.
Health is further affected by the social determinants of health, including socio-economic structures and environmental as well as personal conditions and lifestyle (Berensson, 2009). Historically, Sweden has been considered as one of the most equal countries within the Organisation for Economic Co-operation and Development (OECD) – a state of affairs that has dramatically changed since the 1990s due to increasing differences in income (OECD, 2011). Today, socio-economic inequalities are reflected in unequal distribution of both ill-health and health care, and currently account for considerable physical and mental suffering throughout the country (The National Board of Health and Welfare, 2011). Hence, health inequalities presently constitute one of the major challenges for Swedish health care.

Adolescents’ health and adolescent health services

In Sweden, there is no legal definition of ‘adolescent’. Adolescents may be defined as individuals between 13- and 25-years-old (Bremberg, Haeggman, & Lager, 2006), while the UN Convention on the Rights of the Child defines ‘child’ as individuals up to the age of 18 years (UN General Assembly, 1989). In this study, the first mentioned definition of adolescent was applied in line with Swedish adolescent health services policy.

Different kinds of ill-health dominate at different ages. Dominating factors up to the age of 14 years are physical conditions including cancer, accidents, infections and chronic diseases (The National Board of Health and Welfare, 2013). Amongst those 15–29 years, mental illness is one of the principal causes of ill-health. Other important health aspects during this period are sexual and reproductive health including sexual development, pregnancy, abortion and sexually transmitted infections (STIs); physical activity; eating habits; and overweight-obesity. As in the general population, inequality in health is a major problem amongst young people in Sweden. The social differences are reflected in risk factors as well as in physical and mental suffering, indicating a considerably poorer health situation within socio-economically disadvantaged groups (Bremberg, 2002). Additionally, there are extensive differences between the sexes, especially regarding mental ill-health; most evident is the over-representation of psychiatric symptoms amongst girls/young women compared to boys/young men, as well as the over-representation of suicide amongst young men compared to young women (Bremberg et al., 2006).

Due to the past decades’ rapid political and cultural changes, adolescents worldwide experience increasingly complex challenges, particularly regarding reproductive health problems. In parallel, adolescent health care has gained increased attention, and the concept of youth-friendly care is advancing (World Health Organization, 2009b). In order to be youth-friendly, WHO require health services to fulfil equitability, accessibility, acceptability, appropriateness and effectiveness, which correspond well to the AAAQ-framework.

In a systematic review, Ambresin, Bennett, Patton, Sanci, and Sawyer summarised 22 articles with the ambition to define adolescents’ perspectives of youth-friendly health care (2013). Eight domains emerged as central to young peoples’ positive experiences of care: accessibility, staff attitudes, communication, medical competency, guideline-driven care, age appropriate environments, youth involvement in care and health outcomes. In another review, focusing on young peoples’ perceived barriers to accessing health care, Tylee, Haller, Graham, Churchill, and Sanci (2007) emphasised insufficiencies related to availability, accessibility, acceptability and equity. In both articles, authors stressed the heretofore absence of self-report and adolescent-oriented measures of health care – i.e. health care content and performance proceeding from adolescents’ own preferences – in spite of growing overall awareness and development of the field. Moreover, whereas many studies include comparison of developing and developed countries, few studies have investigated potential variation between different neighbourhoods and contexts within countries (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013; Tylee et al., 2007). Taken together, there is a current gap of knowledge regarding adolescents’ own experiences and needs in relation to health care that concerns them, and in particular regarding potentially distinctive features of needs in relation to local and socio-economic contexts.

Adolescent health services, sometimes referred to as youth centres or youth-friendly clinics, were first initiated in Sweden in 1970 due to growing demands for health care focusing on adolescent
health exclusively (Wiksten-Almströmer, 2006). The services are directed to young men and women 12–25 years, and offer individual visits and group treatment, as well as outreach work such as school visits and participation in local communities and events. Central in every task is health promotion, and the holistic perspective requires a broad competence amongst the staff, which should at the least include midwife, psychologist and/or social worker and physician. Visits should be optional and free of charge. To further ensure equal treatment, special efforts to increase awareness about and inclusion of different sexual orientations, disabilities and different cultural and religious backgrounds are particularly highlighted in the policy programme of the adolescent health services, as is gender equality and the fact that boys generally are under-represented as visitors (Wendt and Leijen 2015). Routines for confidentiality comply with national regulations, with health care professionals prohibited from revealing any personal information without the patient's consent. Exceptions exist for children and adolescents below the age of 18 – though the exact age limit is not fixed but referred to as case-specific – regarding parents or legal guardians being entitled to information about their children's health as well as health care professionals being obliged to take action if suspecting young patients being harmed or subjected to crime.

This study

The Adolescent Health Service at Angered Hospital is part of the 'first line' health care for young people in north-eastern Gothenburg, Sweden. The area consists of the two districts Angered and eastern Gothenburg, with a population of roughly 95,000 inhabitants whereof almost 50% are born outside Sweden (Social Analysis and Statistics, 2013a, 2013b). In comparison with the average in the county of Västra Götaland, socio-economic disadvantage and high-risk lifestyles have substantially higher prevalence amongst children and adolescents in this part of Gothenburg (Healthcare Committee Office of Gothenburg, 2010). Furthermore, north-eastern Gothenburg presents the highest prevalence of self-reported physical and mental ill-health in the region (Region Västra Götaland, 2012).

The Adolescent Health Service at Angered Hospital was initiated in 2011. A needs analysis conducted before the opening highlighted adolescents' perceptions of adolescent health services, difficulties in the dialogue between young people and their parents and differences between girls and boys (Angered Hospital & Centre of Equity in Health, 2011). Generally, adolescent health services were regarded more associated with girls than boys, in accordance with statistics from other youth centres throughout the country.

Since the Adolescent Health Service at Angered Hospital began its operations, there has been no systematic enquiry into why young people choose to visit the service or not, what different conditions that facilitate or obstruct a visit and to what extent the service meets expectations of girls and boys in the area. Moreover, while education and research have been emphasised as instrumental in meeting new challenges associated with segregation and health inequities, there is currently a scarcity of research focusing on the intersection of medicine, equal health care, social inequalities and ill-health, integration and migration. This does not only illustrates the importance of continuous evaluation of young peoples' conceptions and needs in relation to health care offered to them, but also a need for elucidation of the interplay between different aspects of contemporary health care (Siegrist & Marmot, 2006).

The purpose of this study, then, was to evaluate the work of and accessibility to the Adolescent Health Service at Angered Hospital in order to identify factors that may facilitate or impede access to and visits at such services, particularly those based in socio-economically disadvantaged and/or multi-cultural areas. By elucidating adolescents' opinions, fears and wishes with regard to adolescent health services, these may be further developed in order to reach young people who currently do not access and potentially benefit from their services. Thus, this study specifically aims to address the following research questions: how do young people conceive the concept and work of adolescent health services?; which needs do young people have with respect to adolescent health services?; which experiences do young people have of adolescent health services?; and, which factors could facilitate access to and visits at such services for young people?
Method

Study design

The study was designed in collaboration with staff at the Adolescent Health Service at Angered Hospital. As adolescents' opinions and attitudes constituted the main focus of this study, a qualitative, inductive method was chosen because such methods are preferable when focusing on questions such as 'how' and 'why'. Furthermore, while self-perceived events and opinions may be examined through individual interviews, focus groups are arguably favourable when exploring experiences, approaches and attitudes in contexts that include interaction between people. This may be particularly applicable to adolescents who, in their development, often naturally socialise and discuss developmental issues in groups. Hence focus groups as the chosen data collection method.

Recruitment and data collection

As prior experiences indicate that collaboration with schools and established adolescent services are most advantageous for recruitment of youth, recruitment of participants was carried out in cooperation with the school health services at two upper secondary schools and with a local non-profit organisation in Gothenburg. Contact with the two schools' welfare officers and the business developer at the non-profit organisation was initially established by the first author via telephone, upon which written information about the study was sent. These contact persons forwarded the enquiry to teachers at the two schools and to a suitable member of the non-profit organisation respectively, who subsequently put together groups of participants with consideration to the aforementioned information by bringing together volunteering students in the schools, and friends and acquaintances within the non-profit organisation.

Participants – 11 girls and 12 boys over the age of 15 years – were divided into 4 different focus groups, consisting of either 5 or 6 girls or 6 boys. (In order to respect confidentiality, no personal data, including exact age, were collected.) Bearing in mind the potential disadvantages of convenience sampling compared to probability sampling in terms of possibly limited variability, the principle of 'first come, first served' was applied due to pragmatics, resulting in inclusion of the first four groups recruited. Since recruitment was carried out within school classes and the local non-profit organisation, participants in every group knew one another prior to participation; however, potential inter- and intra-group relations beyond this were unknown to the researchers.

All focus groups were conducted by the first author. Discussions were initiated with an information session upon which written consent was obtained. Participants were provided with a Participant Information Sheet and reassured that confidentiality would be maintained throughout the entire study process. In particular, the option to retain as well as to share thoughts, opinions and experiences was stressed, as was the importance of mutual consideration and respect amongst participants both during and after the discussions. Focus groups were semi-structured to ensure inclusion of the main issues in relation to the study purpose. Discussions were audiotaped and transcribed verbatim. Participants received one cinema gift voucher each for their participation. All data were stored securely at the University of Gothenburg.

Data analysis

Data were analysed using thematic analysis (Braun & Clarke, 2006). Transcription and analysis was performed by the first author; the final analysis was validated in consultation with co-authors and the Head of the Adolescent Health Service at Angered Hospital. After transcription, reading and re-reading of data followed in order to familiarise with the content. Notes were simultaneously taken to create an initial list of ideas about the content of the data corpus, generating a starting-point for the following production of codes. In compliance with the inductive approach, the ambition was to allow the findings to depend on the data exclusively, avoiding coding around pre-existing theories or hypotheses.
The coding procedure as such entailed identifying data segments relevant to the research questions, coding these according to content and meaning and collating extracts relevant to each code. During the next phase of analysis, the codes were grouped based on similarity in content and meaning, thus forming potential themes. Gradually, main themes and subthemes were identified. Finally, themes were reviewed on two levels: from top to bottom, ensuring that themes and subthemes correspond to encompassed extracts and codes, and from bottom to top, ensuring that extracts are illustrative of the formulated themes. Selected extracts were translated by the authors.

Ethical considerations

The study protocol was reviewed and approved by the medical degree course administration at the Institute of Medicine, University of Gothenburg, as well as the Head of the Child and Adolescent Services at Angered Hospital. Data collection via interviews entail unique possibilities to reach in-depth understanding of the topics at hand, which is fundamental in qualitative research. Since using personal narratives carries the risk of awakening affections and memories of both positive and painful nature – which during focus groups are also exposed to other participants – extra care was taken to ensure a comfortable and encouraging environment for conversation. In the ethical balance, however, it is also important to consider the potential advantages of participation in potentially sensitive research and the disadvantages of withholding such research. As for the former, being able to share opinions and to contribute to development and progress may be regarded as strengthening and positive for the participant. Concerning the latter, avoiding particular research due to a (perceived) sensitivity of topics could rather be unethical since it could potentially withhold indispensable information, enabling further understanding, development and possibilities for improvement (Fiske, 2009).

Results

The results are presented in relation to the four research questions: young peoples’ conceptions of adolescent health services, their needs with respect to the same, their experiences of adolescent health services and factors that could facilitate access to and visits at such services. In extracts, letters denote informants, ‘All’ is general agreement within the group, and ‘Int.’ the interviewer.

Young peoples’ conceptions of adolescent health services

Most apparent in participants’ conceptions of adolescent health services was the coexistence of positive associations in terms of obtaining help, information and support, and negative associations with something embarrassing, private and uncomfortable. Moreover, girls, boys and their parents (as reported by the participants) perceived adolescent health services to be closely associated with sex. A contributing factor to this effect is how the services commonly and widely distribute condoms. Parents in particular were believed to have poor knowledge about the work of the services, which may result in their disapproval of their children visiting them.

Extract 1 (male group):

A: Well, and then it’s like, ehm, most parents have a quite distorted picture of the adolescent health services, where they may think, if their daughter is visiting the services, well, they will think ‘but she has had sex! What are you going to do there? Abortion?!’ And she may be marked with shame. I’ve met quite a lot of female friends who have ended up in that situation, so to speak. So it’s also, as they say, too little information for the parents.

Furthermore, girls, boys and – according to the youth – parents perceived adolescent health services to be more associated with girls than boys – partly due to the perception of the services being more accommodating to the panorama of female issues such as menstruation and contraceptives, and partly to ideas of femininity and masculinity, which were prominent in all groups.

Due to the notion of men not being allowed to be emotional or seek care, participants expressed girls’ use of psychological services as more accepted than boys. ‘Fear of the truth,’ with reference to
discovering something medically atypical or pathologic (e.g. an STI), was also emphasised as a reason for boys not to seek care. The role of media in distorting images of femininity and masculinity was highlighted, and pornography and rap music were mentioned as factors contributing to expectations on boys to be ‘macho’ and look down on girls. These negative attitudes towards girls proceeded, however, not only from others but just as much from girls themselves. This arose partly from the high pressure on girls to balance traditional demands and religious concerns with modern social expectations, which entailed balancing the avoidance of, for example, sex, parties and alcohol in their endeavour to not be ‘dirty’ on one hand, and the avoidance of being regarded by peers as boring or traditional when refusing these matters on the other.

Extract 2 (female group):

A: I think girls are much more, ehm, careful when it comes to …
B: … sex …
A: … sexually transmitted infections and so on.

/…/

A: Yea, I really think so. I think that there are lots of societal demands, I mean many things come into this question, I mean there are lots of societal demands on a girl that she should be a, well, ‘a good girl’, ehm, she shouldn’t have any sexually transmitted disease, it’s something weird … I think that if we were sitting in a classroom, and a boy said that he has a sexually transmitted disease, it would have been like ‘eww!’, but I mean, I don’t think you would have judged him that much, but if a girl had said it, then it would have been like ‘oh but … my god, she is dirty!’ /…/ Especially here in our neighbourhood, ‘cause there is lots of people who have that idea about women, that, well I don’t know, that traditional, disgusting idea.

Participants expressed that girls are seldom allowed to be associated with sex or sexual activity. Girls perceived to be sexually active are often referred to as ‘hoes’ or ‘bitches’ or, unlike boys, considered ‘dirty’ or ‘guilty’. In contrast, boys collecting condoms at adolescent health services were frequently reported as a prevalent and accepted occurrence. At the same time, however, participants reported that girls are commonly considered to be solely responsible for protection against pregnancy and STIs. Thus, while on one hand, it was considered more standard for girls to visit adolescent health services, it was also considered more problematic for them to do so due to the services’ association with sex. Taken together, participants’ conceived adolescent health services to be associated with help and support, embarrassment, sex and girls.

Young peoples’ needs with respect to adolescent health services

As the most important reason for visiting the adolescent health services, participants reported a need for information or help with physical as well as psychological issues. All groups emphasised adolescence as a period of transformation associated with new and sometimes unfamiliar phenomena, both physical and psychological, and consequently an increased need to discuss questions and concerns. In the female groups, problems with menstruation were raised as a common reason for girls to seek care, while the male groups repeatedly mentioned testing for STIs and collecting condoms as their main reasons. Additionally, unwillingness or inability to talk to one’s family about various problems was discussed in all groups, clarifying the need for seeking external instances such as adolescent health services for counselling purposes.

Also evident was the need for more information on the scope of adolescent health services: their purpose and their work – both in terms of what work they do and how they work. Here, poor knowledge of the diversity of the services offered, amongst youth as well as parents, was especially emphasised.
Extract 3 (female group):
A: Then I don't think that lots of people know that there are many things there. That there are welfare officers, 'cause I mean you don't need to visit the services to talk only about love problems, but you can visit, I mean … And there are, if you are going to stop smoking for example, lots of things, ehm, skin problems, for example acne and so on. Everything. I don't think lots of people know that, but rather, when somebody says that 'yea, but I'm going to visit the adolescent health services', then you think as the first thing that it's something like that, but well, in reality it's not only that.

With such services predominantly being associated with sex, shame and fear of being exposed in such a manner were frequently reported as essential reasons for not visiting the services. Being unaware of the different areas of the services' work was generally believed to contribute to scepticism towards the services, amongst both adolescents and parents. Religious concerns and specific conditions in north-eastern Gothenburg, especially in terms of high prevalence of people with Muslim background, were raised by the participants who repeatedly highlighted differences between north-eastern Gothenburg and other parts of the city or the country in general.

Taken together, these challenges may generate extra need for information on the scope of adolescent health services, to youth as well as parents. The effects of religion, commonly referred to by participants as parents' faith, were repeatedly discussed in all groups. Amongst others, such effects entailed disapproval of sexual activity and contraception. This disapproval was considered the root of parents' negative perceptions of the services – which in turn impeded visits to the services, especially for girls, as previously discussed.

Moreover, the first female group highlighted the contradiction between religion and psychotherapy, since mental health difficulties are supposed to be solved with help of one's faith. Consequently, the need for seeking mental health care elsewhere is regarded as a failure, resulting in scepticism amongst religious parents towards the adolescent health services and their children visiting them.

Extract 4 (female group):
A: /…/ … most immigrant parents think that you can solve your problems on your own. /…/ They don't believe in, like, psychology at all. /…/ It's like, religion, like, if you have a good relation to your religion, then you can kinda solve your life, or cope with this life.

With respect to these many issues, participants repeatedly expressed a need for attitude change, generally as well as specifically, concerning the adolescent health services.

In terms of how adolescent health services work, lack of knowledge amongst adolescents about confidentiality was frequently reported as an important reason for avoiding seeking care at these services – a concern in general but perhaps in particular for girls with regard to abortion, fearing that information may reach their families.

Extract 5 (male group):
A: Well, I don't think that there is enough information to young people, especially about how anonymous you can be. 'Cause ehm, I've met quite many who for example perhaps need to do an abortion or something like that, but don't really dare to turn to the adolescent health services 'cause they don't know. So they need to take some roundabouts and so on before they … 'okay but perhaps I should visit'. So … so there should be a whole lot … much more information, maybe even studies during high school, or primary school. 'Cause we, for example myself, what do I know except to go and get condoms from the services, or … send a girl there who needs to do an abortion? More than that I don't know, I mean.

In sum, need for information and help with physical and psychological issues was the primary reason for participants visiting the adolescent health services. Uncertainty about confidentiality as well as fear of being exposed in connection with the services and thereby in connection with sex were generally mentioned as main reasons for avoiding them. Boys, compared to girls, were commonly regarded as more inclined to refuse to visit the services. Thus, participants expressed a need for more information on the scope of adolescent health services, not least services not connected to sexual health, for both youth and parents.
Young peoples’ experiences of adolescent health services

Experiences of visiting the adolescent health services were generally discussed in favourable terms, especially with regard to the staff. Participants frequently reported feeling welcomed and accepted, listened to and taken seriously and receiving attention and help in desirable manners.

Almost without exception, participants’ initial point of contact with the services was through schools, either by visiting such during class or by being visited by the services’ staff through their outreach work. Participants mainly considered these experiences positive.

Furthermore, confidentiality was raised as being of utmost importance. As mentioned, poor knowledge of procedures concerning confidentiality contributed to insecurity and scepticism towards adolescent health services, while knowledge of the same was described as resulting in confidence and security. Strictness amongst staff concerning whether parents should be informed about their children’s visits was especially appreciated.

Extract 6 (male group):

A: It feels like, if you sorta ever visited them to talk to somebody, then you would know sorta that it would stay between us, and that the person wouldn’t disseminate something. It’s like, security.

Amongst negative experiences of adolescent health services, several female participants reported mistakes in prescribing of contraceptive pills, for example staff referring to different kinds of pills, and receiving unsuitable pills resulting in the girls becoming ill. More commonly, informants in all groups reported having experienced complicated or defective booking systems or insufficient opportunities for drop-in. Regarding the former, being unable to talk to somebody immediately but rather being phoned up later was mentioned as problematic, as were difficulties when trying to use the answering machine. With regard to drop-in, both visiting hours and consultation topics offered during drop-in hours were reported as insufficient.

Extract 7 (female group):

Int. What is it that could be improved, then?

A: Ehm, what's the word, this ... the visiting hours. Or I mean like, the drop-in clinic and so, and then that you perhaps should receive some more help, or I mean like ...

B: Yes, more offered consultation at the drop-in clinic, and that they examine more.

Important, and emphasised in all groups, was also the adverse impact of the service’s distribution of, and thus association with, condoms. Above all, participants frequently highlighted focus on condoms as inevitably contributing to the connection between adolescent health services and sex, both amongst young people and adults, consequently resulting in unwillingness or fear of being associated with the service. Another aspect of excessive condom distribution was repeatedly discussed in the second male group in terms of risks that go with promoted sexual activity and usage of condoms without appropriate information about size or how to manage them in practice.

Extract 8 (male group):

A: But like he says, it’s nor so that everybody has the same size, so then, imagine if somebody has one that’s too small. It has happened several times during everything, they believe that ‘I’m protected’, but then it bursts without them knowing, and then they receive that ejaculation inside, then it’s almost over. So it’s also that ... it’s not only to distribute, no matter how, you have to know, you have to have information, ehm ... Every condom is different. What you are going to do. So, it should be somewhat adapted to you ...

In short, positive experiences of adolescent health services were widespread, specifically with regard to the staff’s approach and confidentiality. Negative experiences included issues related to contraceptive pills, difficulties with booking systems and shortage of drop-in opportunities, as well as unfavourable effects of condom distribution.
Factors that could facilitate young peoples’ access to and visit at adolescent health services

With regard to factors that could facilitate young peoples’ access to and visit at adolescent health services, three main topics were frequently discussed in all groups: extensive information about the services, familiarisation with the services and participation in the activities offered and practicalities. As for information, suggestions offered by participants proceeded from their previously mentioned experiences. For example, more information about confidentiality was proposed. Also, the association between adolescent health services and sex was problematic in various ways which, as mentioned, was often due to insufficient knowledge of the services’ scope. Especially female participants considered boys to be in need of better information; boys’ insufficient knowledge about what the services offer was regarded as a major contributor to their avoiding the services.

Extract 9 (female group):
A: I think that’s the thing, they probably need more information, boys I mean, what it is that can …
B: Yes, what they can help boys against, maybe.
A: Yes, what boys might need help with, I think that’s what might be needed, and kinda where you can receive it.
C: ’Cause we know that we can talk to them … or we know what we can talk to them about.
A: But I don’t think boys …
C: … I don’t think they know …

Parents too were specifically highlighted as having insufficient knowledge about the services, and therefore a sometimes distorted picture of them, which in turn often resulted in inconvenience or impossibility for adolescents to be connected with their activities. Thus, parental education was believed to be instrumental, enabling parents to approach the services from another starting-point than sex and sexual activity.

Consequently, elimination of association with sex was regarded as highly important according to most participants. Important to clarify in this regard, however, is the frequently reported opinion that sex per se should not be excluded, but the association with sex should be eliminated. Broadening the information about the diversity of the services as well as active exclusion of sex and condoms in certain situations was suggested. Also, adding new activities of a different character to the existing work areas, for example study groups and development projects, was suggested to perhaps have the same effect.

Extract 10 (female group):
A: Well I think like initially, the adolescent health services, when they first came to my school, like in the eighth or ninth grade, then they come with condoms, and all the boys took condoms and kinda like lay water balloons, and then like, ‘this place is only a sex-place, I mean, you only visit them if you will have sex or something’. So stop distributing condoms when you go out in the seventh or sixth grade! ‘Cause it demonstrates, or they talk about things but we only focus on the condoms.

Amongst arenas for communication, schools were considered to be the most important and easily accessible, and both direct communication between the services and students and indirect information through teachers were discussed. Advertisements outdoor, in newspapers and on the Internet (including social media such as Facebook and Instagram), information by post or telephone calls and outreach work at venues other than schools were frequently suggested. Moreover, using existing adolescent forums in the area as starting-points for communication and cooperation between young people and the adolescent health services was proposed.

Extract 11 (female group):
A: Do you know what our immigrant parents would love? If you would, like, be able to organise some homework help thing, and I mean, and advertise that instead, and then write like ‘this is the adolescent health services’, then probably the parents will start to get that ‘my god, they probably have different projects going on’.
With regard to familiarisation and participation, the importance of being ‘at-ease’ and familiar with the concept of adolescent health services, and with the idea of visiting them, was repeatedly mentioned in all focus groups. As facilitating factors in this respect, personal experiences of adolescent health services told by celebrities, friends or staff from the services were suggested. Likewise, involving young people in the work, both concerning dissemination of information at schools and in the different activities at the services, was suggested to facilitate adolescents’ familiarisation with the concept.

Extract 12 (male group):

A: You can have like, if there is any bullying, then you can have persons who have been in the same situation, and … Who are sorta experts on that thing, who can sorta help … help that person to … change it, try to find solutions, to not, are you bullied and … well …

B: … and it’s always easier for a person who are bullied to talk to someone who have been bullied, ‘cause they have been in the same situation. So, in certain situations where someone who is bullied wants to talk to, tries to talk to a person, then it might be for the best to use someone from the staff who also has experienced the same … well … to reach … yea.

With regard to practicalities, appointment-booking system, drop-in clinic, visiting hours and reception area were all discussed as potentially benefitting from modification. Once again, participants’ suggestions proceeded from their previously mentioned experiences: expansion of the drop-in clinic, both with regard to number of offered consultation topics and visiting hours, and the possibility to speak to somebody in place instead of calling the answering machine. As a consequence of the adolescent health services being more associated with girls compared to boys, efforts to facilitate access for boys were promoted, particularly by female participants, although without specifying such efforts. Perhaps an idea presented by the first male group, that both girls and boys may benefit from gender-specific visiting hours, may be one such effort.

Finally, different opinions about the entrance of the adolescent health services being visible or hidden were shared, without reaching consensus within any of the groups. It is neither desirable to fuel the picture of the services as something shameful by hiding their existence, nor to create a potential barrier for those who are not allowed or unwilling to visit the services by publicising their entrance. Most participants agreed, however, on the idea to offer both alternatives. Taken together, facilitating factors generally included extensive information about the service’s confidentiality and diversity, the latter as an effort to eliminate association with sex; familiarisation with the services; and practicalities concerning accessibility thereto.

Discussion

Main findings

In the current study, focus groups with 23 adolescents from an area facing both demographical and health-related challenges were conducted with the purpose of evaluating the work of and accessibility to adolescent health services with the ambition to identify factors facilitating access to and visits at such services. In sum, adolescents’ approach to the services comprised of feelings of being supported, respected and cared for, as well as embarrassment and fear of information dissemination to parents and friends. With regard to ideas about girls and boys in relation to adolescent health services, girls were generally regarded as more subjected to negative attitudes associated with traditional or religious considerations which impeded their access to the services, while boys were considered being subjected to norms of masculinity, and therefore not accepted to be in need of support at the services. Moreover, girls were generally regarded being under higher pressure than boys in terms of balancing traditional demands and religious concerns with modern social expectations. Overall, adolescent health services were considered more connected with girls than boys. The close association between the services and sex was reported as a barrier, especially in relation to parents. Concerning young peoples’ needs in relation to the services, extended information to both adolescents and parents was consistently
requested, as well as efforts to increase familiarisation with the services and elimination of the close association with sex.

As demonstrated in our study, Tylee et al. (2007) argue that while many developing countries still struggle with limited availability to health services, deficient accessibility to and acceptability of youth-friendly care – especially concerning confidentiality and lack of information about the services offered – are the main issues in the developed world. Our findings are also in line with those of Ambresin et al. (2013) who found that friendly and respectful staff stood out as universally applicable, while other matters – such as the critical importance of confidential reproductive health care for adolescents with Muslim background – seemed to be more context-specific, indicating the importance of considering local particularities when studying youth-friendliness of health care. As mentioned, there is a current knowledge gap concerning young peoples’ own experiences and needs in relation to health care that concerns them, especially regarding potentially distinctive features of needs in relation to local and socio-economic contexts. By addressing young peoples’ thoughts, fears and wishes in relation to adolescent health services in a multicultural and socio-economically disadvantaged area, with this study we hope to contribute to increased understanding and diminishing of the knowledge gap.

Revisiting the right to health

Revisiting the right to health and health equity, adolescent health services are believed to play an important role in the protection and implementation of these rights on young peoples’ behalf. According to the General Comment No. 14, health care of all UN states must be available, accessible, acceptable and of good quality (AAAQ) (UN CESCR, 2000). The establishing of adolescent health services could be regarded as an effort to increase availability to health care for young people. Regarding accessibility, visiting adolescent health services in Sweden is always free of charge, as is condom distribution, whereas remaining forms of contraception usually is discounted up to the age of 20 years. Outreach work presumably contributes to fulfilling information accessibility requirements; however, as highlighted by participants in this study, information about diversity of the services and confidentiality requires particular attention. Respectful and supportive attitudes amongst staff appear to contribute to acceptability of such services, as well as to good quality.

As factors rather reducing acceptability, close association with sex as well as insufficient options for appointment booking and drop-in should be stressed. Based on findings of the current study, the former seemed to be a concern especially in relation to parents and/or religion, but was also impeding irrespective of culture and gender. The latter, in turn, could potentially reduce both availability and acceptability if booking and drop-in procedures constitute obstacles for young people trying to visit. Finally, the greater tendency amongst boys compared to girls to avoid visiting the adolescent health services ought to be discussed in relation to the AAAQ framework, to identify barriers to accessibility and acceptability for boys. As formulated in General Comment No. 14, health care must be ‘respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned’ (UN CESCR, 2000, p. 5). Hence, the current gender imbalance may be either a result of potential shortcomings in relation to boys’ acceptability requirements, or merely different needs amongst girls and boys. Preferentially, future research may thus consider investigating potential differences between the sexes, particularly in terms of visiting patterns, to better understand boys’ greater avoidance, as well as how to involve them to a larger extent.

As mentioned, today’s adolescent health care faces multiple challenges in terms of young peoples’ specific panorama of physical and mental health issues (The National Board of Health and Welfare, 2013), but also as a result of increasing socio-economic inequality reflected especially in higher prevalence of mental ill-health within socially disadvantaged groups (Bremberg, 2002; Ministry of Health and Social Affairs, 2002). This broadness of problems associated with adolescence was illustrated in the current study through the variety of matters brought up during group discussions, with physical issues as well as the need for mental support being emphasised as important reasons for visiting the services.
In addition, responsiveness with regard to gender equity, different sexual orientations, disabilities and different cultural and religious backgrounds is fundamental in order to ensure universal availability and treatment. In line with previous research (Angered Hospital & Centre of Equity in Health, 2011), participants’ accounts of sexual relationships always entailed heterosexual ones – other sexual orientations were never touched upon. Whether this reflects a taboo, a lacking need amongst adolescents to include this perspective, or was a result of the specific contexts of these studies requires further investigation. Explicitly addressing this matter in future research may be valuable, not least given adolescent health services’ non-discrimination statement and policy programme, which emphasise the importance of including different sexual orientations (Wendt and Leijen 2015).

In contrast to previous findings (Angered Hospital & Centre of Equity in Health, 2011), different cultural and religious backgrounds, religious considerations and negative attitudes towards girls and young women were frequently discussed during the focus groups in the current study, as were the specific conditions of north-eastern Gothenburg. Whether this discrepancy indicates a growing societal problem, an increasing awareness of these issues amongst youth, or is a result of different group constellations and conversation settings across the two studies is yet unclear.

Finally, stressed in both the previous (Angered Hospital & Centre of Equity in Health, 2011) and the current study was the need for extended information and efforts to enable familiarisation with the services. In this regard, new arenas for information to and involvement of adolescents were suggested, such as social media and websites, perhaps illustrating increasing usage of such forums amongst young people today, but also somewhat new channels for reaching out to adolescents.

**Practical implications of study findings**

The findings of our study have a number of practical implications for adolescent health services. In order to adapt such services to the needs of target populations and thereby facilitating access to and visits as such services, we argue that three aspects are particularly potent: information, familiarisation and participation, and practical arrangements.

Information primarily entails marketing and outreach work, and should emphasise the purpose of the services, the specific activities and consultation areas offered, service procedures and policies regarding confidentiality. This in order to increase awareness and knowledge of such services and overcome obstacles arising from the common perception of adolescent health services working only or primarily with sexual matters. Of further importance is to direct this information to adolescents as well as parents. Adolescent health services are rather well-established in the Swedish society, but their existence and the diversity of their activities are sometimes less well-known, perhaps particularly to those born outside of Scandinavia. However, irrespective of country of origin, this study indicates that a close association with sex appears to be widespread amongst parents in general, illustrating the need for a broad approach when disseminating information. Deliberate and strategic decisions concerning promotion or exclusion of sex-related issues in marketing and outreach work are elemental.

Schools may act as a possible initial arena for disseminating information and initiating contact between adolescents and parents and the services. In addition to schools, alternative starting points for contact, such as residents’ associations or local organisations, might be taken into consideration to thoroughly ensure involvement of families whose children do not attend school. Moreover, targeted marketing to parents in terms of letters, advertising posters and newspaper advertisements could all be possible channels for increasing their knowledge of adolescent health services. Continuous evaluation and improvement of outreach work and marketing efforts are crucial in order to ensure continuous adaptation of the services to needs of the target population.

With regard to familiarisation, efforts to facilitate young peoples’ relating to the adolescent health services, in terms of feeling familiar with the concept of such health care services and feeling ‘normal’ and at ease when visiting, is also crucial. Measures in this regard should focus on providing references and role models for girls and boys for normalising the concept of adolescent health care as well as countereacting negative attitudes, prejudices and obstacles in relation to such care. Especially important is to
actively work with ideas of femininity and masculinity and the under-representation of boys amongst visitors to adolescent health services in order to identify suitable interventions for reaching boys and young men. As role models, celebrities as well as local service staff and young people could be involved in above-mentioned efforts. Likewise, as arenas for information and familiarisation, websites and social media are most likely of use when working with young people.

Successful participation entails not only participation by the young people but also by those who support them, such as their parents. Parents’ understanding for, acceptance of and participation in adolescent health services has a potential to increase acceptance also among the young, and thereby increase their access to such services. Hence, in order to fulfil the AAAQ-framework, adolescent health services must be acceptable not only to young people but also to those who support them. This requires involving and allowing adolescents and their support networks to influence the health care that concerns them.

With regard to practical arrangements, offering generous opportunities for drop-in and time reservation is recommended. More investigation is needed, however, in order to reach consensus about optimal solutions for entrances to adolescent health services and the possibility of separate visiting hours for girls and boys.

As a final note, ensuring respectful and supportive attitudes amongst staff across all work and interventions is of utmost importance as this was an essential aspect of adolescent health services according to participants of this study.

Limitations of the study

Some limitations should be considered when interpreting the study results. First, to achieve highest possible comfort for participants, they were not explicitly asked if they had ever visited adolescent health services or not, but allowed to speak either in general terms or from personal experience, as preferred. It is, therefore, important to bear in mind that participants’ accounts could in some cases be based on presumptions as opposed to originating from lived experiences. During discussions, however, most participants chose to speak openly about having visited the services.

Second, as a consequence of using schools and established adolescent organisations for recruitment, participants were believed to know one another prior to participation. Pre-set constellations of people may have internal social dynamics either facilitating or impeding different group members’ participation in discussions. Dominant members may navigate the conversations, thus contributing to a non-representative picture of the opinions within the group (Sandelowski, 1986). While qualitative research does not strive for representativeness or generalisability in the same fashion as quantitative research, applicability of the results of qualitative studies is nonetheless widely debated. Some claim that generalisability in qualitative research is impossible due to the uniqueness of every qualitative study situation and specific interaction between researcher, participant(s) and context, and therefore not relevant in qualitative research (Sandelowski, 1986). Others speak rather of transferability, arguing that it is ultimately up to the reader to decide whether findings are possible to transfer to other situations or not (Graneheim & Lundman, 2004). Irrespective of approach, detailed descriptions of study settings and samples are recommended to facilitate applicability of results to other contexts (Graneheim & Lundman, 2004; Sandelowski, 1986).

Furthermore, focus groups compared to individual interviews entail both benefits and disadvantages. One potential limitation is group dynamics or fear of feeling exposed if sharing personal experiences or saying something that contradicts others, which may hinder participants’ expressing of thoughts and opinions. On the other hand, participating as part of a group may result in feelings of security when partaking with others, especially with others familiar to them. Moreover, focus groups are presumably preferable to individual interviews when examining attitudes and approaches amongst groups of people, which was the case in the current study.
Conclusions

This evaluation of an adolescent health service in a district in a large Swedish city illustrates that, in order to be attainable, comfortable and encouraging for young people, such services would benefit from enhancing qualities such as competence, concern and respect amongst staff; ensuring acceptable practical arrangements; and tailoring efforts to disseminate information about and familiarisation with the services to both adolescents and parents. By providing accessible and acceptable health care for young people in an otherwise eventful and sometimes unstable period of age, adolescent health services can contribute to fulfilment of young peoples’ equal right to health and well-being.

Acknowledgements

Special thanks to the staff at the Adolescent Health Service at Angered Hospital for invaluable advice during the designing of this study. We would also like to extend our utmost gratitude to students and staff at the two upper secondary schools as well as staff and members of the local non-profit organisation for assistance with recruitment and participation in focus groups, without which this study would not have been viable.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

The Centre for Interdisciplinary Gender Research at the University of Gothenburg funded the cinema gift vouchers.

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