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Sexuality and health among young people in Sweden

UngKAB15 – a survey on Knowledge, Attitudes and Behaviour
among young people 16–29 years old.



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Preface

This report is about HIV prevention and parts of the area Sexual and Reproductive Health and Rights (SRHR) among young people in Sweden. The report is based on a randomised survey-based population study which was conducted in 2015. The point of departure of the study is the Public Health Agency of Sweden's work on the national strategy to combat HIV/AIDS and certain other communicable diseases (Government Bill 2005/06:60) and the work with the prevention group adolescents and young adults.

The report is mainly intended for employees and decision-makers within county councils, municipalities, civil society organisations as well as relevant authorities and professional associations. The report aims to contribute with knowledge for health promotion and disease prevention work.

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The Public Health Agency of Sweden, 2017

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Glossary

Bisexual: A person who is emotionally and/or sexually attracted to persons of the opposite and same sex. The definition is based on the assumption that there are two sexes.

Cisgender person: A person whose gender identity and/or gender expression conforms to the norm of the legal sex the person was assigned at birth.

Discrimination: Negative treatment or insufficient accessibility based on any of the grounds of discrimination.

Grounds of discrimination: Equal rights and opportunities irrespective of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age pursuant to the Discrimination Act (2008:567).

LGBTQ persons: An umbrella term for lesbian, gay, bisexual, transgender persons and persons with queer expressions and identities.

Heteronormativity: The assumption that everyone is heterosexual and that men are sexually attracted to women and vice versa.

Heterosexual: A person who is emotionally and/or sexually attracted to persons of the opposite sex. The definition is based on the assumption that there are two sexes.

HIV: Human Immunodeficiency Virus.

Homosexual: A person who is emotionally and/or sexually attracted to persons of the same sex. The definition is based on the assumption that there are two sexes.

Incidence: The number of new cases of a disease within a period of time, often one year.

Intersectionality: A social science analysis tool to study power. It aims to highlight specific situations of superordination or subordination which are created in points of contact for relations based on, for example, ethnicity, sex and socioeconomic status.

Legal sex: The sex stated in, for example, the national registration, in the passport and which regulates the structure of the personal identity number. There are two legal sexes in Sweden – male and female.

Equality or Equity: Equal rights and opportunities for all human beings.

Gender equality: Equal rights and opportunities for women and men.

Abusive treatment: Treatment or conduct which is perceived as derogatory.

Gender identity/gender recognition: The sex/sexes which a person feels they belong to. Some do not feel that they belong to any sex.

Equal treatment: That everyone should be treated so that they have equal rights and opportunities irrespective of the grounds of discrimination.

Norm criticism: An analysis tool which aims to study norms and values, also referred to as norm awareness.

Contraceptives: Medical aid or medicine which protects against pregnancy.

Contraceptive method: Medical aid which protects against sexually transmitted infections and/or pregnancy.

SRHR: Sexual and Reproductive Health and Rights.

Stereotype: Generalised mental view of how something should or ought to be.

STI: Sexually Transmitted Infection.

Transgender person: An umbrella term for persons whose gender identity and/or gender expression do not conform to the norm of the legal sex they were assigned at birth.

Queer: A theory which analyses sex and sexuality. Queer theory goes beyond the binary gender norm and the assumption of heteronormativity.

Mutual sexuality: An alternate and joint structure of sexual acts on equal terms and with respect for the will of those involved, where a no is always respected.

Summary

Sexuality and health among young people in Sweden

UngKAB15 – a survey on Knowledge, Attitudes and Behaviour among young people 16–29 years old

The point of departure of this report is the Public Health Agency of Sweden's monitoring of efforts made to prevent HIV among adolescents and young adults in accordance with the Government Bill 2005/06:60 and the National Action Plan against Chlamydia. The report describes young people's sexual and reproductive health. The analyses are based on 7,755 responses from young people aged 16–29 years in Sweden. The response rate was 26 per cent. The collection of data was carried out by Statistics Sweden (SCB) and the study is a randomised, stratified and survey-based population study. In this summary the report's main results and conclusions are presented.

Background variables: The analyses are based on 50 per cent boys, 49 per cent girls and 1 per cent non-binary gender.¹ A total of 1 per cent were transgender persons. The group of non-binary gender and the group of transgender persons sometimes overlap, but not always. One-tenth of the respondents were born in another country, mainly in Asia, Europe (excluding the Nordic countries), South America and Africa. There was a tendency of girls having a slightly lower income than boys and a higher proportion of girls had a university degree.

Health, relationships, discrimination and violence: A total of 80 per cent reported good or very good health, a higher proportion of boys (82 per cent) than girls (77 per cent) reported this. A total of 22 per cent reported that over the past 12 months they had experienced discrimination or abusive treatment. A higher proportion of girls (29 per cent) than boys (15 per cent) reported having experienced some kind of discrimination or abusive treatment. Among non-binary gender persons the proportion was 51 per cent (CI: 39.4–63.4). A total of 6 per cent reported having been subjected to

1. Read more about the group non-binary gender in the chapter "Methods".

physical violence over the past 12 months. The most common place where girls were subjected to violence was at home (35 per cent) whereas for boys it was in a public place (50 per cent).

Sexuality: A majority of the respondents (56 per cent) reported that they were quite or very satisfied with their present sex life, and 95 per cent reported that their most recent sexual encounter had been in a safe place where they felt secure. 80 per cent of the respondents considered it important to be able to talk about sex with their partner – a higher proportion of girls (84 per cent) than boys (77 per cent) reported this. In total, young people defined their sexual identity as follows: heterosexual (83 per cent), I don't usually categorise myself sexually (5 per cent), bisexual (5 per cent), I don't know (3 per cent), homosexual (2 per cent), and other (1 per cent).² A higher proportion of boys (3 per cent) than girls (2 per cent) had their most recent sexual encounter with a same-sex partner. A total of 40 per cent reported that they had experience of sexual acts against their will at some point in their lives. A higher proportion of girls (54 per cent) than boys (27 per cent) had at some point been subjected to this. Among non-binary gender persons, 53 per cent had been subjected to sex against their will (CI: 41-65.8). A total of 3 per cent had experiences of buying or selling sexual services/reimbursement for sex. A relatively equal proportion of girls (3 per cent) and boys (2 per cent) had experiences of being paid/reimbursed for sex. However, a larger proportion of boys (5 per cent) than girls (1 per cent) reported that they had paid/given reimbursement for sex.

Contraceptive methods and contraceptives: A total of 89 per cent considered it important to use contraceptives to prevent unwanted pregnancies. An equal proportion stated the importance of protection against sexually transmitted infections in a sexual relationship. The protection young people were most likely to consider using was condoms (88 per cent) followed by contraceptive pills (47 per cent). However, the most common protection used during their most recent sexual encounter was the opposite, namely hormonal contraceptives (50 per cent) followed by condoms throughout sexual intercourse (25 per cent). Furthermore, a higher proportion of boys (4 per cent) than girls (1 per cent) reported that they did not want to use a con-

2. The report does not contain decimals, therefore, the sum is not always 100 percent.

dom and that they would be annoyed if their partner suggested it. A higher proportion of girls between the ages of 16 to 19 (80 per cent) were likely to consider using hormonal contraceptives compared to girls between the ages of 25 to 29 (50 per cent). Among those girls who could not afford hormonal contraceptives the highest proportion was found among girls between the ages of 16 to 19 (4 per cent).

Sexually transmitted infections: A total of 11 per cent stated that they have had chlamydia, which makes it the most common sexually transmitted infection among young people. Regarding all sexually transmitted infections, HIV and hepatitis, a higher proportion of girls (67 per cent) than boys (40 per cent) had at some point been tested. Among young people between the ages of 16 to 19, three times as many girls as boys reported having been tested for chlamydia. A higher proportion of girls (79 per cent) than boys (63 per cent) stated that it is important to get tested when you are in a sexual relationship. Out of the 53 per cent who had at some point been tested for a sexually transmitted infection, HIV or hepatitis, 49 per cent had professional counselling on risks and protection on the occasion of their most recent test. A higher proportion of girls (51 per cent) than boys (46 per cent) had such counselling, and a higher proportion of girls (60 per cent) compared to boys (45 per cent) stated that the counselling had motivated them to use protection.

Unwanted pregnancies and abortion: A total of 16 per cent reported that they had experience of themselves or their partner having an abortion and over half of the respondents (58 per cent) reported that they or their partner had seen a counsellor, midwife or doctor for professional counselling. Of those who had counselling, 27 per cent were motivated to consider how to protect themselves in the future. A higher proportion of girls (42 per cent) than boys (20 per cent) reported that counselling had increased their knowledge of how to protect themselves against unwanted pregnancies.

Knowledge and needs: A total of 70 per cent obtained their information about sexuality, contraceptives and sexually transmitted infections from the Internet. A higher proportion of girls (52 per cent) compared to boys (36 per cent) obtained their information from the Internet through quality-assured health and medical care web pages, such as 1177 Vårdguiden (Healthcare Guide at the Internet) and UMO (Youth Health Clinic on the Internet). In

total, 49 per cent of the respondents reported that the school had provided adequate sexual health education in order to take care of their sexual health and among those, there was a higher proportion of boys (58 per cent) than girls (41 per cent). Among non-binary gender persons the proportion was 32 per cent (CI: 19.9-43.2). In total, the respondents reported that school had provided adequate education within the following fields: how to get pregnant (75 per cent), knowledge of the body (64 per cent) and knowledge of condom usage (62 per cent). The areas where the school had provided inadequate education were; sex, relationships and gender equality (35 per cent), HIV (31 per cent) and norms and LGBT perspectives (25 per cent). The area where young people wanted more information was how to make a relationship work well (30 per cent). The two principal areas where young people indicated a need for health promotion and prevention initiatives were cheaper contraceptives (46 per cent) and free condoms (41 per cent).

Conclusion: The results from this study indicate that adolescents and young adults experience good health to a large extent. However, there are differences in health, sexual health and factors that affect sexual and reproductive health and rights between groups of young people, primarily based on sex and gender identity. The drop-out is comparable to the same age group in other similar population studies. Nevertheless, the results should be handled with caution.

The preconditions for good sexual and reproductive health and rights among young people are unequal since groups among girls and young non-binary gender persons experience abusive treatment, discrimination, sex against their will and sexual abuse.

Girls and boys do not take on an equal amount of responsibility for contraceptive and testing for sexually transmitted infections. Furthermore, boys and girls are not reached by society's preventive efforts, such as the services of youth health clinics, to the same extent.

Gender inequality and inequity in sexual and reproductive health and rights, obstructs successful efforts to prevent sexually transmitted infections, unwanted pregnancies, sexual abuse and young people being reimbursed or paid for sex. It also obstructs the promotion of sexual and reproductive health and rights among all young people.

Schools, Youth Health Clinics, healthcare and social services are important arenas in order to further develop the promoting and preventive work within sexual and reproductive health. The efforts would most likely

be more successful if more boys were reached and if they felt that the preventive efforts were motivating and important from their perspectives. Overall, the study indicates a national, regional and local need for development. Activities within municipalities, county councils and the civil society need to analyse their initiatives, strategies and aims systematically and monitor future progress continuously over time in relation to health equity. The initiatives should proceed from a non-oppressive, norm-critical and intersectional perspective. Such strategic work would promote sexual and reproductive health and rights and HIV prevention among young people.

Outline of the report

Chapters 1–2 Background and epidemiology

The report begins with a background which puts HIV prevention and sexual and reproductive health and rights in a context, based on policies, strategies, international agreements as well as theoretical perspectives. Thereafter there is a epidemiological description of HIV and sexually transmitted infections within the area.

Chapters 3–4 Objective and method

The chapter describes the considerations and decisions which form the basis of the study's design, statistical analyses and presentation of the results.

Chapters 5–11 Results

The chapters describe the study's results based on the main areas of the survey: health, social relationships, discrimination and violence, sexuality, contraceptives and contraceptive methods, sexually transmitted infections, unwanted pregnancies and abortion, knowledge and the need of support.

Chapter 12 Methodology discussion

The discussion of method clarifies the strengths and weaknesses of the study design, discusses some of the study's theoretical perspectives and makes a comparison between the base line study (UngKAB09) and monitoring study (UngKAB15).

Chapter 13 Discussion of results

Based on the results, there is a discussion on health, discrimination, contraceptives and contraceptive methods, sexually transmitted infections, sex against your will and sex for payment, the need of health promotion initiatives and the entitlement to knowledge and information. The discussion is based on rights, gender and equity perspectives and provides suggestions for development areas.

Chapter 14 Conclusions

The final chapter of the report summarises the report's overall conclusions.

Summary in Swedish

Bakgrund: Utgångspunkten för den här rapporten är Folkhälsomyndighetens uppföljning av det förebyggande arbetet kring hivprevention som riktats till unga och unga vuxna enligt prop. 2005/06:60 och Nationell handlingsplan för klamydiaprevention. Rapporten beskriver ungas sexuella och reproduktiva hälsa. Analyserna är baserade på 7 755 svar från unga i åldern 16–29 år i Sverige. Svarsfrekvensen var 26 procent. Datainsamlingen genomfördes av Statistiska centralbyrån (SCB) och studien är en randomiserad, stratifierad och enkätbaserad befolkningsstudie. Här återges rapportens huvudsakliga resultat och slutsatser.

Bakgrundsvariabler: Analyserna baseras på 50 procent killar, 49 procent tjejer och 1 procent som inte ville kategorisera sig utifrån kön. Totalt var 1 procent transpersoner. Gruppen som inte vill kategorisera sig utifrån kön och gruppen transpersoner överlappar ibland, men inte alltid.¹ En tiondel av de svarande var utrikes födda, huvudsakligen i Asien, Europa utom Norden, Sydamerika och Afrika. Det fanns en tendens att tjejer hade något lägre inkomst än killar, och att en högre andel tjejer än killar hade en avslutad universitetsutbildning.

Hälsa, relationer, diskriminering och våld: Totalt ansåg 80 procent att de hade en bra eller mycket bra hälsa, en högre andel killar (82 procent) än tjejer (77 procent) uppgav detta. Totalt uppgav 22 procent att de under de senaste 12 månaderna upplevt att de blivit behandlade eller bemötta på ett sätt så att de känt sig diskriminerade eller kränkta. En högre andel tjejer (29 procent) än killar (15 procent) uppgav att de upplevt någon form av diskriminering eller kränkning. Bland personer som inte vill kategorisera sig utifrån kön var andelen 51 procent (KI: 39,4-63,4). Totalt hade 6 procent varit utsatta för fysiskt våld under de senaste 12 månaderna och den vanligaste platsen där tjejer utsattes för våld var i hemmet (35 procent) medan det för killar var allmän plats (50 procent).

1. För mer information om hur andelar och konfidensintervall presenteras i rapporten se kapitlet "metod".

Sexualitet: Över hälften (56 procent) ansåg att de var ganska eller mycket nöjda med sitt nuvarande sexliv. 95 procent uppgav att de vid senaste sextillfället hade sex på en trygg plats där de kände sig säkra. 80 procent ansåg att det är viktigt att kunna prata om sex med sin partner – en högre andel tjejer (84 procent) än killar (77 procent) tyckte detta. Totalt definierade unga sin sexuella identitet enligt följande: heterosexuell (83 procent), brukar inte kategorisera mig sexuellt (5 procent), bisexuell (5 procent), vet ej (3 procent), homosexuell (2 procent), annat (1 procent).² En högre andel killar (3 procent) än tjejer (2 procent) hade samkönat sex vid senaste sextillfället. Totalt angav 40 procent att de någon gång hade erfarenhet av en sexuell handling mot sin vilja. En högre andel tjejer (54 procent) än killar (27 procent) hade någon gång varit utsatt för detta. Bland personer som inte vill kategorisera sig utifrån kön hade 53 procent varit utsatta för sex mot sin vilja (KI: 41-65.8). Totalt hade 3 procent erfarenhet av att ha gett eller fått ersättning vid sex. Relativt lika andelar tjejer (3 procent) och killar (2 procent) hade erfarenhet av att ha fått ersättning för sex, men en högre andel killar (5 procent) än tjejer (1 procent) hade gett ersättning för sex.

Preventivmetoder och preventivmedel: Totalt ansåg 89 procent att det är viktigt att skydda sig med preventivmedel om man inte vill bli gravid och lika stor andel angav att det, i en sexuell relation, är viktigt att skydda sig mot en sexuellt överförd infektion. Det skydd högst andel unga kunde tänka sig att använda var kondom (88 procent) följt av p-piller (47 procent) men vanligaste skyddet som använts vid senaste sextillfället var omvänt, hormonell preventivmetod (50 procent) följt av kondom under hela samlaget (25 procent). Vidare beskriver en högre andel killar (4 procent) än tjejer (1 procent) att de inte ville använda kondom och att de blev irriterade om partnern föreslår det. En högre andel 16–19-åriga tjejer (80 procent) kunde tänka sig att använda något hormonellt preventivmedel jämfört med 25–29-åriga tjejer (50 procent). Bland de tjejer som inte hade råd att hämta ut sitt hormonella preventivmedel återfanns högst andel (4 procent) bland 16–19-åringarna.

2. På grund av att rapportens totaler inte innehåller decimaler uppgår inte summan till 100 procent.

Sexuellt överförda infektioner: Totalt uppgav 11 procent att de hade haft klamydia, vilket gjorde den till den vanligaste sexuellt överförda infektionen bland unga. För alla sexuellt överförda infektioner, hiv och hepatit gällde att en högre andel tjejer (67 procent) än killar (40 procent) någon gång hade testat sig. Bland 16–19-åringarna hade tre gånger så hög andel tjejer som killar erfarenhet av att ha testat sig för klamydia. En högre andel tjejer (79 procent) än killar (63 procent) ansåg att det är viktigt att testa sig när man är i en sexuell relation. Av de 53 procent som någon gång testat sig för en sexuellt överförd infektion, hiv eller hepatit hade 49 procent haft ett samtal med en professionell om risker och skydd vid det senaste testtillfället. En högre andel tjejer (51 procent) än killar (46 procent) hade ett sådant samtal, och en högre andel tjejer (60 procent) än killar (45 procent) uppgav att samtalet gjorde dem motiverade att använda skydd.

Önskad graviditet och abort: Totalt hade 16 procent erfarenhet av att de själva eller deras partner genomgått en abort. Lite mer än hälften (58 procent) av dem uppgav att de själva eller deras partner haft ett samtal med en kurator, barnmorska eller läkare. Av dem som haft ett samtal ansåg 27 procent att de blev motiverade att fundera på hur de skyddar sig i framtiden. En högre andel tjejer (42 procent) än killar (20 procent) ansåg att de efter samtalet hade bättre koll på hur de kunde använda graviditetsskydd.

Kunskaper och behov: Totalt hämtade 70 procent sin information om sexualitet, preventivmedel och könssjukdomar från internet. En högre andel tjejer (52 procent) än killar (36 procent) hämtade sin information från internet via kvalitetssäkrade sidor från hälso- och sjukvården, som via webbsidorna 1177 Vårdguiden och UMO. Totalt ansåg 49 procent att skolan gett dem tillräckliga kunskaper för att ta hand om sin sexuella hälsa, och av dem utgjorde killar en högre andel än tjejer. Bland personer som inte vill kategorisera sig utifrån kön ansåg 32 procent (KI:19,9-43,2) att skolan gett dem tillräckliga kunskaper. Totalt ansåg unga att skolan gett tillräckliga kunskaper inom följande områden: hur man blir gravid (75 procent), kunskaper om kroppen (64 procent) och kunskap om kondom användning (62 procent). De områden där skolan gett för lite kunskaper var: genus, relationer och jämställdhet (35 procent), hiv (31 procent) samt normer och HBT-perspektiv (25 procent). Det område där unga önskade mer information gällde hur man får en relation att fungera bra (30 procent). De två främsta områden där unga ansåg sig ha behov av hälsofrämjande och förbyggande

insatser var billigare preventivmedel (46 procent) och gratis kondomer (41 procent).

Slutsats

Resultaten från den här studien visar att unga och unga vuxna i stor utsträckning upplever en god hälsa. Men det finns skillnader i hälsa, sexuell hälsa och faktorer som påverkar sexuell och reproduktiv hälsa och rättigheter mellan grupper av unga, framförallt baserat på kön och könsidentitet. Bortfallet är jämförbart med denna åldersgrupp i andra liknande befolkningsundersökningar, dock bör resultatet hanteras med försiktighet.

Förutsättningarna till god sexuell och reproduktiv hälsa och rättigheter bland unga är ojämlika, eftersom grupper bland tjejer och unga som inte vill kategorisera sig utifrån kön upplever kränkningar, diskriminering, sex mot ens vilja och sexuella övergrepp.

Tjejer och killar tar olika stort ansvar för preventivmedel, preventivmetoder och testning av sexuellt överförda infektioner. De nås också i olika utsträckning av samhällets förebyggande insatser så som exempelvis ungdomsmottagningarnas arbete.

Ojämlika och ojämsställda förhållanden bidrar till skillnader i tillgång och tillgänglighet till hälsofrämjande insatser, och det försvårar ett framgångsrikt arbete med att förebygga sexuellt överförda infektioner, oönskade graviditeter, sex mot någons vilja, sexuella övergrepp och sex mot ersättning. Det försvårar också främjandet av sexuell och reproduktiv hälsa och rättigheter bland alla unga.

Skolan, ungdomsmottagningarna, hälso- och sjukvården samt socialtjänsten är centrala arenor för att vidareutveckla det främjande och förebyggande arbetet inom sexuell och reproduktiv hälsa. Arbetet skulle sannolikt vara mer framgångsrikt om det nådde fler killar och om de kände att insatserna var angelägna och motiverade utifrån dem.

Sammantaget visar studien på ett nationellt, regionalt och lokalt utvecklingsbehov. Verksamheter inom kommuner, landsting och civilsamhälle behöver systematiskt analysera sina insatser, strategier och mål samt göra kontinuerliga uppföljningar som visar områdets utveckling över tid i relation till jämlikhet i hälsa. Utvecklingsarbetet bör utgå från normkritiska och intersektionella perspektiv. Ett sådant strategiskt utvecklingsarbete skulle främja sexuell och reproduktiv hälsa och rättigheter samt hivpreventionen bland unga.

CHAPTER 1

Background



1. Background

Why a study on sexuality and health among young people?

This report is a part of the Public Health Agency of Sweden's monitoring of the work on sexual health, HIV prevention as well as parts of the area sexual and reproductive health and rights which focuses on young people aged 16–29 years in Sweden. The work was conducted within the framework of the National Action Plan against Chlamydia by county councils, metropolitan municipalities, civil society organisations and agencies between 2009–2014 (1, 2). The purpose of the monitoring work is to conduct analyses and provide knowledge-based data which can lead to permanent changes towards better health in the future (1, 3). The analyses aim to examine whether the health is as good as possible and study to what extent it is as equal and gender equal distributed as possible (4).

This study monitors the base line study UngKAB09 from 2009 (1). The process monitoring of the action plan against chlamydia conducted by the Public Health Agency of Sweden among contact persons within county councils and metropolitan municipalities revealed that there was a need for greater support on issues related to sexual and reproductive health and rights. Consequently the survey of 2015 had wider question areas. Despite the fact that both studies have different study designs and methods, a certain level of monitoring and comparison over time is enabled (see chapter 12 Discussion of method).

Global and regional public health policy objectives

The UN Sustainable Development Goals, Agenda 2030, clearly state the importance of greater work on sexual and reproductive health and rights. In goal 3, healthy lives and well-being, interim goal 3.7 indicates that member states should ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. In goal 5, gender equality, interim goal 5.6 clarifies that all member

countries should ensure universal access to sexual and reproductive health and reproductive rights (5). For Sweden this also includes sexual rights.

The UN Political Declaration on HIV and AIDS of 2016 stresses that there is a need to develop the gender equality work within the sexual health and HIV prevention area. The Declaration highlights strategic areas which should be considered in the planning of HIV prevention, such as gender equality and the importance of understanding the power perspective based on sex and socioeconomic factors. The Declaration also clarifies that all countries should ensure that gender equality strategies also handle the effects of harmful gender norms (6).

On a regional level WHO/Europe has adopted a new action plan for sexual and reproductive health. The primary objective of the action plan is to enable all human beings to make well-founded decisions on their sexual and reproductive health and that their human rights are respected, protected and fulfilled. The objective is also for all human beings to be entitled to the best possible level of well-being in terms of sexual and reproductive health and to even out inequalities. The action plan is closely linked to Agenda 2030, primarily to interim goal 5.6 (7). Within the WHO cooperation, Sweden focuses on the following three perspectives:

- *Rights perspective:* That all human beings should be entitled to their rights, including the right to sexual health.
- *Gender perspective:* To ensure that women and men have the same opportunities to attain good sexual health from a lifetime perspective.
- *Equity perspective:* To improve the conditions for good and equally distributed sexual health and reduce health differences (8).

For a long time WHO has promoted strengthened analyses and initiatives for equal health globally and regionally. The work had a significant impact in connection with the Marmot Commission report “Closing the gap in a generation”. The report illustrated how unequal conditions in society create social vulnerability and result in ill-health. It also showed that society contains systematic inequality, which leads to unequal distribution of power, wealth and other necessary social resources which comprise prerequisites for health. The Commission showed that unequal conditions can be changed and prevented if the causes are known and can be influenced (9). Even though the report did not have an intersectional perspective, it specifies

important paths in terms of issues of how the health area handles issues on sex, power and allocation of resources in relation to existing knowledge.

Health 2020 is a policy framework which describes how focused leadership and strategic control can create the conditions for equal health. The policy framework was adopted by all WHO member countries in 2012. The work is based on the vision that every human being's fundamental right is to attain the best possible health, which is also the vision of the Constitution of WHO. The countries which have acknowledged the right to health have also undertaken to organise and finance their health and medical care systems based on the fundamental values universality, solidarity and equal access. The policy framework contains two overall strategic objectives which are linked to each other: to improve the health of everyone and reduce unequal health and to improve leadership and participation in the control of health. The objective is to attain the highest possible health level, irrespective of ethnicity, sex, age, social status or payment capacity. These values comprise justice, sustainability, quality, openness, liability, gender equality, dignity and the right to participate in decision-making (10). The implementation of Health 2020 is now the highest priority for the WHO European Region.

National public health policy objectives

In Sweden the area HIV prevention comprises the health promotion and prevention work on HIV and sexually transmitted infections. The work is based on the Government Bill "A renewed public health policy" and Government Bill "A national strategy to combat HIV/AIDS and certain other communicable diseases" (hereinafter referred to as the "HIV strategy") (2, 3). The HIV strategy has specifically highlighted seven at risk groups as a priority, of which adolescents and young adults (hereinafter referred to as "young people") are one of them. The HIV strategy is based on the United Nations General Assembly Special Sessions on HIV/AIDS and the subsequent documents and strategies developed by UNAIDS (11). The objective is to reduce the transmission of HIV and to end discrimination and stigma against persons living with HIV. In Sweden the HIV strategy specifies that HIV prevention for young people should take place with the prevention work on sexually transmitted infections and unwanted pregnancies. The strategy also mentions that special efforts are needed to get across to young boys. The prevention work should be cross-sectoral and take place together with civil society organisations. Schools and youth health clinics are key arenas (2). In

some countries strategies and policies for HIV prevention are merged with the area sexual and reproductive health and rights, but in Sweden this is a separate area with a separate strategy. The prevention work performed by municipalities and county councils at a regional and local level and which promotes sexual health, also prevents HIV and other sexually transmitted infections. The activities are often performed at the same arenas, for example, within schools and youth health clinics.

Sexual and reproductive health and rights cover HIV prevention, sexual health, reproductive health and non-discrimination, among other areas. For Sweden's international work, SRHR are defined in the following manner: Sexual health refers to quality of life and personal relationships, counselling and health care. Sexual rights include the right of all people to decide over their own bodies and sexuality. Reproductive health is a state of complete physical, mental and social well-being in relation to the reproductive system and all its functions, and is more than the mere absence of disease. Reproductive rights comprise the right of individuals to decide on the number of children they have and the intervals at which they are born (12). Sweden does not have a national definition within the SRHR area yet. In 2012 the National Board of Health and Welfare, Swedish Institute for Communicable Disease Control and Swedish National Institute of Public Health were commissioned to prepare supporting material for a national strategy on sexual and reproductive health and rights (13). Since 2016 the Public Health Agency of Sweden has been the coordinating agency for SRHR issues and has thereby started development work within the area to promote national coordination and knowledge development and monitor development in the area (14).

Sweden has active gender equality work where two of the interim goals have a direct impact on the work on sexual and reproductive health and rights as well as HIV prevention (15). These are:

- *Goal 5. Equal health:* Women and men, girls and boys must have the same conditions for a good health and be offered care on equal terms.
- *Goal 6. Men's violence against women must stop:* Women and men, girls and boys, must have the same right to and opportunity for physical integrity.

The interim goal equal health refers to physical, mental as well as sexual and reproductive health, and covers both preventative public health work and

initiatives for individual persons within, for example, health and medical care or through social services (4).

Sweden also has a national strategy for equal rights and opportunities, regardless of sexual orientation, gender identity or gender expression. The strategy aims to create an open and inclusive society in which the equal value, rights and opportunities of all human beings are respected. All human beings should be able to lead their lives without having to hide their sexual orientation, gender identity or gender expression due to a fear of being subjected to discrimination, violence or other abusive treatment. The strategy's focus areas are directly linked to the SRHR area: violence, discrimination and other abusive treatment, young LGBT persons, health, care and social services, private and family life as well as the role of the cultural area for greater openness and diversity (16).

Sexual health of young people

Sexuality is one of the many factors in the life of human beings which impact health and well-being. Sexual health is an area in which both physical and mental aspects of sexuality are considered in relation to health. The World Health Organization (WHO) has developed a definition of sexual health(17):

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

The sexuality and sexual health of human beings is shaped in relation to others and based on the conditions in society (18, 19). By interaction with the surrounding community, human beings learn where, how and with who to act sexually (19, 20). Biological, emotional, social and religious factors and values impact the view of sexuality in society. Values change in significance

and over time among individual persons, in different groups and in society. Having positive experiences of sexual acts, as well as the surrounding community's supportive approach and sexual view can impact the sexual health of young people in a positive direction. Prevention initiatives are required to strengthen the identity, self-esteem and ability to handle sexuality and relationships with others (3). During the transition from childhood to adolescence and adulthood, the personal perceptions of norms and values are tested while experiences of sexual acts are accumulated (21). Therefore, as a part of the health promotion and prevention work, it is important to communicate with young people about acts, norms and values which promote health and prevent ill-health at an early stage.

Previous studies of the population level have shown that the average age of the first sexual intercourse has been stable at around 16–17 years over the past 50 years (22–24). There is nothing to indicate that the use and influence of the Internet and social media among young people has impacted the age of sexual debut. Over the past 20 years hormonal contraceptives have been more common than condoms (22, 23, 25). Furthermore, over time you can see that young people 20–24 years old are more inclined to have sex without a condom compared to young people 15–19 years old and that boys are more risk-inclined than girls. For several years roughly 25 per cent of boys have stated that they would have sex without a condom, even if they exposed themselves to the risk of a sexually transmitted infection (25). In 1990 a study among 17 year olds showed that 33 per cent of boys and 18 per cent of girls did not use any protection at all during their most recent sexual encounter, and that 55 per cent of girls but only 26 per cent of boys had been to a youth health clinic at some point (26). In the population as a whole the number of sex partners has increased over time and the relative increase has been highest among women, which means that the number of sex partners evened out between the sexes (27). It was observed that between the years 1967 and 1996 contraceptive pills (or other hormonal methods and coils) have increased to the same extent as the decline in condom usage (28).

Furthermore, over time more boys than girls are dissatisfied with their sex life, or state that they cannot live sexually as they want to (22, 25, 29). Young people within theoretical or vocationally-oriented upper secondary school programmes have better sexual health compared to young people who have dropped out of school (26). Studies also show that young people who have sold sex report worse sexual health than others (29, 30). Young people within institutional care have significantly worse sexual health than

others (31). To sum up, over time there has been a large proportion of young people who have sex without a condom. Over time socioeconomic differences in sexual health and differences between sexes have also been observed, both in terms of the attitude towards safer sex and the extent to which boys and girls have been to a youth health clinic.

It has been seen that over time young people, as well as adults, generally have good knowledge of how HIV is transmitted and how to protect yourself during sex (27, 29). Despite this, the view of persons living with HIV has been characterised by prejudices. The prejudices have been more common among young people than the elderly (27). Young men who have sex with men have less knowledge of HIV and get tested to a lesser extent than older men who have sex with men (32). Several surveys show that young homosexuals and bisexuals experience more vulnerability, discrimination and general ill-health than heterosexuals (29, 33). Young transgender persons report a worse general health condition and greater exposure to mental ill-health, abusive treatment, discrimination and violence, both compared to heterosexuals and cisgender persons and compared to older transgender persons(34). Previous studies and surveys show that there is a difference between girls and boys in terms of the grounds on which young people are subjected to abusive treatment or discrimination. The most common cause reported by girls is sex or age. Among boys the most common causes are ethnicity, gender identity or sexual orientation (25, 35). To sum up, it has been seen that abusive treatment and discrimination are important for the sexual health of young people.

Protective factors and risk factors

Sexuality is important for well-being and health (36) and sexuality is an important factor in the lives of human beings for desire and zest for life (3). Even though there is more comprehensive research on risk factors for sexual ill-health, there is also data on health factors and protective factors which can increase general health and well-being. Factors such as self-confidence, optimism and curiosity are important, but primarily close relationships with others, good relationships between parents and children as well as emotional support from the surrounding community (37).

Previous studies have shown that the risk-taking of young people, that is, the acts which young people control, are closely linked to risk exposure (29, 38). Risk exposure are social conditions and living conditions which young

people cannot control as easily. Risk exposure within sexual health and HIV prevention entail discriminatory structures (39), negative expectations, lower socioeconomic conditions, abusive treatment or discrimination at school, work, within health and medical care and in social contexts (29, 33, 34, 40).

How young people approach and expose themselves to risks are often discussed in the prevention work. In the HIV prevention work, risk-taking covers the acts which may result in transmission of HIV, sexually transmitted infections or unwanted pregnancies (2). Risk factors which can be linked to sexual risk-taking are, for example, experience of sexual abuse, difficult conditions during childhood and adolescence, feelings of hopelessness, depression and suicide attempts (31). A high consumption of alcohol, drug abuse, having a sexually transmitted infection over the past 12 months, sexual debut before the age of 15, experience of sexual acts against your will, sex for payment and vulnerable socioeconomic living conditions are also risk factors (29, 41). Greater knowledge of why young people have unprotected sex aims to propose methods and initiatives which can prevent sexual risk-taking and promote sexual health.

Norms and power structures

In order to improve understanding of the protective factors and risk factors of young people, analysis tools which examine sex, power structures and norms in relation to sexuality are needed. Such perspectives and theories include equity, gender equality, norm criticism and intersectionality. The perspectives and concepts overlap with each other and are different aspects of human rights.

Equity is a perspective which entails equal rights and opportunities for all human beings. The equity perspective includes the right not to be subjected to negative treatment, that is, discrimination. The equity perspective mainly refers to the exercise of power of public institutions towards the individual, but can also be interpreted more widely, such as within the public health area where it has been observed that self-perceived discrimination is linked to ill-health (33, 39, 42). In order to strengthen equity, Sweden has an act which aims to combat discrimination by public institutions based on the following seven grounds of discrimination: sex, transgender identity or expression, ethnicity (previously race), religion or other belief, disability, sexual orientation and age (43). The grounds of discrimination are based on the

United Nations Universal Declaration of Human Rights (44, 45). The right to non-discrimination within the public health area is essential, as previous surveys have shown that the groups in society which are most exposed to ill-health are also the groups which are most exposed to discrimination (39, 42, 46). The right not to be discriminated is the point of departure of almost all international treaties, public health policy objectives as well as declarations and conventions. The right to equal treatment and non-discrimination is also a point of departure of the Health and Medical Services Act, Social Services Act and Education Act (13).

Gender equality is about equality between women and men, girls and boys, who should have the same opportunity to shape society and their own lives. Differences in the health of women and men have been frequently highlighted in surveys. However, gender equality aspects do not only entail establishing differences, but also strategies and development paths on how health can become more equally distributed between the sexes (15).

Norm-critical analysis aims to highlight, problematise and change the stereotypical views on norms which form the basis of discriminatory structures (47). The concept norm criticism was created as an alternative to the previously used concept tolerance perspective. The aim was to increase the opportunity of attaining the objectives of equality, gender equality and equal treatment by not only tolerating that which falls outside the norm (deviates), but instead highlighting the differences of all individuals, positions and conditions to discuss equality issues in an effective manner.

Intersectionality is a theory and analysis method which aims to highlight specific situations of superordination or subordination which are created in connection with social interaction. The analysis takes into account a large number of social categorisations such as, for example, sexual identity, ethnicity, sex, functional variation and class, and brings them together in a discussion and analysis on norms and power (13, 39). An intersectional perspective draws attention to how different social categorisations eliminate or strengthen obstacles for social vulnerability and links together several parallel discussions and perspectives in a complex investigation of norms and power structures (39, 48-51).

CHAPTER 2

Epidemiological development and statistics



2. Epidemiological³ development and statistics

The chapter summarises the epidemiological development of HIV, sexually transmitted infections and abortion.

HIV

There are approximately 7,000 persons in Sweden with a diagnosed HIV infection. In 2016 a total of 430 cases of HIV infection in Sweden were reported, and over the past five year period on average 447 new cases were reported every year. Similar to other countries in the Nordic region, there is a low prevalence of HIV in the group adolescents and young adults. Now there are approximately 550 children and young people (0–29 years) living with HIV in Sweden, of which approximately 400 are above 20 years of age. There are now very few new cases of HIV among young people where HIV has been transmitted in Sweden (52).

The Swedish situation differs from that in Eastern Europe and the rest of the world. In Sweden over 90 per cent of those living with HIV have effective treatment, as a result of which the risk of HIV transmission is minimal if a condom is used. Those with HIV and effective treatment can live a long life with a good quality of life (53). The global situation is different, as far from everyone living with HIV has access to treatment. In addition, there is lack of equality and gender equality, which creates vulnerable groups without access to information, care and treatment or they lack the power and empowerment to protect themselves through safer sex. Vulnerable groups are, for example, women, LGBT persons, men who have sex with men, persons who inject drugs and persons who have sex for payment. In total the global rate of increase has declined slightly, but the number of persons who get HIV is approximately 1.9 million every year. One of the several global HIV prevention problems is that many of those living with HIV are unaware

3. Read current statistics on HIV and sexually transmitted infections on www.folkhalsomyndigheten.se

of it. Besides access to prevention and HIV treatment, the access to testing needs to increase (54, 55).

Chlamydia

From 1997 the number of chlamydia cases in Sweden increased for several years, but over the past 10 years the number of cases has been stable at approximately 37,000 cases annually. In 2016, there were 36,203 reported cases of chlamydia infection (incidence 362 cases per 100,000 inhabitants), which was a decrease of 4 per cent compared to 2015. Chlamydia infection is transmitted through unprotected sex and is the most common sexually transmitted infection in Sweden which is reported in accordance with the Communicable Diseases Act. Chlamydia is used as an indicator of sexual risk-taking (56). The most common mode of transmission is sexual intercourse with the opposite sex. Of the total number of reported cases six of ten are women, but over recent years more than twice as many women as men have also been tested for chlamydia. Of those who were tested, the proportion who have chlamydia (positive cases) is twice as high among men as women. The situation of more women than men getting tested has been the same for a long time. Among the total number of chlamydia cases, the group 15–29 year olds now accounts for approximately 80 per cent of the cases (57).

Gonorrhoea

In 2015, there were 1,778 reported cases of gonorrhoea (incidence 17.8 cases per 100,000 inhabitants), which corresponded to an increase of 6 per cent compared to 2015. In recent years the number of gonorrhoea cases has increased among young women from previously low levels. It is assumed that the number of cases for young men is unreported as, similar to chlamydia, primarily young women get tested for gonorrhoea. Gonorrhoea is also an infection which is now largely transmitted between men who have sex with men. In 2016, half of the new cases were found among men who have sex with men (58).

Syphilis, hepatitis B and hepatitis C

In 2016, there were 349 reported cases of syphilis (incidence 3.5 cases per 100,000 inhabitants). The number of reported cases of syphilis varies from year to year. Syphilis is more common among men than women, primarily among men who have sex with men (59).

In 2016, there were 2,148 reported cases of hepatitis B infection. Of these 94 cases reported getting the infection in Sweden, corresponding to 4 per cent. The majority (86 per cent) got the hepatitis B infection abroad (60).

In 2016, there were 1,889 reported cases of hepatitis C infection, which is at the same level as the recent five year period. The majority of the reported cases got the infection in Sweden, which is a consistent trend over the years. The highest number among those who got the infection in Sweden cases (621) comprised the group of persons who inject drugs. Of the reported cases who got the hepatitis C infection in Sweden, 18 per cent (172 cases) were children and youths 0–24 years old. Of these the majority (81 per cent), got the infection in connection with injecting drugs (61).

Abortion

Since 2006 the number of abortions has been approximately 37,000 per year.⁴ The highest proportion of abortions are performed by women 20–29 years old, followed by women 30–44 years old. The lowest proportion of abortions take place among the youngest up to 19 years old. Even though Sweden now has the highest proportion of abortions in the Nordic region, abortions among teenagers comprise a small share of the abortions which are performed (62). Similar to chlamydia, abortion is used as an indicator of the risk-taking of young people (56). Currently the majority of abortions are medical abortions which take place at an early stage. The reason for the decline in abortion numbers among teenagers has not been established, but is expected to be linked to girls having greater access to effective long-acting reversible contraception, such as hormonal coils, copper coils and contraceptive vaginal rings.

4. Read current epidemiological data on abortions on www.socialstyrelsen.se/statistik/statistikefteramne/aborter

CHAPTER 3

Objective



3. Objective

This report examines the sexual health of young people in relation to HIV and sexually transmitted infections as well as factors important to the area of sexual and reproductive health and rights. The aim is to monitor the Public Health Agency of Sweden's work on the national strategy to combat HIV/AIDS and certain other communicable diseases (Government Bill 2005/06:60) for the work with the prevention group adolescents and young adults. The objective of the report is to contribute with knowledge for health promotion and disease prevention work within the area sexual health and HIV prevention.

CHAPTER 4

Methods



4. Methods

Study design

The investigation is a survey-based, cross-sectional study among young people in Sweden. It is based on a stratified randomised sample of the population. Data was collected by the survey unit at Statistics Sweden (SCB) in accordance with the quality requirements of ISO 20252:2012 for market, opinion and social surveys.

Sample

The survey population comprised youths and young adults 16–29 years old with national registration in Sweden. The sampling frame was developed using data from the Total Population Register, version 31/01/2015. There were 1,730,161 persons in the sampling frame. The sample size was determined by the Public Health Agency of Sweden in consultation with Statistics Sweden. The sampling frame was stratified by legal sex, age and region. In the random sample calculation design weights were created which specified how many persons in the population each respondent could represent. The random sample calculation for sample size was based on six regions which used the Public Health Agency of Sweden's six knowledge networks within the work on HIV prevention as a point of departure: North, Centre, Stockholm-Gotland, Adlon, Västra Götaland and Skåne. Stratum was also based on three age groups: 16–19 years, 20–24 years and 25–29 years, and the two legal sexes of the Statistics Sweden register; female and male. In total 36 strata were formed.

An expected proportion of 50 per cent yes responses was assumed within each stratum in the random sample calculations. The proportion 50 per cent provided the largest random sample size and therefore minimised the risk of underestimating the study with respect to the number in the sample. Furthermore, the estimated number in the sample was adjusted upwards based on an expected drop-out of 70 per cent. An accuracy of the estimated proportion of yes responses of 3 per cent was assumed in the calculations. Based on the random sample calculation, a stratified Simple Random Sample (SRS) of 29,997 persons was taken from the sampling frame. Before the survey was dispatched, the identity of persons in the sample was checked

against the population data to obtain current address details. During the check and collection phase it was revealed that 47 persons no longer belonged to the population as they had passed away or emigrated, referred to as overcoverage. The final sample comprised 29,950 individuals.

The survey

The Public Health Agency of Sweden formulated the survey questions. Thereafter the survey questions were reviewed by the unit for measurement techniques of Statistics Sweden which tested the survey in a focus group interview with youths and young adults. The questions were adjusted after the measurement technique test. The final survey comprised 64 numbered questions. As several of them had sub-questions, the respondents could get 135 questions in total. As the survey was based on experience, the respondents could also omit questions which did not concern them. For example, those without sexual debut needed to answer a maximum of 43 questions.

The survey's main question areas concerned sexual health divided in the following main areas: health, security and social relationships, abusive treatment, discrimination and physical violence, sexuality and relationships, sexual acts, most recent sexual encounter, contraceptives and contraceptive methods, abortion and counselling, sex against your will, sex for payment, sexually transmitted infections, HIV, testing and counselling, measuring knowledge and the need of health promotion initiatives. In addition to the variables which were collected through the survey, a number of background variables were obtained such as country of birth/region, income group, grants, level of education and merit rating from Statistics Sweden's register. This followed Statistics Sweden's practice through information in the preliminary letter which described that those who respond to the survey also consented to the study being performed with anonymous analysis of these variables collected from the register.

Data collection and response rate

The data collection comprised a introduction letter which presented the study, an initial dispatch of the survey, a thank you and reminder card (postcard format) and an additional survey reminder (letter with a new survey). Together with dispatch of the preliminary letter, a letter for guardians was also dispatched to custodial parents for persons below 18 years of age. The letter for

guardians provided information on the purpose of the survey, how data collection took place and provided contact details of the Public Health Agency of Sweden, where custodial parents could call if they had any questions.

In connection with dispatch of the survey and also in connection with the survey reminders, the informants received information on the option of responding to the survey online. Respondents received login details with a username and password which they could then use to login through Statistics Sweden's website. In total 67 per cent chose to respond on the paper survey and 33 per cent chose to respond to the survey online. The postal surveys which were received were registered by scanning them. Among the respondents, there were 2,753 boys and 4,780 girls.⁵ Of the 29,950 young people who were a part of the sample, in total 7,865 persons responded to the survey, that is, 26 per cent in response rate.

Drop-out analysis and drop-out adjustment

Unit non-response, which means that the questionnaire was not answered at all, amounted to 22,085 persons. Unit non-response was based on, among other things that the informant was unwilling to participate in the survey, that the informant could not be reached or that the informant was unable to participate. The item non-response, that is, that the survey was only partially answered, was consistently relatively small and is described in detail in the list of partial drop-out (appendix 2). Over recent years the response rate in the surveys has declined considerably. As it was possible to presume in advance that this would also be the case with this survey, the Public Health Agency of Sweden decided to commission Statistics Sweden to conduct an extended non-response analysis. The purpose was to see whether certain groups in the sample would have responded to the survey to a higher degree than others. During the non-response analysis it was revealed that the non-response was not random, but there were variables which were linked with the degree to which persons in the sample responded to the survey. The analysis showed that the survey was answered to a lower degree by the following groups: young people with low merit ratings (grades in school year 9), young people without post-secondary education, boys, foreign born persons

5. Thereafter calibration weights were used for correction so that girls and boys had a representative distribution in the analysis work.

and young people whose parents had a low level of education. These variables, which the analysis revealed affected the non-response, were thereafter used to revalue, that is calibrate, the design weights and adjust the non-response impact on the conclusions of the population which are made in the study. Therefore, the estimates in this report can portray the conditions among young people 16-29 years old in Sweden more securely.

Data processing for further analysis

Statistics Sweden conducted basic checks, among other things, to ensure that only valid values are included in the material. The data file delivered to the Public Health Agency of Sweden had 7,865 respondents. The Public Health Agency of Sweden conducted additional data cleaning, which was primarily based on quality assurance of the statistical method and expert knowledge within the subject area. After cleaning unreasonable and incongruent responses, 7,755 persons remained for further analysis in the report and advanced work in the future.

Interpreting the study's results

UngKAB15 was conducted as a stratified sample survey, which means that by means of random sample calculation, each respondent is assigned to represent a proportion of the total population of young people 16-29 years old in Sweden. The estimates of such a study design are always uncertain. The uncertainty is described with a 95 per cent confidence interval (CI), which shows between which values there is 95 per cent certainty that the population values in the total population 16-29 years old lie. This means that estimates, especially when the results are broken down in different groups, should be interpreted with confidence intervals.

Analysis and presentation of results

The report is mainly descriptive and the results which are presented in table form are divided based on the sex categories girls and boys as well as the age classes 16-19 years, 20-24 years and 25-29 years. The survey questions which had a categorised response option are consistently presented in the report with proportions (per cent). The proportions which are presented in the results area of the report are estimates of how the relationship is struc-

asured at population level and not proportions which directly relate to the respondents (n=7,755). Therefore, the number of respondents is not presented by each question but in a list of partial drop-out (appendix 2). A review and thematisation was conducted of all questions with open answers and comments are made in the report where relevant. Survey questions which respondents could answer with numbers are presented with mean value or median. All results in the tables are presented in proportions (per cent, %) and with a 95 per cent confidence interval (CI).

As the non-binary gender group had relatively few respondents (n= 87), it is not presented in tables broken down by age and sex/gender identity. Results which show how the groups answered are instead presented in text with proportions followed by confidence interval (CI). The confidence interval should always be taken into account when the results for this group are analysed.

Statistical connections and differences

The statistical analyses presented in the report were performed in the software R. All differences between subgroups mentioned in the report were assessed based on probability analysis of 95 per cent confidence interval (overlaps or not). For certain results, the differences are within the statistical error margin and if those differences are considered to be important, they are described in the report with the concept tendency. In those cases the differences are still deemed to exist and they were probably deemed to be statistically significant with a larger base.

Survey and inclusion of a third option for sex

The aim of having three response options for sex was to create an inclusive survey and provide an option in addition to the binary gender norm female and male. At present there is relatively little documented experience of a third option besides male and female within other large surveys. Together with other authorities and the unit for measurement techniques of Statistics Sweden, the Public Health Agency of Sweden has had discussions on how to formulate inclusive and non-normative questions on gender identity in surveys in the best manner.

For the question “Are you male or female?”, the third option of the survey for sex besides male and female was “I do not wish to categorise myself

(non-binary gender).” The option is not comprehensive and possible reasons for the respondents choosing the option may be: that they perceive themselves as neither female nor male (non-binary), and that they perceive themselves as a female or male but feel that their body does not conform to the gender identity (transgender experience), that they do not want to categorise themselves as female or male due to principal or other reasons even though they identify themselves as female or male, that they did not understand the question or did not perceive the question in the manner intended by the questioner. In addition to this, there is a possible methodological problem, as the non-binary gender group is not included in Statistics Sweden’s register and no design and calibration weights have been adjusted to them.

All in all the methodological problem was considered to be manageable and the consideration of excluding the response group from the study was ruled out. From a non-discrimination perspective, it was important to provide a response option besides male and female, and to present the group’s results in the report. As the group is relatively small, it is not presented for all variables and neither divided by age in tables but in continuous text, however with written-out confidence interval besides it.

Ethical considerations

Prior to commencing the assignment, it was ensured that the subject area did not breach the ethical guidelines of Statistics Sweden. As the survey contained questions on suicidal thoughts, suicide attempts and sexual abuse, Statistics Sweden imposed the requirement that parents of children below the age of 18 should receive a separate preliminary letter with a description of the study and its background and aim. The letter was called letter for guardians and contained details of a contact person at the Public Health Agency of Sweden who would be able to answer any questions. In addition, both the letter for guardians and preliminary letter for the respondents contained written information with further references to institutions and organisations which could answer questions or provide advice and guidance within the areas addressed in the survey. This was ensured and contact was specifically established with Nationella hjälplinjen (National helpline), which is a part of 1177 Vårdguiden. The survey and its study design were examined and approved by the Regional Ethical Review Board in Stockholm on 9 April 2015 (ref. no.: 2015/5:4).

CHAPTER 5

Background variables



5. Background variables

The chapter addresses results of the background variables such as age, sex, education, finances and country of birth/region.

Main results

- The analyses are based on 50 per cent boys, 49 per cent girls and 1 per cent non-binary gender.
- A total of 1 per cent were transgender persons. The group of non-binary gender and the group of transgender persons sometimes overlap, but not always.
- One-tenth of the respondents were born in another country.
- There was a tendency of girls having a slightly lower income than boys.

Age, sex and gender identity

The question on sex had the following three response options: female, male and I do not wish to categorise myself (non-binary gender).⁶ Henceforth this report uses the designation girls and boys instead of females and males. During a comparison of register data and survey responses, it was revealed that there was a tendency for slightly more persons with the legal sex girls than boys, to state non-binary gender. Therefore, the analyses in the report are based on 50 per cent boys, 49 per cent girls and 1 per cent non-binary gender.⁷

The proportion of non-binary gender persons within the different age groups was in the following order: among 16–19 year olds 0.4 per cent, among 20–24 year olds 0.5 per cent, and among 25–29 year olds 0.2 per cent.

6. Read more about how the responses for the group are handled in chapter 4 Methods.

7. Based on the study's design, design and calibration weights were used for correction so that girls and boys have a representative proportion in the analysis work. Read more in chapter 4 Methods.

Transgender experience

Of the young people, 1 per cent considered that they are or have been a transgender person.⁸ Among non-binary gender persons the proportion was 38 per cent (CI: 26.7-50.1). The group of non-binary gender and the group of transgender persons sometimes overlap, but not always. Among boys and girls, the proportion of transgender persons was less than 1 per cent.

Education

In total, young people had the following educational background: 45 per cent had completed a 3–4 year upper secondary or vocational school programme, 25 per cent only had compulsory school education, 14 per cent had completed a university or college programme of 3 years or longer. Thereafter, 7 per cent had completed a folk high school programme or qualified vocational training and 5 per cent had completed a university or college programme which was shorter than 3 years. The highest completed educational qualification of 3 per cent of the respondents was a 2 year upper secondary or vocational school programme.

Among 25–29 year olds, there was a tendency for a higher proportion of girls (33 per cent) than boys (28 per cent) to have a university education of 3 years or longer. Among non-binary gender persons in the age group 25–29 years, the proportion with a university education of 3 years or longer was 23 per cent (CI: 0–47).

Foreign born persons

Among the respondents, 90 per cent were born in Sweden and 10 per cent were foreign born persons. The most common birth regions for the foreign born persons were in the following order: Asia, Europe (excluding the Nordic countries), South America, Africa, the Nordic region (except Sweden), North America and the rest of the world.

8. Transgender person is an umbrella term used to describe persons whose gender identity and/or gender expression at times or always do not conform to the norm of the legal sex registered for them at birth.

Financial situation

80 per cent reported that their finances were quite or very good. There was a tendency for a higher proportion of girls (16 per cent) than boys (15 per cent) to report that they had poor finances.⁹ Among non-binary gender persons the proportion who reported that they had poor finances was 12 per cent (CI: 4–20.6)

Housing

The most common housing situation was in the following order: with parents or siblings (42 per cent), spouse/live-in partner or partner (35 per cent), nobody (18 per cent), children (7 per cent), other adults (5 per cent), collective or student hall (4 per cent).

A higher proportion of boys (20 per cent) than girls (15 per cent) lived alone, while a higher proportion of girls (42 per cent) than boys (29 per cent) lived with a spouse/live-in partner or partner. Also, a higher proportion of girls (10 per cent) compared to boys (5 per cent) lived with children.

Among 25–29 year olds, it was twice as likely for boys (12 per cent) compared to girls (6 per cent) to live with parents/siblings.

9. Poor finances comprise those who stated the options “not particularly good finances” and “not good finances at all.”

CHAPTER 6

Health, relationships and social support



6. Health, relationships and social support

The chapter addresses young people's perceptions and experiences of general health, close relationships, social support, mental health, self-esteem, suicide as well as self-perceived abusive treatment and discrimination.

Main results

- In total, 80 per cent reported that they have good or very good health. A higher proportion of boys (82 per cent) than girls (77 per cent) state that they have good or very good health.
- A higher proportion of girls (88 per cent) than boys (81 per cent) reported that they have somebody to talk to about their intimate thoughts and feelings. Among non-binary gender persons the corresponding proportion was 78 per cent (CI: 67.7-87.7).
- Among 16–19 year olds, a higher proportion of boys (65 per cent) than girls (57 per cent) felt happy when they thought about their future.
- A total of 22 per cent reported that over the past 12 months they had experienced discrimination or abusive treatment. A higher proportion of girls (29 per cent) than boys (15 per cent) reported having experienced some kind of discrimination. Among non-binary gender persons the proportion was 51 per cent (CI: 39.4-63.4).
- In total, 6 per cent had been exposed to physical violence over the past 12 months.

Health

In total, 80 per cent reported that they had good or very good health. A higher proportion of boys (82 per cent) than girls (77 per cent) reported that they have good or very good health. Among non-binary gender persons the corresponding proportion was 56 per cent (CI:44.3–67.9). The highest proportion (85 per cent) who felt good or very good was among boys 16–19

years old, and the highest proportion (5 per cent) who felt bad or very bad was among girls 16–19 years old.

Feeling low

In total 10 per cent reported that they had felt low almost every day over the past 6 months. The proportion was higher among girls (13 per cent) than boys (9 per cent). Among non-binary gender persons the corresponding proportion was 26 per cent (CI: 16.1-35.1).

Use of non-prescription medicine

In total 21 per cent had used prescription medicine without a doctor's prescription at some point, such as painkillers, sedatives or sleep-inducing drugs. The proportion was higher among girls (23 per cent) than boys (18 per cent). Among non-binary gender persons the corresponding proportion was 32 per cent (CI: 20.2-43.1).

Close relationships

84 per cent reported that they have somebody to talk to about their intimate feelings. The proportion was higher among girls (88 per cent) than boys (81 per cent). Among non-binary gender persons the corresponding proportion was 78 per cent (CI: 67.7-87.7).

Social support

In total, 66 per cent reported that they could always get help and advice if they had practical problems or were sick. The proportion was higher among girls (68 per cent) than boys (65 per cent). Among non-binary gender persons the proportion was 58 per cent (CI: 46.1-69.5).

Happy with themselves

65 per cent reported that they were happy with themselves on the whole. The proportion was higher among boys (71 per cent) than girls (58 per cent). Among non-binary gender persons the corresponding proportion was 41 per cent (CI: 29.2-53.2).

As well as others

In total, 79 per cent reported that they did things as well as most others. The proportion was higher among boys (82 per cent) than girls (76 per cent). Among non-binary gender persons the proportion who reported that they did things as well as others was 66 per cent (CI: 54.7–76.5).

Belief in the future

62 per cent reported that they felt happy when they thought about their future. The same proportion of girls as boys (62 per cent) had belief in the future. Among non-binary gender persons the proportion who stated that they felt happy when they thought about their future was 37 per cent (CI: 24.9–48.7) in total. Among 16–19 year olds, a higher proportion of boys (65 per cent) than girls (57 per cent) felt happy when they thought about their future. Among 25–29 year olds, the proportion who felt happy when they thought about their future was highest among girls (65 per cent).

Sense of control

In total 66 per cent reported that they felt that they had control of their lives. The proportion was higher among boys (70 per cent) than girls (63 per cent). Among non-binary gender persons the proportion was 41 per cent (CI: 28.9–53.3).

Self-perceived discrimination or abusive treatment

22 per cent reported that over the past 12 months they had experienced discrimination or abusive treatment. Among non-binary gender persons the proportion was 51 per cent (CI: 39.4–63.4). A higher proportion of girls (29 per cent) than boys (15 per cent) reported having experienced some kind of discrimination.

The most common cause of self-perceived discrimination or abusive treatment, based on the grounds of discrimination, was in the following order: sex (41 per cent), age (26 per cent), ethnicity (21 per cent), sexual orientation (10 per cent), disability (9 per cent), religion (8 per cent), gender

identity/gender expression (7 per cent) and other (28 per cent).¹⁰ The most common option below the category “other” was appearance and weight (n=64).

Among girls the most common cause of abusive treatment and self-perceived discrimination was sex (51 per cent) while for boys it was ethnicity (33 per cent). Among non-binary gender persons the most common cause of abusive treatment and self-perceived discrimination was sex 65 per cent (CI: 49.4–80.6), followed by sexual orientation (58 per cent) (CI: 41.8–74.8) and thereafter gender identity/gender expression (52 per cent) (CI: 36-69.2).

The three most common arenas where young people experienced discrimination or abusive treatment was in the following order: at school or work (56 per cent), public place (29 per cent) as well as the Internet and social media (20 per cent). Among non-binary gender persons the experience of abusive treatment and discrimination within different social arenas was the following; at school/work 73 per cent (CI: 59–86.4), public place 60 per cent (CI: 44.8–76) and social media 48 per cent (CI: 31.1-63.8).

Physical violence

In total, 6 per cent had been exposed to physical violence over the past 12 months. Of them, the proportion of girls (5 per cent) was approximately the same as the proportion of boys (7 per cent). Among non-binary gender persons 10 per cent (CI: 3.7–15.8) had been exposed to violence over the past 12 months.

The most common place of physical violence was in the following order: public place/place of entertainment (41 per cent), at home by my family or relatives (22 per cent), at school or work (21 per cent), in someone else’s home/in the residential area (10 per cent) and in or close to public transport (8 per cent).

Approximately one-fifth of both girls (23 per cent) and boys (21 per cent) reported that the violence took place at school or work. Among non-binary gender persons the proportion with experience of violence at school or work was 34 per cent (CI: 2.4-64.2).

10. The response option “other” does not constitute a ground of discrimination by Swedish law but was included as an option in the survey.

Within the group exposed to violence, a higher proportion of girls (35 per cent) than boys (11 per cent) reported that the violence occurred at home, while a higher proportion of boys (50 per cent) than girls (27 per cent) reported that the violence occurred at a public place/place of entertainment. Among non-binary gender persons the proportion with experience of violence at home was 49 per cent (CI: 17–81.2) and the proportion who had been exposed to violence at a public place/place of entertainment was 56 per cent (CI: 24.8–87.8).

Suicide

In total, 36 per cent had *thought* of committing suicide at some point.¹¹ A higher proportion of girls (41 per cent) than boys (30 per cent) had thought of committing suicide at some point. Among non-binary gender persons the corresponding proportion was 65 per cent (CI: 53.4–77.4).

In total 10 per cent reported that they had *attempted* committing suicide at some point. Among those who had attempted committing suicide over the past 12 months, the proportion of girls (5 per cent) was almost as large as the proportion of boys (4 per cent). Among non-binary gender persons the corresponding proportion was 9 per cent (CI: 1.8–16.7).

11. The survey question was formulated generally on whether respondents had thought of committing suicide at some point and differs from, for example, the formulation in the national public health survey which asked whether respondents had seriously considered committing suicide at some point.

CHAPTER 7

Sexuality



7. Sexuality

The chapter presents results on questions on debut age, number of partners, equal decision-making, satisfaction and well-being, sex against your will and sex for payment.

Main results

- A majority of the respondents (56 per cent) reported that they were quite or very satisfied with their present sex life.
- 95 per cent reported that their most recent sexual encounter had been in a safe place where they felt secure.
- 8 of 10 considered that it is important to be able to talk about sex with your partner. A higher proportion of girls (84 per cent) than boys (77 per cent) reported this.
- In total, young people defined their sexual identity as follows: heterosexual (83 per cent), I don't usually categorise myself sexually (5 per cent), bisexual (5 per cent), I don't know (3 per cent), homosexual (2 per cent), and other (1 per cent).
- A total of 40 per cent reported that they had experience of sexual acts against their will. The proportion was higher among girls (54 per cent) than boys (27 per cent). Among non-binary gender persons the proportion was 53 per cent (CI: 41-65.8).
- The proportion of young people with experience of sex for payment was the same among girls and boys (3 per cent), but a higher proportion of boys (5 per cent) than girls had paid for sex (1 per cent). Roughly the same proportion of girls (3 per cent) and boys (2 per cent) had experience of *receiving* payment for sex.

Proportion who have had sex

In total 81 per cent stated that they have had sex at some point. A higher proportion of girls (86 per cent) than boys (76 per cent) had sexual debut. Among non-binary gender persons the proportion who had sexual debut was 67 per cent (CI: 55.7-78.1).

Age of sexual debut

The average and median age of sexual debut with a partner was 16 years. The average debut age for girls was 16.1 years and boys was 16.6 years. Among non-binary gender persons the average age was 15.7 years (CI: 15–16.4) and the median was 15 years.

Satisfied with sex life

A majority of the respondents (56 per cent) reported that they were quite or very satisfied with their present sex life. All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner. A higher proportion of girls (32 per cent) than boys (26 per cent) were very satisfied with their sex life. Among non-binary gender persons the proportion who were very satisfied was 24 per cent (CI:14.2-34.2). In all age groups there is a tendency for a higher proportion of boys than girls who were quite or very dissatisfied with their present sex life. Table 1 shows how satisfied girls and boys are with their present sex life.

Table 1. Satisfied with sex life
How satisfied are you with your current sex life? Question 21.

Age and sex	Very satisfied Proportion (95 % CI)	Quite satisfied Proportion (95 % CI)	Neither satisfied nor dissatisfied Proportion (95 % CI)	Quite dis- satisfied Proportion (95 % CI)	Very dis- satisfied Proportion (95 % CI)
Girls 16–29 years	31,8 (30,2–33,5)	29,2 (27,7–30,7)	28,1 (26,6–29,5)	7,5 (6,6–8,3)	3,5 (2,8–4,1)
Boys 16–29 years	25,6 (23,8–27,4)	25,9 (24,1–27,7)	31,2 (29,4–33,1)	11 (9,8–12,3)	6,3 (5,2–7,3)

Being able to talk about sex

80 per cent considered that it is important to be able to talk about sex with your partner. The proportion was higher among girls (84 per cent) than boys (77 per cent). All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner. Among non-binary gender persons the proportion who reported that it was important to be able to talk about sex with your partner was 80 per cent (CI: 70.6–88.8). The highest proportion (28 per cent) who reported the option I don't have an opinion/I don't know was among the youngest boys 16–19 years old.

Equal decision-making about sex

78 per cent considered that it is important for both partners to decide equally in terms of how and where to have sex. The proportion was higher among girls (83 per cent) than boys (74 per cent). All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner. Among non-binary gender persons 80 per cent (CI: 70.4–89.2) reported that it is important to decide equally in terms of how and where to have sex. The proportion who believed this was highest among girls 25–29 years old (85 per cent) and lowest among boys 20–24 years old (74 per cent). The highest proportion (25 per cent) who reported the option I don't have an opinion/I don't know was among the youngest boys 16–19 years old.

Safe and secure place for sex

In total 95 per cent of everyone reported that their most recent sexual encounter had been in a safe place where they felt secure. The proportion among girls was 96 per cent and among boys 95 per cent. Among non-binary gender persons the proportion who had sex in a safe and secure place was 85 per cent (CI: 74.1–96.2). The highest proportion (4 per cent) who did not feel secure and safe during their most recent sexual encounter was among boys 20–24 years old.

Sex in a way I wanted

90 per cent thought that during their most recent sexual encounter they had sex in a way they wanted. The proportion was higher among girls (92 per cent) than boys (89 per cent). Among non-binary gender persons the corresponding proportion was 82 per cent (CI: 71.3–94). The highest proportion (93 per cent) was among girls 25–29 years old and the lowest proportion (87 per cent) was among boys 20–24 years old.

Sexual acts

Among those who had debut with a partner, the most common sexual acts during their most recent sexual encounter were: vaginal sexual intercourse (91 per cent), non-penetrative sex/outercourse (63 per cent), oral sex (57 per cent), use of sex toys (9 per cent), anal sexual intercourse (6 per cent) and online sex (1 per cent). Vaginal sexual intercourse was the most common

sexual act among both girls (92 per cent) and boys (91 per cent). Among non-binary gender persons 74 per cent (CI: 60.9–86.9) had vaginal sexual intercourse during their most recent sexual encounter.

A higher proportion of boys (7 per cent) than girls (5 per cent) had anal sex during their most recent sexual encounter. Among non-binary gender persons the proportion was 9 per cent (CI 1.1–17.2). A higher proportion of boys (60 per cent) than girls (54 per cent) also had oral sex during their most recent sexual encounter. Among non-binary gender persons the corresponding proportion was 68 per cent (CI: 53.6–82.6). There was also a tendency for a higher proportion of boys and non-binary gender persons to have online sex. The most common open answer on sexual acts was that lubricants were used (n=14) followed by BDSM¹² (n=10).

Sexual identity

In total, young people defined their sexual identity as follows:¹³ heterosexual (83 per cent), I don't usually categorise myself sexually (5 per cent), bisexual (5 per cent), I don't know (3 per cent), homosexual (2 per cent), and other (1 per cent). All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner. Table 2 presents the responses by age and sex.

The same proportion of girls and boys (2 per cent) considered themselves to be homosexual. Among non-binary gender persons the proportion of homosexuals was 3 per cent (CI: 0–6.1). A higher proportion of girls (7 per cent) than boys (3 per cent) considered themselves to be bisexual. Among non-binary gender persons the proportion of bisexuals was 68 per cent (CI: 10.7–30.3).

A higher proportion of boys (87 per cent) than girls (80 per cent) considered themselves to be heterosexual. Among non-binary gender persons the proportion of heterosexuals was 26 per cent (CI: 15.2–37.3).

12. BDSM is an abbreviation for a group of erotic and sexual techniques which are based on the concept Bondage, Discipline, Sadism and Masochism (BDSM). In BDSM the participants decide on specific rules in advance which guarantee that they completely agree to the circumstances and that BDSM is performed based on the free will of those involved in order to attain shared pleasure.

13. As the totals in the report do not contain decimals, the total amount does not equal 100 per cent.

In terms of the question on sexual identity, the respondents provided a large number of descriptions in the open answer field. The most common description which was mentioned was pansexual (n=36), which means that a person may be sexually attracted to persons/personalities irrespective of gender recognition. Sometimes pansexuality is seen as a form of bisexuality or a queer lifestyle. Other reported sexual identities include, for example, gray-asexual, omnisexual, metrosexual, bi-curious and hetero-asexual.

Table 2. Sexual identity

Do you consider yourself currently to be:... Claim in question 20.

Age and sex	Bisexual % (95 % CI)	Homosexual % (95 % CI)	I don't usually categorise myself sexually % (95 % CI)	Heterosexual % (95 % CI)	Other % (95 % CI)
16-19 years old - girls	7,7 (6,2-9,2)	1,3 (0,7-1,9)	5,1 (3,9-6,4)	77,8 (75,4-80,1)	2,4 (1,5-3,2)
16-19 years old - boys	2,8 (1,7-3,8)	2 (1,1-2,9)	3,8 (2,5-5,1)	87,5 (85,3-89,7)	1,2 (0,5-1,9)
20-24 years old - girls	8,2 (6,6-9,8)	2,9 (2-3,9)	6 (4,7-7,4)	78,2 (75,8-80,6)	1 (0,4-1,7)
20-24 years old - boys	4,7 (3,1-6,2)	2,2 (1,2-3,3)	5,8 (3,9-7,6)	84,4 (81,6-87,1)	1 (0,2-1,8)
25-29 years old - girls	6,5 (5-7,9)	1,2 (0,6-1,9)	6 (4,5-7,5)	83,2 (80,8-85,5)	0,8 (0,3-1,3)
25-29 years old - boys	1,6 (0,7-2,4)	1,9 (1-2,8)	4,1 (2,5-5,6)	88,6 (86,1-91)	0,4 (0-0,7)

Partner during most recent sexual encounter

Over 95 per cent among girls and boys in all age groups had sex with someone of the opposite sex during their most recent sexual encounter. 3 per cent of boys and 2 per cent of girls had their most recent sexual encounter with the same sex. Among non-binary gender persons the most common recent sex partner was a boy (52 per cent) (CI: 37.5-67). The highest proportion who had a sexual encounter with the same sex was among boys in the age group 20-24 years old (4 per cent) followed by boys in the age group 16-19 (2 per cent). 1 per cent of boys and 0.3 per cent of girls had their most recent sexual encounter with more than one person.

Number of partners over the past year

Among those who had sexual debut, the average number of partners over the past 12 months was 2 and the median was 1. Over the past 12 months,

51 per cent of those who had sexual debut with a partner had 1 sex partner. 26 per cent did not have any partner at all over the past year.

A higher proportion of girls (57 per cent) than boys (45 per cent) only had 1 partner over the past 12 months. Among non-binary gender persons 40 per cent (CI: 28.4–52.2) had 1 partner over the past 12 months.

A higher proportion of boys (33 per cent) than girls (19 per cent) did not have any partner over the past 12 months. Among non-binary gender persons 45 per cent (CI: 32.4–56.3) did not have any partner over the past year.

In total, 2 per cent had 10 or more sex partners over the past 12 months.

Approximately the same proportion of girls (2 per cent) as boys (3 per cent) had 10 sex partners or more over the past 12 months. Among non-binary gender persons 3 per cent (CI: 0–7) had 10 partners or more. Table 2 shows the distribution of number of partners by age group.

Table 3. Number of partners over the past year

How many people have you had sex with over the past 12 months? If you are unsure, please estimate. Question 28.

Number of partners over the past year (12 months)	16–19 years old % (95 % CI)	20–24 years old % (95 % CI)	25–29 years old % (95 % CI)
None	54,6 (52,5–56,8)	22,5 (20,5–24,4)	10,9 (9,4–12,5)
1 partner	25,5 (23,7–27,4)	49,9 (47,6–52,1)	67,5 (65,3–69,7)
2 partners	9,3 (8–10,5)	10,4 (9–11,7)	8,5 (7,2–9,8)
3 partners	4,2 (3,4–5,1)	6,6 (5,5–7,7)	4,5 (3,6–5,5)
4 partners	2,9 (2,1–3,6)	3,7 (2,8–4,5)	3,7 (2,8–4,6)
5 partners	1,5 (1–2)	3,3 (2,5–4,1)	2,5 (1,8–3,2)
6–10 partners	0,9 (0,5–1,3)	0,4 (0,2–0,7)	0 (0–0,1)
10 or more partners	1,1 (0,6–1,6)	3,2 (2,4–4)	2,3 (1,6–3)

Unprotected sex

Young people had unprotected vaginal or anal sexual intercourse with 1 sex partner on average in total over the past 12 months (median 1).¹⁴

14. In UngKAB15 one question was included on sexual acts which can transmit HIV or other sexually transmitted infections (STIs) and result in pregnancy. The most risky act is unprotected anal and vaginal sexual intercourse. There is also a risk of transmission of STIs during oral sex. UngKAB15 only asked about experiences of unprotected vaginal and anal sexual intercourse. The question is still deemed as adding important information and is therefore presented.

A higher proportion of girls (48 per cent) than boys (39 per cent) reported that they had unprotected vaginal or anal sexual intercourse with 1 partner over the past 12 months. Among non-binary gender persons the proportion was 40 per cent (CI: 42.4-67.3).

A higher proportion of girls (3 per cent) than boys (2 per cent) also had unprotected vaginal or anal sexual intercourse with 6-10 partners over the past 12 months. The same proportion of girls and boys (1 per cent) had 10 or more partners.

Among non-binary gender persons 0 per cent (CI: 0) had unprotected vaginal or anal sexual intercourse with 6-10 partners, and 0 per cent (CI: 0) had unprotected vaginal or anal sexual intercourse with 10 partners or more over the past 12 months.

The age group with highest proportion of unprotected sexual contacts (number of partners) was 20-24 year olds, where 4 per cent had 6-10 partners with who they had unprotected vaginal or anal sexual intercourse over the past 12 months (table 4).

Den åldersgrupp med högst andel oskyddade sexuella kontakter var 20-24-åringarna, där 4 procent hade 6-10 partner med vilka de hade oskyddade vaginala eller anala samlag under de senaste 12 månaderna (tabell 4).

Table 4. Number of sex partners with who you had unprotected sex
How many sex partners have you had unprotected anal or vaginal sexual intercourse with over the past 12 months? If you are unsure, please estimate. Question 49.

Number of unprotected contacts over the past 12 months	16-19 years old % (95 % CI)	20-24 years old % (95 % CI)	25-29 years old % (95 % CI)
None	64 (61,9-66,2)	36 (33,9-38,2)	24,8 (22,8-26,8)
1 partner	21,8 (19,9-23,6)	40,3 (38,2-42,5)	58,3 (56-60,5)
2 partners	5,8 (4,7-6,8)	8,9 (7,6-10,1)	7,3 (6-8,5)
3 partners	3,2 (2,4-4)	5,4 (4,3-6,4)	2,7 (2-3,4)
4 partners	1,7 (1,1-2,3)	2,4 (1,8-3,1)	2,8 (2-3,5)
5 partners	1,5 (1-2,1)	2 (1,4-2,6)	1,7 (1,1-2,3)
6-10 partners	1,5 (1-2,1)	3,7 (2,8-4,5)	1,7 (1,1-2,3)
10 or more partners	0,4 (0,1-0,8)	1,3 (0,7-1,8)	0,8 (0,4-1,2)

Alcohol and drugs in connection with the most recent sexual encounter

19 per cent had consumed alcohol in connection with the most recent sexual encounter. Among other drugs, hash, marijuana or cannabis (2 per cent)

dominated, while a smaller proportion (0.6 per cent) had used amphetamine, cocaine or other Internet drugs. In total (0.1 per cent) had injected drugs.

A higher proportion of boys (22 per cent) than girls (17 per cent) had consumed alcohol during their most recent sexual encounter. A higher proportion of boys (3 per cent) than girls (1 per cent) had also used hash, marijuana or cannabis. In terms of use of other narcotics such as, for example, amphetamine, cocaine, heroin or other Internet drugs, they were used by equally large proportions of boys and girls (1 per cent) during their most recent sexual encounter. An equally large proportion of both girls and boys had also injected drugs during their most recent sexual encounter (0.1 per cent). Among non-binary gender persons there was a tendency for lower proportions who had consumed alcohol and used drugs compared to girls and boys, for example, 10 per cent (CI: 1.6-18.1) had consumed alcohol and 2 per cent (CI: 0-7) had used hash or marijuana and 0 per cent had used Internet drugs.

Sex against ones will

A total of 40 per cent reported that they had experience of sexual acts against their will at some point in their lives. The proportion was higher among girls (54 per cent) than boys (27 per cent). Among non-binary gender persons the proportion was 53 per cent (CI: 41-65.8).

The most common sexual acts against ones will were in the following order: that someone touched your genitals or breasts (29 per cent), that someone exposed themselves indecently (16 per cent), vaginal sexual intercourse (13 per cent), oral sex (11 per cent), masturbated for someone (8 per cent), anal sexual intercourse (5 per cent), that someone has distributed nude photographs of you (2 per cent) and that you have distributed nude photographs of yourself without your will (2 per cent). Table 4 shows the proportions divided by age and sex.

More than twice as many girls (42 per cent) compared to boys (16 per cent) have experienced someone touching their genitals or breasts against their will. Among girls 18 per cent had vaginal sexual intercourse against their will. Among girls, a higher proportion also had experience of someone distributing nude photographs of them on the Internet (3 per cent) compared to boys (1 per cent).

Among non-binary gender persons 40 per cent (CI: 28.3–52.3) had experienced someone touching their genitals or breasts against their will, 17 per cent (CI: 7.7–26.2) had vaginal sexual intercourse against their will

and 5 per cent (CI: 0.1–8.9) had anal sexual intercourse against their will. Bland personer som inte ville kategorisera sig utifrån kön hade 40 procent (KI: 28,3–52,3) erfarenhet av beröring av kön eller bröst mot deras vilja, 17 procent (KI: 7,7–26,2) hade haft vaginalt samlag mot sin vilja och 5 procent (KI: 0,1–8,9) procent) hade haft analt samlag mot sin vilja.

Table 5. Sex against ones will
Have you experienced the following acts against your will? ... Question 47.

Most common reported incident against your will	Girls 16–29 years old % (95 % CI)	Boys 16–29 years old % (95 % CI)
1	Someone has touched your genitals or your breasts 42.4 (40.8-44.1)	Someone has touched your genitals or your breasts 16.2 (14.6-17.7)
2	Someone has exposed themselves indecently in front of you 21.4 (20-22.8)	Someone has exposed themselves indecently in front of you 10.1 (8.8-11.4)
3	You have had vaginal sexual intercourse 18.4 (17-19.8)	You have had vaginal sexual intercourse 7.4 (6.3-8.6)
4	You have had oral sex 13.6 (12.3-14.8)	You have had oral sex 7.2 (6.1-8.3)
5	You have masturbated for someone 10.4 (9.4-11.5)	You have masturbated for someone 5.9 (5-6.9)
6	You have had anal sexual intercourse 7.2 (6.3-8.2)	You have had anal sexual intercourse 2.4 (1.7-3.1)
7	Someone has distributed nude photographs of you on the Internet 2.8 (2.1-3.4)	Someone has distributed nude photographs of you on the Internet 1.3 (0.8-1.8)
8	You have distributed nude photographs of yourself 2.1 (1.6-2.7)	You have distributed nude photographs of yourself 1.2 (0.7-1.6)

Reimbursement for sex

In total 3 per cent of the young people had paid for sex or had given other reimbursement for sex at some point. The proportion was higher among boys (5 per cent) than girls (1 per cent). The highest proportion (8 per cent) who paid for sex/had given reimbursement was among boys 25–29 years old. Among non-binary gender persons the proportion who paid was 3 per cent (CI: 0-7.1).

The proportion of young people who received payment for sex or had given other reimbursement for sex was 3 per cent. The proportion among girls was 3 per cent and among boys it was 2 per cent. Among non-binary gender persons the proportion was 5 per cent (CI: 3 (0-7.1)). Table 6 presents the responses by age and sex.

Table 6. Reimbursement for sex.

Have you ever paid or received payment for a sexual service? Question 48a and b.

Age and sex % (95 % KI)	Given reimbursement or payment for sex % (95 % KI)	Received reimbursement of payment for sex % (95 % KI)
16-19 years old - girls	1,2 (0,6-1,9)	2,4 (1,5-3,3)
16-19 years old - boys	1,1 (0,4-1,8)	1,3 (0,6-2)
20-24 years old - girls	0,7 (0,2-1,2)	2,8 (1,8-3,9)
20-24 years old - boys	3,8 (2,4-5,2)	2,1 (1-3,2)
25-29 years old - girls	0,4 (0,2-0,8)	3,4 (2,2-4,5)
25-29 years old - boys	8,3 (6,3-10,3)	2,1 (1-3,2)

CHAPTER 8

Contraceptive methods and contraceptives



8. Contraceptive methods and contraceptives

The chapter presents young people's attitude towards, experience of and any obstacles to contraceptive methods and contraceptives. In this context contraceptive method refers to condom, female condom (also referred to as Femidom), safe periods (previously referred to as natural family planning which can now be supported by computer-based applications) and sexual intercourse interrupted by withdrawal of the penis before ejaculation. Contraceptives refer to all others listed in the survey.

Main results

- In total 89 per cent reported that it is important to protect oneself with contraceptives to avoid unwanted pregnancy. The same proportion stated that it is important to protect oneself against a sexually transmitted infection if necessary in a sexual relationship.
- The protection the highest proportion were likely to consider using was a condom (88 per cent), followed by contraceptive pills (47 per cent). However, the most common protection which was used during the most recent sexual encounter was the hormonal method¹⁵ (50 per cent), followed by a condom throughout sexual intercourse (25 per cent).
- A higher proportion of boys (4 per cent) than girls (1 per cent) did not want to use a condom and reported that they would be annoyed if their partner suggested it.
- A higher proportion of girls between the ages of 16 to 19 (80 per cent) were likely to consider using hormonal contraceptives compared to girls between the ages of 25 to 29 (50 per cent).
- The highest proportion (4 per cent) who could not afford their hormonal contraceptives comprised girls 16–19 years old.

15. In the survey the option hormonal method comprised: contraceptive pills, mini-pills, contraceptive implants, contraceptive vaginal rings, contraceptive patches, coils.

Are contraceptives and contraceptive methods important?

In total 89 per cent reported that it is important to protect oneself with contraceptives to avoid unwanted pregnancy. All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner. A higher proportion of girls (91 per cent) than boys (86 per cent) reported that protection from unwanted pregnancy is important. Among non-binary gender persons 81 per cent (CI: 72.2–90.2) reported that this was important. The highest proportion (13 per cent) who did not know whether protection against unwanted pregnancy in a sexual relationship is important was among boys 16–19 years old.

In total 89 per cent stated that it is important to protect oneself against a sexually transmitted infection if necessary in a sexual relationship. The proportion was higher among girls (92 per cent) than boys (86 per cent). Among non-binary gender persons the proportion was 88 per cent (CI: 80.4–95.2). All respondents in the study were asked this question, irrespective of whether they had sexual debut with a partner.

Possibility to suggest using a condom or other contraceptive

In total 89 per cent reported that they could suggest using a condom or other contraceptive, if they wanted to, during their most recent sexual encounter. Approximately the same proportion among girls (90 per cent) as boys (89 per cent) felt that they could suggest using protection. Among non-binary gender persons the proportion was 78 per cent (CI: 64.4 - 90.9).

Possible contraceptive methods and contraceptives

In a ranking of possible contraceptives and contraceptive methods, condoms ranked first (88 per cent), followed by contraceptive pills (47 per cent), mini-pills (39 per cent), so called “safe periods” (38 per cent), coils (38 per cent), contraceptive implants (31 per cent), contraceptive vaginal rings (23 per cent), contraceptive patches (21 per cent), female condoms, also referred to as Femidom (16 per cent) and diaphragms (13 per cent) were the last option.

The highest proportion (80 per cent) who were likely to consider using contraceptive pills was among girls 16–19 years old, and the highest proportion (95 per cent) who were likely to consider using a condom was among boys in the age group 16–19 years old. Among non-binary gender persons 39 per cent (CI: 58–61.7) reported that they were likely to consider using contraceptive pills and 90 per cent (CI: 82.8–97.4) reported that they were likely to consider using a condom.

Used contraceptive methods and contraceptives

The contraceptive methods and contraceptives which were actually used during the most recent sexual encounter were the hormonal method (50 per cent), a condom throughout the sexual intercourse (25 per cent), sexual intercourse interrupted by withdrawal of the penis before ejaculation (8 per cent), wearing a condom right before ejaculation (4 per cent), copper coil (4 per cent) and safe periods (3 per cent).

In total a small group used female condoms (0.3 per cent) and diaphragms (0.1 per cent). 8 per cent did not use any protection, as they had sex in a way that they did not need protection. Furthermore, 7 per cent stated that they used protection other than the options stated in the survey. The open responses showed that the most common protection which is not listed in the survey but which was used by the respondents was a fertility computer. A fertility computer registers the body temperature and is based on the principle of “safe periods,” i.e. that you avoid having sexual intercourse on the days around ovulation.

A higher proportion of girls (53 per cent) than boys (48 per cent) reported that they used the hormonal method during their most recent sexual encounter. The case was the opposite for use of condoms, where a higher proportion of boys (30 per cent) than girls (20 per cent) reported that they had used a condom during their most recent sexual encounter. The highest proportion (52 per cent) who used the hormonal method during their most recent sexual encounter comprised girls 16–19 years old. Among boys, the highest proportion (30 per cent) who had used a condom during their most recent sexual encounter was among 16–19 years old.

Attitude towards condoms

The respondents reported the following attitude and approach towards condoms: *A sex partner who suggests using a condom is responsible and considerate* (69 per cent), *It is good because you do not have to worry afterwards* (51 per cent), *Prefer using a condom and therefore it is good if a partner suggests it* (46 per cent). All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner.

A higher proportion of girls (73 per cent) than boys (66 per cent) stated that a partner who suggests using a condom is responsible and considerate. Among non-binary gender persons the corresponding proportion was 68 per cent (CI:56.6-78.5). The same proportion of girls and boys (10 per cent) reported that a partner who suggests using a condom assumes that either of them has a sexually transmitted infection. A higher proportion of boys (4 per cent) than girls (1 per cent) did not want to use a condom and reported that they would be annoyed if their partner suggested it. A higher proportion of boys (13 per cent) than girls (9 per cent) also stated that a condom is not needed if you know your partner from before.

How were condoms used during the most recent sexual encounter?

A condom is a contraceptive method which needs to be used correctly in order to attain a safe level of protection. As mentioned earlier, in total one-fourth (25 per cent) stated that they used a condom throughout the sexual intercourse. Among non-binary gender persons 33 per cent (CI: 18.9–47.7) used a condom throughout their most recent sexual encounter.

In terms of condom use by boys (see table 7) during their most recent sexual encounter, the highest proportion (40 per cent) of those who had used a condom throughout the sexual encounter was among 16–19 year olds

Table 7. How condoms were used during the most recent sexual encounter
Did you/your partner use any of the following types of protection or contraceptives during the most recent sexual encounter? Question 33.

Age and sex	Condom throughout sexual intercourse % (95 % KI)	Condom right before ejaculation % (95 % KI)
16–19 years old - boys	39,7 (34,6–44,9)	3,3 (1,3–5,3)
20–24 years old - boys	33,5 (29,7–37,2)	3,7 (2,2–5,2)
25–29 years old - boys	25,3 (22–28,6)	3,6 (2,1–5,1)

Reasons for not using hormonal contraceptives

Girls who did not use hormonal contraceptives over the past 12 months stated the following reasons: not required (40 per cent), did not want to use hormonal methods (25 per cent), worried about side effects (23 per cent), use a condom instead (18 per cent), want to get pregnant (12 per cent), advised against use of hormonal contraceptives by medical care services (4 per cent), cannot afford them (3 per cent), did not have the time to collect the prescription (3 per cent).

The highest proportion (6 per cent) who did not have the time to collect their hormonal contraceptives was among 16–19 year olds. The highest proportion (4 per cent) who could not afford their hormonal contraceptives was also among 16–19 year olds. Among 25–29 year olds the highest proportion (25 per cent) reported a fear of side effects or a dislike of hormones (30 per cent).

A review of the survey's open answers revealed that the two most common reasons for not using hormonal contraceptives over the past 12 months was the experience of side effects ($n= 60$) or pregnancy or breastfeeding ($n= 48$).

CHAPTER 9

Sexually transmitted infections



9. Sexually transmitted infections

The chapter addresses young people's experience of having or living with a sexually transmitted infection, HIV or hepatitis. The chapter also addresses experiences of counselling in connection with testing.

Main results

- In total 11 per cent had chlamydia. It is thus the most common sexually transmitted infection among young people.
- A higher proportion of girls (79 per cent) than boys (63 per cent) stated that it is important to get tested when you are in a sexual relationship.
- A higher proportion of girls (67 per cent) than boys (40 per cent) had been tested for a sexually transmitted infection, HIV or hepatitis at some point in their lives. Among young people between the ages of 16 to 19, three times as many girls as boys reported having been tested for chlamydia.
- Out of the 53 per cent who had at some point been tested, 49 per cent had counselling on risks and protection at the occasion of their most recent test. A higher proportion of girls (51 per cent) than boys (46 per cent) had such counselling. In addition, a higher proportion of girls (60 per cent) than boys (45 per cent) also reported that the counselling motivated them to use protection.

Sexually transmitted infections, HIV and hepatitis

The most common sexually transmitted infection young people report currently having or which they have had in the past is chlamydia (11 per cent), condyloma (4 per cent), genital herpes (2 per cent), gonorrhoea (0.4 per cent), hepatitis B (0.2 per cent), hepatitis C (0.2 per cent) and syphilis (0.1 per cent).

A higher proportion of girls (15 per cent) than boys (7 per cent) reported currently having chlamydia or having had chlamydia in the past. Among non-binary gender persons the proportion with chlamydia was 4 per cent (CI: 0-8.6).

In terms of gonorrhoea there was a tendency for a higher proportion of boys (1 per cent) than girls (0 per cent) currently having gonorrhoea or having had gonorrhoea in the past. However, among 25–29 year olds the same proportion of boys (1 per cent) as girls (1 per cent) had gonorrhoea in the past. Among non-binary gender persons the proportion with gonorrhoea was 0 per cent. Furthermore, a higher proportion of girls (4 per cent) than boys (1 per cent) reported that they had genital herpes.

Among boys 0.2 per cent had syphilis, but none of the girls and non-binary gender persons reported having syphilis (0 per cent). There was a tendency for a higher proportion of boys having hepatitis B (0.4 per cent) than girls (0.1 per cent). In terms of hepatitis C, almost the same proportion of girls (0.1 per cent) and boys (0.2 per cent) reported having hepatitis C. Among boys 0.1 per cent had HIV, while no girls and non-binary gender persons reported living with HIV (0 per cent). Table 8 presents the four most common sexually transmitted infections divided by age and sex.

Table 8. Chlamydia, condyloma, genital herpes and gonorrhoea.

Do you currently have or have you in the past had any of the following infections? Question 50 a, b and d as well as question 51b.

Age and sex	Chlamydia % (95 % KI)	Condyloma % (95 % KI)	Genital herpes % (95 % KI)	Gonorrhoea % (95 % KI)
16–19 years old – girls	3,1 (2,1–4,2)	0,4 (0–0,7)	0,5 (0,1–0,9)	0,1 (0–0,2)
16–19 years old – boys	0,8 (0,2–1,4)	0,2 (0–0,5)	0 (0–0)	0,3 (0–0,7)
20–24 years old – girls	14,7 (12,7–16,8)	3,2 (2,2–4,2)	3,3 (2,4–4,3)	0 (0–0)
20–24 years old – boys	6,8 (5–8,6)	1,6 (0,8–2,5)	0,5 (0–1,1)	0,4 (0–0,8)
25–29 years old – girls	21,1 (18,6–23,5)	8,4 (6,8–10)	5,8 (4,3–7,2)	0,6 (0,1–1,1)
25–29 years old – boys	11 (8,8–13,2)	5,1 (3,7–6,6)	1,3 (0,6–2)	0,7 (0,1–1,4)

Is it important to get tested?

71 per cent stated that it is important to get tested when you are in a sexual relationship. The proportion was higher among girls (79 per cent) than boys (63 per cent). A higher proportion of boys (13 per cent) than girls (5 per cent) stated that it is not important to get tested. The highest proportion (14 per cent) who reported that testing is not important was among boys 25–29 years old. A higher proportion of boys (24 per cent) than girls (15 per cent) did not know or did not have an opinion. All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner.

Experience of testing

In total 53 per cent had been tested¹⁶ for a sexually transmitted infection, HIV or hepatitis at some point in their lives. Regarding all sexually transmitted infections, HIV and hepatitis, a higher proportion of girls (67 per cent) than boys (40 per cent) had at some point been tested.

It was most common to get tested for chlamydia (49 per cent) followed by HIV (23 per cent), gonorrhoea (23 per cent), condyloma (21 per cent), genital herpes (20 per cent), hepatitis B (18 per cent), hepatitis C (18 per cent) and syphilis (17 per cent). All respondents in the study were asked the question, irrespective of whether they had sexual debut with a partner.

The difference between the experience of girls and boys for testing of a sexually transmitted infection, HIV or hepatitis was greatest for chlamydia and HIV. Almost twice as many girls as boys have been tested for this. 64 per cent of girls and 31 per cent of boys had been tested for chlamydia, and 35 per cent of girls and 17 per cent of boys had been tested for HIV. The greatest difference was in testing for chlamydia among 16–19 year olds, where three times as many girls (28 per cent) as boys (9 per cent) had been tested.

Where did the most recent test take place?

The six most common places where respondents got tested most recently for a sexually transmitted infection, HIV or hepatitis were youth health clinics (46 per cent), medical centres or family doctors (20 per cent), midwifery clinics (13 per cent), ordered tests on the Internet (7 per cent), venereologists, gynaecologists, or sexual health clinics (7 per cent) and infectious disease clinics (7 per cent).

As mentioned earlier, a significantly higher proportion of girls than boys got tested. Of those who got tested at some point, roughly the same proportion of girls (46 per cent) and boys (45 per cent) have been to a youth health clinic on the occasion of their most recent test. Twice as many boys (30 per cent) as girls (15 per cent) got tested in a medical centre or by a family doctor. 21 per cent of the girls got tested at a midwifery clinic. A higher proportion of boys (10 per cent) than girls (6 per cent) had ordered a test on the Internet, and a higher proportion of boys (3 per cent) than girls (1 per cent) got tested

16. For some of these sexually transmitted infections examination applies and not just testing. The concept testing is used in this report for the sake of simplicity.

at an infectious disease clinic. The same proportion of girls and boys (7 per cent) got tested at other clinics by, for example, venereologists, gynaecologists, or at sexual health clinics .

Counselling on protection

In total 49 per cent of those who got tested for a sexually transmitted infection, HIV or hepatitis, had counselling on protection at the occasion of their most recent test. A higher proportion of girls (51 per cent) than boys (46 per cent) had such counselling. Among non-binary gender persons the proportion who had counselling was 32 per cent (CI: 13.1-50.2). The highest proportion (71 per cent) who had counselling was among girls 16-19 years old and the lowest proportion (38 per cent) was among boys 25-29 years old.

Experience of the counselling

The majority (81 per cent) reported that they were treated with respect during the counselling they had in connection with testing of a sexually transmitted infection, HIV or hepatitis. There was no difference between girls and boys. Among non-binary gender persons 61 per cent (CI: 28.4–94.5) stated that they were treated with respect. In total roughly half (55 per cent) reported that they were motivated to use contraceptives. The proportion was higher among girls (60 per cent) than boys (45 per cent).

For the question on whether the counselling had resulted in behaviour change, 46 per cent stated that after the counselling they use condoms or other contraceptives. The proportion was higher among girls (52 per cent) than boys (34 per cent). In total 19 per cent reported that the counselling resulted in them not having unprotected sex and the proportion was higher for girls (22 per cent) than boys (14 per cent) in this context as well.

Why don't young people get tested for sexually transmitted infections or HIV?

With the aim of exploring any obstacles to testing, a number of questions were asked to those who had sexual debut but had not got tested. All those who reported that they did not get tested for any sexually transmitted infection or HIV were asked this question. The most common reasons for respondents not to get tested were: I haven't thought about it (50 per cent),

I haven't had unprotected sex (46 per cent), I don't know where to get tested (7 per cent), I'm scared of being recognised by the staff or other visitors (4 per cent), I don't have faith in the obligation of secrecy (3 per cent), The opening hours don't suit me (2 per cent), It is hard for me to get to a clinic (2 per cent) or I was refused a test even though I wanted one (1 per cent). A higher proportion of boys (52 per cent) than girls (45 per cent) responded that the reason they had not got tested was that they had not thought about it. The results also showed that 6 per cent of the girls and 8 per cent of the boys did not know where to get tested.

CHAPTER 10

Unwanted pregnancies and abortion



10. Unwanted pregnancies and abortion

The chapter addresses issues on unwanted pregnancies and abortion and the counselling young people had in connection with abortion.

Main results

- A total of 16 per cent reported that they had experience of themselves or their partner having an abortion.
- Among those who stated that they or their partner had an abortion, 58 per cent reported that they or their partner had seen a counsellor, midwife or doctor for professional counselling in connection with the abortion.
- Of those who had counselling, 27 per cent reported that they were motivated to consider how to protect themselves in the future. A higher proportion of girls (42 per cent) than boys (20 per cent) reported that counselling had increased their knowledge of how to protect themselves against unwanted pregnancies.

Emergency contraceptive pills after the most recent sexual encounter

In total 1 per cent responded that they had used emergency contraceptive pills after the most recent sexual encounter.¹⁷ Among non-binary gender persons 4 per cent (CI: 0-9.2) used emergency contraceptive pills after their most recent sexual encounter. Among girls the highest proportion (3 per cent) was among 16–19 year olds.

Erfarenhet av abort

17. Emergency contraceptive pills contain a hormone which makes ovulation stop or postpones it. Thus, emergency contraceptive pills do not terminate a pregnancy and are therefore not considered as constituting abortion.

16 per cent reported that they had experience of themselves or their partner having an abortion. The proportion of girls (16 per cent) was approximately the same as the proportion of boys (15 per cent). Among non-binary gender persons the proportion who had experience of abortion was 6 per cent (CI:0-13.1). 5 per cent of the boys did not know whether their partner had an abortion.

Which clinics were the young people in contact with in connection with the abortion?

The most common clinics young people had contact with in connection with abortion were gynaecological clinics at hospitals (40 per cent), youth health clinics (33 per cent), midwifery clinics (31 per cent), medical centres (13 per cent), health clinics within social service or addiction care (16 per cent).

Counselling in connection with abortion

Of those who had an abortion, 58 per cent had seen a counsellor, midwife or doctor in connection with the abortion. A higher proportion of girls (69 per cent) than boys (46 per cent) reported that they or their partner had counselling. Among 16–19 year olds, three times as many girls (72 per cent) as boys (24 per cent) reported that they or their partner had counselling in connection with the abortion. A higher proportion of boys (26 per cent) than girls (5 per cent) reported that they did not know whether their partner had counselling in connection with the abortion. The highest proportion of boys (53 per cent) who did not know whether they or their partner had counselling was among 16–19 year olds.

Experience of counselling in connection with abortion

Those who had counselling stated the following: More knowledge of protection against unwanted pregnancy (35 per cent), I did not start to think about how I protect myself or choice of contraceptive (29 per cent), I think about it but it has not affected my choice of contraceptive method (21 per cent). A higher proportion of girls (42 per cent) than boys (20 per cent) reported that counselling had increased their knowledge of how to protect themselves against unwanted pregnancies.

46 per cent reported that they were treated with respect in connection with the counselling. The proportion was higher among girls (63 per cent) than boys (24 per cent). 27 per cent reported that they were motivated to consider how to protect themselves in the future. The proportion was higher among girls (37 per cent) than boys (15 per cent).

CHAPTER 11

Knowledge and needs



11. Knowledge and needs

The chapter addresses results on knowledge of chlamydia and HIV, from where young people obtain their information and their need of health promotion initiatives.

Main results

- Boys in all age groups had lower knowledge of sexually transmitted infections and HIV than girls and non-binary gender persons.
- In total the majority (70 per cent) obtained their information about sexuality, contraceptives and sexually transmitted infections from the Internet. A higher proportion of girls (52 per cent) compared to boys (36 per cent) obtained their information from the Internet through quality-assured health and medical care web pages, such as 1177 Vårdguiden and UMO.
- 49 per cent reported that the school had provided them adequate education to maintain their sexual health. The proportion was higher among boys than girls. Among non-binary gender persons 32 per cent (CI:19.9-43.2) reported that the school had provided adequate education to them.
- The school had provided adequate education on how to get pregnant (75 per cent), knowledge of the body (64 per cent) and knowledge of condom usage (62 per cent). The school had provided inadequate education on gender, relationships and gender quality (35 per cent), HIV (31 per cent) and norms and LGBT perspectives (25 per cent).
- The three main areas where young people wanted more information include how to make a relationship work well (30 per cent), the current situation for those living with HIV (28 per cent), how to find someone to have a relationship with (21 per cent). The two principal areas where young people had a need for health promotion and prevention initiatives were cheaper contraceptives (46 per cent) and free condoms (41 per cent).

Knowledge

Based on a number of claims, young people presented their knowledge of chlamydia and HIV. Young people had greatest knowledge of the protection purpose of condoms, where 88 per cent responded that if you use a condom every time you have sex then the risk of chlamydia decreases. Also, 87 per cent reported that if you use a condom every time you have sex, the risk of HIV transmission decreases.

A higher proportion of girls (80 per cent) than boys (67 per cent) were aware that it is important to get tested if you stop using a condom with a new partner. Among non-binary gender persons the corresponding proportion was 71 per cent (CI: 59.7-82.6).

A higher proportion of girls (56 per cent) than boys (46 per cent) were aware that persons living with HIV and receiving treatment can live as long as others.

Main source of information

In total, young people mainly obtained their information on relationships, sexuality, contraceptives and sexually transmitted infections in the following manner: the Internet (70 per cent), friends (60 per cent), education on gender equality, sexuality, sex and relationships in school (55 per cent), youth health clinics (47 per cent) the websites 1177 Vårdguiden and UMO (44 per cent), TV, magazines and radio (32 per cent), partner (24 per cent), mother (22 per cent) printed information (12 per cent), father (11 per cent), clinics within health and medical care (10 per cent), siblings (10 per cent), student health service (8 per cent), other (3 per cent), guardian (1 per cent).

A higher proportion of boys (72 per cent) than girls (66 per cent) mainly obtain their information on sexuality, contraceptives and sexually transmitted infections from the Internet. Among non-binary gender persons the proportion was 78 per cent (CI: 66.1-86.7).

In terms of information on the Internet, a higher proportion of girls (52 per cent) than boys (36 per cent) obtained quality-assured information from health and medical care through, for example, 1177 Vårdguiden and UMO. Among non-binary gender persons the proportion was 50 per cent (CI: 38-62.7).

A higher proportion of girls (66 per cent) than boys (54 per cent) mainly obtained information from friends. A higher proportion of girls (59 per cent) than boys (36 per cent) also mainly obtained information from youth

health clinics. Among non-binary gender persons the proportion was 39 per cent (CI: 27.6-51.1).

On the contrary, a higher proportion of boys (59 per cent) than girls (52 per cent) obtained information on relationships and sexuality from school education. Among non-binary gender persons the proportion was 59 per cent (CI: 46.4-70.8).

A higher proportion of boys (10 per cent) than girls (7 per cent) also mainly obtained information from the student health service. Among non-binary gender persons the proportion was 10 per cent (CI 2.4-17.6).

School

In total, 49 per cent reported that they obtained adequate education to take care of their sexual health, while 44 per cent reported that they had inadequate education. 7 per cent reported that they did not receive any teaching at all. A higher proportion of boys (58 per cent) than girls (41 per cent) stated that school had provided them adequate education. Among non-binary gender persons 32 per cent (CI:19.9-43.2) reported that the school had provided adequate education to them.

The three areas which were highlighted the most in the education and which provided adequate knowledge were: how to get pregnant (75 per cent), knowledge of the body (64 per cent) and knowledge of condom usage (62 per cent). The three areas which were least highlighted in the education were gender, relationships and gender equality (35 per cent), HIV (31 per cent) and norms and LGBT perspectives (25 per cent).

A higher proportion of girls (79 per cent) than boys (72 per cent) reported that they obtained adequate education on how to get pregnant. A higher proportion of boys (49 per cent) than girls (33 per cent) reported that they obtained adequate education on sexually transmitted infections. Furthermore a higher proportion of boys (45 per cent) than girls (27 per cent) reported that they obtained adequate education on gender, relationships and gender equality. In terms of LGBT perspectives, a higher proportion of boys (34 per cent) than girls (16 per cent) reported that they obtained adequate education in school.

The knowledge needs of young people

Young people would like more knowledge of how to make a relationship work well (30 per cent), the current situation for those living with HIV (28 per cent), how to find someone to have a relationship with (21 per cent), how sexually transmitted infections are transmitted (20 per cent), how to flirt and pick up (20 per cent), use of contraceptives (19 per cent), how HIV is transmitted (17 per cent), how to prevent a condom from breaking (16 per cent), how to talk about sex with a partner (16 per cent), different methods of safer sex (14 per cent), how to prevent unwanted pregnancy (11 per cent), how to talk about contraceptives with a sex partner (9 per cent) and condom usage (7 per cent). In addition, 32 per cent reported that they did not need new knowledge.

A higher proportion of boys (25 per cent) than girls (17 per cent) wanted more knowledge of how to find someone to have a relationship with. Among non-binary gender persons the corresponding proportion was 39 per cent (CI: 26.6-51.1).

The same proportion of boys as girls (31 per cent) wanted more knowledge of how to make a relationship work well. Among non-binary gender persons the corresponding proportion was 48 per cent (CI: 35.5-60.6).

Roughly the same proportion of girls (15 per cent) as boys (16 per cent) want more knowledge of how to talk about sex with a partner and the same proportion of girls as boys (7 per cent) want more knowledge of condom usage.

The needs of young people for promotion and prevention initiatives

In terms of health promotion and prevention initiatives, young people would mainly like to have cheaper contraceptives (46 per cent), free condoms (41 per cent), more knowledge of fertility and pregnancy (30 per cent), more knowledge of sexually transmitted infections (29 per cent), more knowledge of the body (24 per cent), knowledge of how to order chlamydia tests on the Internet (23 per cent), opportunity to talk to someone about sexuality and relationships (21 per cent) as well as clinics for testing and advice which are open during the weekends (21 per cent).

A higher proportion of boys (45 per cent) than girls (37 per cent) stated that they needed free condoms. Among non-binary gender persons 49 per

cent (CI: 36.4–60.9) reported a need of free condoms. Roughly the same proportion of girls (24 per cent) as boys (23 per cent) wanted more knowledge of how to order a chlamydia test on the Internet.

A higher proportion of girls (55 per cent) than boys (33 per cent) stated that they needed cheaper contraceptives. Among non-binary gender persons 44 per cent (CI:31.9-56.5) reported that they required cheaper contraceptives.

A higher proportion of girls (25 per cent) than boys (17 per cent) stated that they needed to talk to someone about sexuality and relationships. Among non-binary gender persons 46 per cent (CI: 33.6–58.4) reported that they needed to talk to someone about sexuality and relationships.

CHAPTER 12

Methodology discussion



12. Methodology discussion

Study design

The results of UngKAB15 are based on 7,755 respondents and an analysis of those who did not participate in the study. The response rate 26 per cent was expected and is comparable to this age group in other similar population surveys (63, 64). During a comparison with the population-based sample in UngKAB09 (24 per cent), the response rate in UngKAB15 was slightly higher (29). The problem of declining response rates exists among several quantitative studies in Sweden and globally. The possibility of linking responses to the population data in registers makes survey-based studies at population level in Sweden still being relevant and provides the opportunity of advanced analyses.

The study design which was selected was considered to provide the best quality-assurance in several of the method steps, which is essential. Statistics Sweden's access to a large amount of register data with help information which can create understanding of the results, both in the response groups and in the drop-out, was considered as increasing the validity considerably. Even though the data collection through Statistics Sweden offered quality assurance in several method steps and the opportunity of linking register data to the study, there were deficiencies in the implementation. An improvement area for future studies is to offer respondents the opportunity to answer through mobile online surveys, apps or similar. This could not be offered and in UngKAB15 the digital survey was only customised for completion through a computer. The survey could be completed on the mobile but was not customised in the optimal manner, which could have resulted in a large drop-out. Improvements to the digital survey would probably increase the response rates.

Even though the study design has enabled correction for drop-out based on sex, age (at the end of the year), country of birth, region, level of education, level of education of parents and final grades in school year 9, it is still likely that the drop-out adjustment cannot adjust all aspects. As the drop-out adjustment is weighed into the responses which have already been provided, there may be irrelevant responses. Therefore, it is possible that UngKAB15 has a tendency to, in some respects, describe young people

who have a relatively good socioeconomic status and are relatively active in society. Based on this assumption, it is important to supplement UngKAB15 with advanced studies.

Non-binary gender group

In the results the non-binary gender group is presented. As mentioned earlier (see chapter 4 Methods), the third option for the question on gender identity is not comprehensive and possible explanations for the respondents choosing the option may be that they perceive themselves as non-binary, queer or that they did not understand the question in the manner intended by the survey. In addition, a certain proportion of persons chose non-binary gender persons as they are or have been transgender persons. However, there are no signs in the data to indicate that these individuals did not understand the question, as no major differences in the level of education, income or country or birth could be noted between non-binary gender persons and other young people. General conclusions cannot be drawn based on this categorisation and the results should be interpreted with caution.

Self-perceived discrimination

The questions on discrimination were structured based on knowledge of the fact that discriminatory structures based on the grounds of discrimination impact health. The perspective is based on the three year collaborative project “Discrimination and health”(42). The results of the project showed that discrimination occurs both consciously and unconsciously, that it takes place everywhere in society and that there is a strong connection with ill-health. The reason is that the groups who perceived themselves as being subjected to discrimination the most also had the highest proportions of ill-health. The project concluded that it is useful to monitor self-perceived discrimination based on the grounds of discrimination, but that there are also methodological problems associated with this. The question on self-perceived discrimination captures those who perceived themselves as being subjected to discrimination, but not those who did not have such an experience but may still have been subjected to discrimination. The conclusion was also that it is possible to use an approach which is based on that all forms of discrimination, irrespective of whether it is committed by individuals or institutions, are structurally induced, that is, are based on prevailing

social structures. Discriminatory structures which are captured through self-reported discrimination concern relationships of power within and between groups in society (42, 65). The grounds of discrimination do not comprise a comprehensive perspective on equality issues, as there may be additional reasons for people perceiving that they have experienced discrimination or abusive treatment. However, they comprise a tool for capturing areas where the rights perspective is highlighted and can be discussed based on areas which are particularly important to consider in relation to equality according to the Riksdag.

Comparison UngKAB09 and UngKAB15

The study design of both studies UngKAB09 and UngKAB15 is different, but conforms well with the results of the questions which are exact repetitions (see chapter 13, Discussion of results). The majority of the comparability between the two studies is for the area sexually transmitted infections and safer sex.

The results of both studies indicate that overall there is a high level of knowledge of sexually transmitted infections and that it is possible to protect yourself with a condom. Both studies also show that condom usage is low. As mentioned earlier, young people in UngKAB09 also reported that chlamydia was not considered to be a serious problem. This question was not repeated in UngKAB15, but several of the other questions related to condom usage, safer sex and testing indicate that young people still do not consider chlamydia as being a serious infection.

The HIV prevention work needs to discuss the risk-taking of young people and their attitude towards risks. It may be worth reflecting on the extent to which these questions have been formulated from an adult perspective and do not comprise perspectives which seem to be important for young people. What adults sometimes consider as constituting a risk rather comprises an opportunity for proximity, pleasure and acknowledgement (23, 31, 38). Both UngKAB studies indicate that in terms of knowledge issues, the highest proportion of young people are interested in how to make a relationship work well and how they can find someone to have a relationship with. In future studies it may be important to delve deeply into issues of relationships and relationship perspectives. This can provide new knowledge of the approach of young people towards sexual risk-taking and how society's prevention initiatives for safer sex may be relevant for them.

In terms of study design and method, both surveys can together provide input for future studies. UngKAB09 had a two-piece method with a self-selected sample (5,606 respondents) and an independent random sample (9,329 respondents). The strength was a study with a large number of respondents, but the self-selected sample turned out to be difficult to assess. In addition the random sample did not have calibration weights and no drop-out analysis was performed. The lessons were that despite the large amount of data with 15,000 respondents, it was difficult to convert the study's hypotheses into evidence. As mentioned earlier, the study design of UngKAB15 is very different to this. The survey of 2015 contains several quality requirements which are needed for population surveys.

KAPITEL 13

Discussion of the results



13. Discussion of the results

Eight of ten young people report that they have good or very good health and the results are supported by previous studies (25, 35, 66). The perception of good health increases well-being and can encourage continued healthy choices (36).

However, the results of UngKAB15 show that within the youngest age group 16–19 year olds there is more mental ill-health than in the older groups. In the youngest group, a higher proportion of girls and non-binary gender persons report more ill-health, such as mental ill-health, suicidal thoughts, feelings of not being as good as others and not having control of their lives. The group which consistently experiences generally worse health and self-esteem is young non-binary gender persons and only five of ten among them perceived good or very good health.

In total, 22 per cent report that they have experienced discrimination or abusive treatment over the past 12 months. UngKAB15 shows that girls and non-binary gender persons have experienced abusive treatment within several areas to a higher extent than boys. This indicates that norms on sex create vulnerable positions for girls and non-binary gender persons and non-binary gender identity persons. The fact that boys experience discrimination based on ethnicity and sexual identity indicates that norms within these areas create vulnerable situations among them. The proportion of young people who experience some form of discrimination is the same as that in the latest national public health survey, when 28 per cent of 16–29 year olds experienced that they were treated in a discriminatory or abusive manner. The proportion of young people who experienced discrimination and abusive treatment was higher compared to all other age groups and the proportion of girls was higher than boys (35).

Violence, sexual violence and abuse

In both UngKAB studies, more than four of ten have experienced sexual acts against their will. A higher proportion of girls and non-binary gender persons have been subjected to such abuse compared to boys (29). The fact that there are differences between girls and boys in terms of exposure to sexual acts against ones will has been illustrated in previous studies (28,

30). All sexual acts against a person's will comprise abuse (67). Sexual abuse and sexual violence may include everything from threats or nagging to have sex to forcing someone to perform different types of sexual acts or rape (68). Knowledge within the area shows that there are deficiencies, primarily among boys, in terms of the ability to assess where the boundary for sexual abuse is and that nagging for sex or persuasion for sexual acts is common (49). The prevention work on sexual violence needs to be structured so that it reaches young people irrespective of sex or gender identity and that the perspective of boys also being victimised for sex against their will needs to be included.

UngKAB15 showed that among those who had been exposed to violence, three times as many girls (35 per cent) as boys (11 per cent) have experience of violence at home. Research shows that girls with experience of physical violence have both lower mental and sexual health than those who are not exposed to violence (69). UngKAB15 also shows that almost twice as many boys (50 per cent) as girls (27 per cent) had experience of physical violence in a public place, a result which is in line with previous studies (35, 70). The largest proportion of physical violence in the public space is entertainment-related assault crime, where both the offender and victim are young men under the influence of alcohol, who do not have a close relationship.

Reimbursement for sex

The proportion of young people who have experience of sex for payment or reimbursement for sex is 3 per cent in both UngKAB studies (29). Young people with experience of sex for payment/reimbursement for sex are often socially vulnerable or have experience of discriminatory structures (31, 34, 71).

Within UngKAB15 no covariance analyses have been performed yet which can establish covariation between sex for payment and other variables. In 2009 the results showed that young people with low self-esteem, those who had debut before the age of 15 and high alcohol consumers, cannabis users or users of other drugs had received payment for sex to a greater extent than others (29). Previous studies show that a large proportion of young people with experience of sex for payment comprise young LGBT persons (34, 71).

Existing knowledge highlights the challenge of reaching young people with health promotion and prevention if they already are under socioec-

conomic risk exposure or are exposed to discriminatory structures (38, 71). Young people who have sex for payment do not always seek help, but they have contact with social services more often than others (72).

Existing knowledge within the area also shows that the average age of young people to start selling sex is 15 years among boys and 16 years among girls. Among boys it is more common for the buyer to be of the same sex, while girls almost always report buyers of the opposite sex. The most common forms of compensation are money, but also alcohol, cigarettes and clothes (72).

Safer sex

The primary choice of protection of young people is condoms, but hormonal methods were used to the highest extent during the most recent sexual encounter. This is consistent with results of previous studies (22, 25, 26). Condom usage is a situation-dependent contraceptive method and therefore complex, which is supported by previous research which examined the difference between intent and act (73).

The results of UngKAB15 show that over 85 per cent have knowledge of the protection purposes of condoms. This indicates that the development areas are the capacity for talking about sexuality and safer sex with a partner and building action strategies for safer sex. This is also evident in UngKAB09, where only half of the respondents used condoms during the most recent sexual encounter with a new/casual partner while nine of ten had good knowledge of condoms protecting against sexually transmitted infections (29).

UngKAB15 shows that the majority, but not all (3 per cent), of girls can afford and have access to hormonal contraceptives. Among girls who did not use hormonal methods over the past 12 months, 25 per cent reported that the reason was that they did not want to use hormones. Almost the same proportion reported that they are scared of side effects. The dislike of hormones and worry about side effects should be taken seriously and the reasons need to be studied further and monitored in future studies.

Based on the difference between intent and act, between the intended protection and what was used, the capacity of young people to have double protection (both condoms and hormonal contraceptives) during sexual intercourse between opposite sexes needs to be strengthened. The fact that so few young people used condoms during their most recent sexual encounter

in relation to the incidence of chlamydia and gonorrhoea in the youth group indicates that protection against unwanted pregnancy is insufficient. The preventive work needs to provide conditions for boys becoming more active and responsible to protect themselves and their partner against sexually transmitted infections and if necessary, also against unwanted pregnancy.

Counselling on contraceptives and contraceptive methods needs to involve boys to a higher extent (56, 74). The counselling should also result in a larger number of boys feeling motivated to take responsibility for condom usage in the future. The purpose of involving boys is to strengthen their ability to make own decisions which result in safer sex and promote sexual health.

The health promotion initiatives which young people in the study demand are mainly subsidised or free condoms and contraceptives. There are now examples of a reduction in the number of abortions in county councils which have provided young people the opportunity to have subsidies for a large selection of long-acting reversible contraception (75, 76). As of 2017 the subsidies will be increased up to the age of 21 (77). The results of UngKAB15 show that young people 20–24 years old have the highest proportion of unprotected sexual contact, which means that it is important for subsidies to reach them in the future as well. Accessibility to health and medical care for contraceptives and counselling must also reach boys. Their access to subsidised condoms needs to be discussed. UngKAB15 also shows that young adults 20–29 years old need access to health and medical care for all SRHR issues just like the teenagers.

The number of sex partners has increased over time (22, 27). In UngKAB15 the highest number of unprotected sex contacts (partners) was among 20–24 year olds. Among them 4 per cent had 6–10 unprotected sex contacts (partners) over the past year. Those who had unprotected sex with many partners need to be reached by the prevention work as the number of partners can impact the risk of sexually transmitted infections (41). Counselling on the number of partners and sexual health should contain an investigation and openness of how the persons live sexually, whether they have the number of partners which they want to have and whether they use protection against HIV, sexually transmitted infections and unwanted pregnancy to the extent necessary (78).

Being able to talk about sex facilitates an equal and gender equal sex life, where those involved can attain reciprocity, increase understanding of each other's will and feel safe knowing that refusal, a no, will always be respected. More girls than boys report that it is important to be able to talk about sex in

a sexual relationship. A higher proportion of girls than boys also think that it is important to decide equally. The results reflect current norms on sexuality and that girls assume the majority of the responsibility for communication. Being able to talk about sex with your partner provides the opportunity to together decide on, for example, contraceptive methods, contraceptives and sexual practices. It is also a factor which increases the opportunity of feeling satisfied and attaining well-being. The results of UngKAB15 show that young people, especially boys, need to be strengthened to have such conversations with their partner.

Testing

The proportion of young people who report that they have had chlamydia at some point is approximately 11 per cent in both UngKAB studies. The prevention work on chlamydia is now based on girls almost routinely being tested during counselling for contraceptives (79). The results in UngKAB15 indicate a major difference in the experience of testing for chlamydia between the sexes – 65 per cent of the girls have been tested but only 35 per cent of the boys. The biggest difference is among 16–19 year olds, where more than three times as many girls have been tested compared to boys.

As chlamydia is a sexually transmitted infection which is mainly transmitted between boys and girls, the differences in testing are a problem for the prevention work. That there are unequal conditions for testing of chlamydia has been known for a long time (57, 80).

A higher proportion of boys need to be reached by the prevention work of youth health clinics and the health care sector on sexually transmitted infections. The results of UngKAB15 show that fewer boys than girls have counselling on risks and protection in connection with getting tested for a sexually transmitted infection. Furthermore, boys to a lower extent than girls feel that the counselling encouraged them to use condoms or other contraceptives. This may indicate that guidance counselling and advisory situations are based on stereotypical approaches to the sexuality of girls and boys, and that boys are not involved but experience a sense of alienation or encounter a lack of understanding (81). Boys need better opportunities to seek advice and care on sexual health. They need to be treated in a manner which is adapted to them and where their issues are the starting point (49). Furthermore, health and medical care personnel need to treat boys and girls

in an equal manner, by offering and conducting counselling on risks and protection to a higher extent with boys in connection with testing.

The right to knowledge and information

UngKAB15 shows that only half of the young people feel that they have obtained sufficient knowledge in the education in order to maintain their sexual health. UngKAB15 also shows that to a large extent schools convey knowledge of the body, which is a good basis for continued knowledge acquisition of sexual and reproductive health and rights, HIV and sexually transmitted infections. In order to obtain access to action strategies and empowerment, the education also needs to address issues on norms and rights. UngKAB15 shows that young people obtain the least knowledge of LGBT perspectives, gender equality and norms. The results indicate that most schools need to develop their work. Education on gender equality, sexuality, sex and relationships is compulsory in Swedish schools and should reach all young people. The knowledge area should be covered by several courses, subject and subject area syllabuses (82-87). The education in school comprises the basis of a rights-based, equal and gender equal health promotion perspective on sexual and reproductive health and rights among young people in Sweden. That issues on rights, norms and sex are covered insufficiently has been demonstrated earlier (88). The Swedish National Agency for Education has prepared a range of supporting material for the education and it is hoped that several head teachers and teachers will manage the subject-integrated education which is compulsory in many subjects based on the curriculum for 2011. The material also clarifies that schools should combat traditional gender patterns (89-91).

Both UngKAB studies show that schools are particularly important for boys. As previous studies clarify that boys only comprise 10–15 per cent of the visitors at youth health clinics, schools are a possible development area to satisfy the needs of boys for knowledge, information and health promotion initiatives (92-95). To a large extent girls can today supplement the school's information during visits to youth health clinics, but this opportunity does not reach most boys. Therefore, a development area comprises the work of the student health care service where issues on sexual and reproductive health and rights should become more comprehensive (94).

Development areas

In order to attain the objectives of equal and gender equal conditions for young people, new perspectives are required for the health promotion and prevention work. Schools, the student health service, youth health clinics, health and medical care, social services as well as child and youth psychiatry need to have a norm-critical and intersectional perspective on the work to a greater extent. Teaching methods, knowledge areas and conduct issues need to be analysed to prevent discrimination and abusive treatment. All young people need to have access to information, knowledge, guidance counselling, testing and care irrespective of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.

Everyone who works with young people needs to have knowledge and awareness of the widespread experience of sexual abuse, sexual coercion and violence among young people. Greater knowledge is also required of how negative stereotypical masculinity norms, the heterosexual norm and other power structures that affects sex and sexuality. Such knowledge can develop methods, initiatives and activities and prevent girls, non-binary gender persons, transgender persons as well as homosexuals or bisexuals from being subjected to discrimination or ending up in vulnerable positions, violence and suffering from ill-health. Understanding the conditions for sexual health of young people from a perspective on norms and power structures can strengthen the personal and physical integrity and sexual health of young people, and promote the health of young people on the whole.

The fact that discrimination and ill-health are related needs to be highlighted and rectified. The results of UngKAB15 show that 14 per cent of all young people consider themselves as one of the following: bisexual, I don't usually categorise myself sexually, homosexual or an option not included in the survey. The variety of sexual identities, as well as the young non-binary gender persons group and the group of transgender persons, impose demands on society to have good knowledge of LGBTQ issues. Heteronormative assumptions on the life situation of young people need to be analysed from a norm-critical and intersectional perspective. The issues of human rights and non-discrimination need to be central in the design of activities, methods and projects which cater for young people.

The work of youth health clinics needs to be developed so that it reaches all young people. Now the promotion and prevention work primarily reaches young girls. UngKAB15 shows that this is insufficient. For all young people to have the prerequisites for good sexual health, both girls and boys

need to be reached and experience that the initiatives are important based on their needs. All young people need to have the knowledge and tools to meet others in reciprocal relationships. Thus the unequal conditions, where boys are not reached by health promotion initiatives need to be rectified, so that boys are involved and viewed as being active in the prevention to a greater extent. This would strengthen boys to protect themselves and their partner against sexually transmitted infections and, if necessary, also against unwanted pregnancy.

Boys are also entitled to receive information and to discuss their issues based on their conditions in the same manner as girls during counselling for contraceptives. Such counselling may combat negative stereotypical masculinity norms. In addition, health and medical care (including youth health clinics) need to develop the advisory counselling on double protection, and particularly involve boys. It is essential to reach boys and young men in order to end the ongoing chlamydia epidemic among young people. Health and medical care (including youth health clinics) need to increase the proportion of boys who, in connection with testing for a sexually transmitted infection, have guidance counselling in which they are encouraged to use condoms.

The subsidies which young people would like to have will probably be most important for socioeconomic vulnerable young people and young people who do not have support at home to prioritise expenses for contraceptive methods and contraceptives. This is important from an equity perspective. As long as girls assume the majority of responsibility for contraceptives and contraceptive methods and at the same time earn lower income than boys, it is particularly important that having the opportunity of suitable protection is not a financial issue for them.

The health promotion and prevention arenas for boys could be strengthened by a further development of schools as an arena with more and new assignments for the student health service. Often nurses with training on the physical and mental development of young people work at the student health service, but it is necessary for professional groups who work in schools to obtain knowledge of sexual and reproductive health and rights in their undergraduate education. The knowledge should primarily be a part of the vocational training of preschool teachers, teachers and personnel within the student health service (nurses, psychologists, doctors and social workers) and it should be a part of the recurring skills development of teachers. This would increase the opportunities of young people to have equal conditions.

CHAPTER 14

Conclusion



14. Conclusion

The results from this study indicate that adolescents and young adults experience good health to a large extent. However, there are differences in health, sexual health and factors that affect sexual and reproductive health and rights between groups of young people, primarily based on sex and gender identity. The drop-out is comparable to the same age group in other similar population studies. Nevertheless, the results should be handled with caution.

The preconditions for good sexual and reproductive health and rights among young people are unequal since groups among girls and young non-binary gender persons experience abusive treatment, discrimination, sex against their will and sexual abuse.

Girls and boys do not take on an equal amount of responsibility for contraceptive and testing for sexually transmitted infections. Furthermore, boys and girls are not reached by society's preventive efforts, such as the services of youth health clinics, to the same extent.

Gender inequality and inequity in sexual and reproductive health and rights, obstructs successful efforts to prevent sexually transmitted infections, unwanted pregnancies, sexual abuse and young people being reimbursed or paid for sex. It also obstructs the promotion of sexual and reproductive health and rights among all young people.

Schools, Youth Health Clinics, healthcare and social services are important arenas in order to further develop the promoting and preventive work within sexual and reproductive health. The efforts would most likely be more successful if more boys were reached and if they felt that the preventive efforts were motivating and important from their perspectives.

Overall, the study indicates a national, regional and local need for development. Activities within municipalities, county councils and the civil society need to analyse their initiatives, strategies and aims systematically and monitor future progress continuously over time in relation to health equity. The initiatives should proceed from a non-oppressive, norm-critical and intersectional perspective. Such strategic work would promote sexual and reproductive health and rights and HIV prevention among young people.

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APPENDIX 1

Survey UngKAB15



APPENDIX 1

Survey UngKAB15

First there will be some questions on you and your background.

<p>1. What is your year of birth?</p> <p>Year: <input type="text" value="1"/><input type="text" value="9"/><input type="text"/><input type="text"/></p>
<p>2. What is your year of birth?</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> I do not wish to categorise myself (non-binary gender)</p>
<p>3. Are you or have you been a transgender person?</p> <p><i>Transgender person is an umbrella term used to describe persons whose gender identity and/or gender expression at times or always do not conform to the norm of the sex registered for them at birth.</i></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>4. Please specify your highest completed educational qualification.</p> <p><input type="checkbox"/> Compulsory school or equivalent</p> <p><input type="checkbox"/> 2 year upper secondary or vocational school</p> <p><input type="checkbox"/> 3-4 year upper secondary school</p> <p><input type="checkbox"/> Folk high school, qualified vocational training (KY and YH) or equivalent</p> <p><input type="checkbox"/> University or college less than 3 years</p> <p><input type="checkbox"/> University or college 3 years or longer</p>
<p>5. Who do you live with?</p> <p><i>That is, who you live with most of the week. You can select several options.</i></p> <p><input type="checkbox"/> Nobody</p> <p><input type="checkbox"/> Parents/siblings</p> <p><input type="checkbox"/> Spouse/live-in partner/partner</p> <p><input type="checkbox"/> Other adults</p> <p><input type="checkbox"/> Children</p> <p><input type="checkbox"/> In a collective or student hall</p>
<p>6. How would you describe your household finances?</p> <p><input type="checkbox"/> Very good</p> <p><input type="checkbox"/> Quite good</p> <p><input type="checkbox"/> Not particularly good</p> <p><input type="checkbox"/> Not at all good</p> <p><input type="checkbox"/> I don't know</p>

Now there will be questions on your health, and social relationships

<p>7. What do you think about your state of health?</p> <p><input type="checkbox"/> It's very good</p> <p><input type="checkbox"/> It's good</p> <p><input type="checkbox"/> It's quite good</p> <p><input type="checkbox"/> It's bad</p> <p><input type="checkbox"/> It's very bad</p>																																							
<p>8. Which of the following claims best describe you?</p> <p><input type="checkbox"/> I have an unproblematic relationship with food and eating</p> <p><input type="checkbox"/> I have a problematic relationship with food and eating</p>																																							
<p>9. Do you have somebody to talk to about your intimate feelings?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>																																							
<p>10. Can you get help from someone or some people if you have practical problems or become sick? <i>For example, get advice, borrow things, get relocation help.</i></p> <p><input type="checkbox"/> Yes, always</p> <p><input type="checkbox"/> Yes, mostly</p> <p><input type="checkbox"/> No, not mostly</p> <p><input type="checkbox"/> No, never</p> <p><input type="checkbox"/> I don't know</p>																																							
<p>11. If you think about the past 6 months, how often have you experienced the following problems?</p> <table border="1"> <thead> <tr> <th></th> <th>Once a month or less frequently</th> <th>Once a week</th> <th>Almost every day</th> </tr> </thead> <tbody> <tr> <td>a. Headache</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Stomach ache</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Backache</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Felt low</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Have been irritated or in a bad mood</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f. Felt nervous</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g. Found it difficult</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h. Felt dizzy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>					Once a month or less frequently	Once a week	Almost every day	a. Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Stomach ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Felt low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Have been irritated or in a bad mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Felt nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Found it difficult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Felt dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<p>12. Have you used prescription medicine at some point without a doctor's prescription, such as painkillers, sedatives or sleep – inducing drugs?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>																																							

Now there will be questions on discrimination and physical violence.

13. Have you experienced discrimination or abusive treatment over the past 12 months?

- Yes
- No

Please go to question 16.

14. Was the discrimination or abusive treatment related to any of the following?

You can select several options.

- Ethnicity
- Sex
- Sexual orientation
- Age
- Disability
- Gender identity and/or gender expression

Other:

15. Where did you experience discrimination or abusive treatment?

You can select several options.

- At school/the workplace, in my job
- At home by family and/or relatives
- In someone else's home/in the residential area
- At a public place
- On or close to trains, buses, trams/in the underground or close to it
- The Internet and social media
- Health and medical care
- Night club, restaurant
- Social service/homes for care or residence/institutional care
- The Police
- Correctional treatment
- Religious community, church, mosque
- Club activities/organisation (includes sport movements)
- Other authority or social function

Other:

16. a) Have you been exposed to physical violence over the past 12 months?
 Yes
 No **→** *Please go to question 17.*

b) Where did the violence take place?
You can select several options.
 At school/the workplace, in my job
 At home by my family and/or relatives
 In someone else's home/in the residential area
 At a public place/place of entertainment
 On or close to trains, buses, trams/in the underground or close to it
 Some other place

c) Was it related to discrimination?
 Yes
 No

17. Please indicate to what extent you agree with the following claims.

	Completely agree	Completely disagree	Unsure
a. I am happy with myself at large	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I can do things as well as most others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel happy when I think about my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have control of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Have you thought of committing suicide at some point?
 No **→** *Please go to question 20.*
 Yes

19. Have you tried to commit suicide?
 No
 Yes, over the past 12 months
 Yes at some point more than 12 months ago

Now there will be questions on sexuality and relationships

<p>20. Do you consider yourself currently to be:</p> <p><input type="checkbox"/> Heterosexual</p> <p><input type="checkbox"/> Homosexual</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> I don't usually categorise myself sexually</p> <p><input type="checkbox"/> I don't know</p> <p><input type="checkbox"/> Other: <input style="width: 300px; height: 20px;" type="text"/></p>																															
<p>21. How satisfied are you with your current sex life?</p> <p><input type="checkbox"/> Very satisfied</p> <p><input type="checkbox"/> Quite satisfied</p> <p><input type="checkbox"/> Neither satisfied nor dissatisfied</p> <p><input type="checkbox"/> Quite dissatisfied</p> <p><input type="checkbox"/> Very dissatisfied</p>																															
<p>22. Have you undergone circumcision or genital mutilation?</p> <p><input type="checkbox"/> No, I have not undergone circumcision or genital mutilation</p> <p><input type="checkbox"/> Yes, I have undergone circumcision or genital mutilation and it does not affect my well-being or my sexual health</p> <p><input type="checkbox"/> Yes and it affects my well-being and my sexual health</p>																															
<p>23. What is important for you in a sexual relationship?</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">I don't have an opinion/I don't know</th> </tr> </thead> <tbody> <tr> <td>a. That I can talk about sex</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. That we have the same level of interest in sex</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. That we decide equally about how and where to have sex</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. That we protect ourselves against sexually transmitted infections if necessary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. That we protect ourselves with contraceptives if we do not want to get pregnant/have children</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. That we have been tested for sexually transmitted infections</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>					Yes	No	I don't have an opinion/I don't know	a. That I can talk about sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. That we have the same level of interest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. That we decide equally about how and where to have sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. That we protect ourselves against sexually transmitted infections if necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. That we protect ourselves with contraceptives if we do not want to get pregnant/have children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. That we have been tested for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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24. When you have sex with a new partner who wants to use a condom during sexual intercourse, how do you react then?

You can select several options.

- I think that the person seems to be considerate/responsible
- It would feel like the person perhaps has a sexually transmitted infection or thinks that I have a sexually transmitted infection
- I would like to use a condom myself and think that it is good if my partner suggests it
- I think that it is good as I do not have to worry afterwards
- I do not want to use a condom myself and feel disturbed if my partner suggests it
- I think that it is good as it becomes easier to have sex with a condom
- If I know the person from before then I don't think it's necessary
- I don't know
- Not applicable, I don't have sexual intercourse when I have sex

Here there will be questions on sexual intercourse and other sexual activities

25. Have you ever had sex?

- Yes
- No → *Please go to question 47.*

26. How old were you when you had sex with someone the first time?

If you are unsure, please provide the approximate age.

I was years old

27. How many people have you had sexual contact with in total?

If you are unsure, please estimate.

person/people

28. How many people have you had sex with over the past 12 months?

If you are unsure, please estimate.

person/people

29. Have you ever been in a steady relationship and had sexual contacts outside the relationship?

- No
- Yes

Now there will be questions on sexuality and relationships

30. If you think about the last time you had sex, do you agree with the following claims?			
	Yes	No	Can't answer/ don't want to answer
a. I had sex in a way I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I felt that I could suggest and use a condom or other contraceptive if I wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I had sex in a safe place where I felt secure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Who did you have sex with at that time?			
<input type="checkbox"/> With a boy			
<input type="checkbox"/> With a girl			
<input type="checkbox"/> With a non-binary gender person			
<input type="checkbox"/> With several people			
32. Did you perform any of the following acts or use any of the following things the last time you had sex with someone else?			
<i>You can select several options.</i>			
<input type="checkbox"/> Non-penetrative sex/outercourse or petting			
<input type="checkbox"/> Oral sex			
<input type="checkbox"/> Online sex/sex on the Internet			
<input type="checkbox"/> Vaginal sexual intercourse			
<input type="checkbox"/> Anal sexual intercourse			
<input type="checkbox"/> Sex toys/aids			
<input type="checkbox"/> Other: <input type="text"/>			

33. Did you/your partner use any of the following types of protection or contraceptives during the most recent sexual encounter?

You can select several options.

- Contraceptive pills, mini-pills, contraceptive implants, contraceptive vaginal rings, contraceptive patches, coils (hormonal method)
- A condom which was used throughout the sexual intercourse/sexual encounter
- A condom, which was worn right before ejaculation
- A copper coil
- Yes, a female condom (also referred to as Femidom)
- Diaphragms
- Sexual intercourse interrupted by withdrawal of the penis before ejaculation
- Used natural family planning (referred to as safe periods)
- Emergency contraceptive pills
- It was not necessary as we had sex in a way which did not necessitate condoms or other contraceptives
- We did not use any protection, but it was needed
- I'm unsure/don't know

Other:

IF YOU DID NOT USE A CONDOM:

34. What was the most important reason for this?

You can select several options.

- We did not have a condom available
- Used other protection against unwanted pregnancy (contraceptive pills, coils or similar)
- I was under the influence of alcohol
- I think that it feels better without one
- We had been tested and knew that neither of us had a sexually transmitted infection, HIV or hepatitis

Other:

35. Did you consume alcohol the last time you had sex with someone else?

- No
- Yes
- Don't want to/can't answer

36. Did you use hash or marijuana (cannabis) the last time you had sex with someone else?

- No
- Yes
- Don't want to/can't answer

37. Did you use any other narcotics besides hash or marijuana (for example: amphetamine, cocaine, heroin, ecstasy, LSD, Spice or other Internet drugs) the last time you had sex with someone else?

- No
- Yes
- Don't want to/can't answer

38. Did you inject drugs (use an injection to take drugs) the last time you had sex with someone else?

- No
- Yes
- Don't want to/can't answer

Now there will be some questions on abortion and contraceptives.

39. Would you consider using any of the following contraceptive methods?

	Yes	No	Don't want to/ can't answer	Not applicable
a. Mini-pills (contraceptive pills without oestrogen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Contraceptive pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Contraceptive vaginal rings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Contraceptive implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Contraceptive patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Coils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Diaphragms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Female condoms/Femidom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Natural family planning (safe periods)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Which contraceptives have you used over the past 12 months?
You can select several options.

I have not used any contraceptive method

Contraceptive pills

Mini-pills (contraceptive pills without oestrogen)

Contraceptive vaginal rings

Contraceptive implants

Contraceptive patches

Coils

Diaphragms

None of the afore-mentioned options are applicable

Female condoms/Femidom

Condoms

Condoms/Femidom not applicable

Other:

If you consider yourself to be male → Please go to question 42

41. If as a female you have not used hormonal contraceptives over the past 12 months, what is the reason for this?
You can select several options.

I have not had the time to collect the prescription

I can't afford them

I want to get pregnant

I am worried about side effects

I don't want to use hormonal contraceptives

I use condoms instead

I was advised against use of hormonal contraceptives by medical care

Not applicable

Other:

42. Have you or a partner had an abortion?

- Yes
 No  Please go to question 47
 I don't know  Please go to question 47

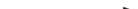
Questions 43-46 should be answered by those who have had an abortion or those who have a partner who has had an abortion. The remaining respondents should proceed to question 47. **If you have had several abortions, please think about your most recent abortion.**

43. Which clinics were you or your partner in contact with in connection with the abortion?

You can select several options.

- The student health team at school (school counsellor, school psychologist or nurse)
 Medical centre
 Youth health clinic
 Sex and relationship clinic (SESAM)
 Gynaecological clinic at a hospital
 Midwifery clinic or maternity services
 Student health clinic
 Health clinic in correctional treatment, state institutional care (SIS)
 Health clinic within asylum/refugee clinic
 Health clinic within social services/addiction care
 I don't know

44. Did you or your partner have counselling with a counsellor, doctor or midwife in connection with the abortion?

- Yes
 No  Please go to question 47
 I don't know

45. Did the counselling lead to you thinking more about contraceptive methods and contraceptives?

- Yes, I think about it but it has not affected my choice of contraceptive method
 Yes, I have more knowledge of protection against unwanted pregnancy
 No, I did not start to think about how I protect myself or choice of contraceptive
 I did not participate in the counselling

46. Which of the following statements apply for you in connection with the abortion?

You can select several options.

- You felt that you were treated with respect
 You were motivated to consider how to protect yourself in the future
 You felt that you were treated badly and humiliated during the counselling
 The counselling did not affect you
 I did not participate in the counselling

Now there will be some questions on sex against your will or sex for payment.

47. Have you experienced the following acts against your will?			
	Yes	No, it did not happen	Prefer not to answer
a. ...Someone has exposed themselves indecently in front of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ...Someone has touched your genitals or your breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ...You have masturbated for someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. ...You have had vaginal sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. ...You have had oral sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. ...You have had anal sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. ...Someone has distributed nude photographs of you on the Internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. ...You have distributed nude photographs of yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Have you at some point...			
	No	Yes	Prefer not to answer
a. ...given any compensation/paid for a sexual service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ...received any compensation/payment for a sexual service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Here there will be some questions on sexually transmitted infections, HIV and testing.

49. How many sex partners have you had unprotected anal or vaginal sexual intercourse with over the past 12 months?			
<i>If you are unsure, please estimate.</i>			
	person/people		
50. Do you currently have or have you in the past had any of the following infections?			
	No	Yes	I don't know
a. Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Condyloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Do you have any of the following infections?			
	No	Yes	I don't know
a. HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. Have you been tested or examined for any of the following infections at some point?

	No, never	Yes	Prefer not to answer
a. Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Condyloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have **not been tested** for any sexually transmitted infection or HIV, please go to question 57.

Questions 53-56 should be answered by those **who have been tested** for any sexually transmitted infection or HIV.

53. Why did you get tested?

You can select several options.

- I started a new relationship
- I get tested at regular intervals
- I had unprotected sex with a new/casual partner
- I was subject to contact tracing/partner notification for HIV or another sexually transmitted infection
- Other:

54. Where did you get tested most recently?

- Medical centre/healthcare centre/family doctor
- Youth health clinic
- Midwifery clinic
- Venereology/gynaecology/sex and relationship clinic
- Infectious disease clinic
- The National Federation of Noah's Ark Associations Noah's Ark (Noaks Ark), Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights (RFSL, Check point) or Swedish Association for Sexuality Education (RFSU).
- Student health service clinic
- Health clinic in correctional treatment or state institutional care (SIS)
- Health clinic within asylum/refugee clinic
- I ordered a test on the Internet
- I purchased a test at the pharmacy
- Other:

55. The last time you got tested, did someone provide counselling to you on risks and protection associated with sex?

- Yes
- No  Please go to question 58
- I don't know

56. How were you affected by the counselling?

	No	Yes	I don't know
a. I don't have unprotected sex as a result of the counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I was motivated to use contraceptives as a result of the counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I was motivated to use condoms or other contraceptives as a result of the counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I was irritated by the counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I felt that I was treated with respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I received good and useful information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 57 should be answered by those who have **not been tested** for any sexually transmitted infection or HIV.

57. Why did you not get tested?

You can select several options.

- I haven't thought about it
- I haven't had unprotected sex
- I was refused or advised against a test by medical care even though I wanted one
- I don't know where to get tested
- The opening hours of the clinic for testing don't suit me
- It is hard for me to get to a clinic
- I don't have faith in the obligation of secrecy
- I'm scared of being recognised by the staff or other visitors at the clinic
- Other:

Now there will be some questions on the knowledge you have and what you need and where you obtain information on sexuality and relationships.

58. Please select the claims you know about chlamydia and HIV.

You can select several options.

- Chlamydia is highly infectious
- You can have chlamydia without being aware of it
- If you have chlamydia you can infect others even if you do not have any symptoms
- If you use a condom every time you have sex then the risk of getting chlamydia decreases
- Chlamydia can spread through vaginal and anal sexual intercourse as well as oral sex
- If you treat HIV, the risk of transmission of HIV to others is very low
- Everyone who has HIV is not aware of it
- A person who looks healthy may have HIV
- If you use a condom every time you have sex then the risk of getting HIV decreases
- Everyone living with HIV and receiving treatment can live as long as others
- It is important to get tested if you stop using a condom with a new partner
- You need to get tested to know whether you have HIV

59. In which areas do you need more knowledge?

You can select several options.

- How to flirt and pick up
- Different methods of safer sex
- How HIV is transmitted
- How sexually transmitted infections are transmitted
- The current situation for those living with HIV
- How to talk about sex with a partner
- How to talk about contraceptives with a sex partner
- How to prevent a condom from breaking
- How to prevent unwanted pregnancy
- How to find someone to have a relationship with
- How to make a relationship work well
- Condom usage
- Use of contraceptives (contraceptive pills, contraceptive implants, etc.)
- Nothing
- Other:

60. What are your main sources of information on relationships, sexuality, contraceptives and sexually transmitted infections?

You can select several options.

- The Internet
- Websites which health and medical care are behind such as, for example, 1177 and UMO.se
- Youth health clinic
- A clinic within health and medical care (for example, sex and relationship clinic, medical centre, midwifery clinic, etc.)
- Education on relationships and sexuality in school
- Student health service
- Friends
- Printed information material
- TV, magazines, radio
- Partner(s)
- Father
- Mother
- Guardian (if somebody else besides mother and father)
- Siblings
- Other:

61. You can learn about sex and relationships in several different subjects in school. How much did you learn...
Please think about the situation in both compulsory school and upper secondary school.

	Nothing	Too little	Sufficient
a. ...about the body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ...about menstruation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ...about sexuality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. ...about condom usage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. ...about contraceptive methods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. ...about how to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. ...about HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. ...about sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. ...about gender, relationships and gender equality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. ...about norms and the LGBT perspective?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

62. Did you receive the knowledge in school that you need in order to take care of your sexual health?

Yes, but too little
 Yes, sufficient
 No, there was no education on sexuality and relationships in school

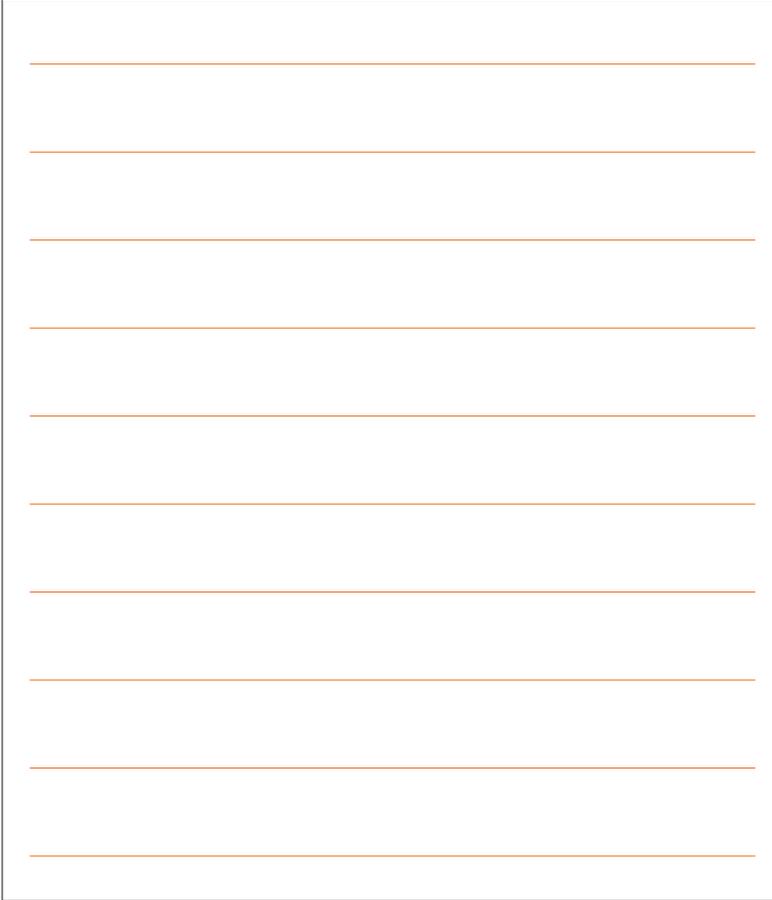
63. Do you require any of the following?

	Yes	No	I don't know
a. Testing and advice at clinics open during weekends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Opportunity to talk to someone about sexuality and relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Free condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Cheaper contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. More knowledge of sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. More knowledge of how to order chlamydia tests on the Internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. More knowledge of the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. More knowledge of fertility (the ability to have children) and pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

64. What are your views on answering this questionnaire?
Please think about the situation in both compulsory school and upper secondary school.

The questions were important
 The questions were unpleasant
 It was fun answering the questions
 It was difficult answering the questions
 I answered the questions honestly

65. If you have any additional comments, please feel free to write them here:



Many thanks for answering the survey!

Do you have questions about the survey?

If you have specific questions about the survey, you can contact the head of investigation Monica Idestrom at the Public Health Agency of Sweden by e-mailing: monica.idealstrom@folkhalsomyndigheten.se or calling: 0102052717. Louise Mannheimer is the head of the Unit for Sexual Health.

Would you like to read more about sexuality and relationships?

- **UMO, online youth guidance centre**, www.umo.se. At UMO you can get answers to questions on sex, health and relationships. You can obtain knowledge on the body, sex, relationships, mental health, alcohol and drugs, self-esteem and much more. You can get answers to your questions or new ideas on how to think about your life. You can ask questions anonymously to Ask UMO and get a personal reply from an employee of UMO or youth health clinic. You can also read questions and answers of other people. If you want to contact a youth health clinic near you, you can search UMO's catalogue of all youth health clinics. UMO.se is linked to:
- [1177/wardguiden.se](http://1177vardguiden.se) (Healthcare Guide 1177) is a gathering point for information and services within health and care for the entire country. It offers medical care counselling, information, inspiration and e-services. It is available online and over the telephone and is open around the clock. The website address is 1177.se and the telephone number 1177 applies for medical advice throughout the country. By means of all county councils and regions in collaboration, Swedish medical care is behind 1177 Vårdguiden.
- Sakraresex.se for everyone aged between 18 and 29 years. On www.sakraresex.se you can find answers to your questions about sex, health and relationships. Stockholm County Council is behind sakraresex.se.
- On folkhalsomyndigheten.se there is more information on sexually transmitted infections and statistics which describe how many people in Sweden are diagnosed with any of the infections which are covered by the Communicable Diseases Act.
- Kvinnofridslinjen – Sweden's National Women's Helpline (020-50 50 50) is for women who have been subjected to threats and violence. The line is open around the clock and your call is free of charge irrespective of your location in Sweden. Your call will not appear on the telephone bill. You can phone Kvinnofridslinjen if you have questions or if you want to speak to someone about your experiences. Their job is to listen and provide you with professional support. They can give you practical advice so that you can change your current situation and move on. The calls are received by social workers and nurses used to dealing with people in crisis or in difficult life situations. They are bound by professional secrecy and you can remain anonymous. You only need to tell them what you want and feel like telling them.

Do you require counselling?

If you require professional counselling as a result of the survey's question areas, you can call Nationella hjälplinjen (National helpline) on telephone number 020- 22 00 60, telephone hours all days 13.00 - 22.00. All county councils and regions are behind Nationella Hjälpplinen through the organisation 1177. The helpline offers an initial counselling session, but no treatment or repeated contact. The helpline also offers advice on how you can proceed for obtaining the right assistance. Social workers, psychologists and psychiatric nurses with experience of supporting people in crises work in the helpline.

APPENDIX 2

Partial drop-out UngKAB15



Appendix 2 – Partial drop-out UngKAB15

Survey question	Proportion of partial drop-out per question in per cent (%)	Proportion of partial drop-out per question	Number of respondents per question (n)	Total number of respondents in the study (N)
f1	1,1	89	7666	7755
f2	1,7	135	7620	7755
f3	1,2	93	7662	7755
f4	1,6	124	7631	7755
f5	0,6	49	7706	7755
f6	0,9	69	7686	7755
f7	0,4	29	7726	7755
f8	0,9	67	7688	7755
f9	0,9	70	7685	7755
f10	0,3	26	7729	7755
f11	0,3	27	7728	7755
f12	0,5	40	7715	7755
f13	1,4	111	7644	7755
f14	9,7	171	1599	1770
f15	1,5	27	1743	1770
f16a	1,7	129	7626	7755
f16b	2,3	9	380	389
f16c	2,1	8	381	389
f17	1,4	107	7648	7755
f18	4,5	348	7407	7755
f19	4,6	360	7395	7755
f20	0,8	65	7690	7755
f21	1,8	140	7615	7755
f22	1,0	77	7678	7755
f23	0,6	49	7706	7755
f24	1,6	123	7632	7755
f25	1,7	130	7625	7755
f26	0,5	29	5927	5956
f27	1,1	68	5888	5956
f28	0,6	37	5919	5956
f29	0,4	22	5934	5956
f30	0,3	16	5940	5956
f31	0,4	22	5934	5956

Survey question	Proportion of partial drop-out per question in per cent (%)	Proportion of partial drop-out per question	Number of respondents per question (n)	Total number of respondents in the study (N)
f32	1,9	112	5844	5956
f33	2,4	144	5812	5956
f34	4,3	165	3673	3838
f35	0,7	41	5915	5956
f36	0,9	56	5900	5956
f37	0,7	42	5914	5956
f38	0,8	45	5911	5956
f39	0,8	49	5907	5956
f40	1,9	111	5845	5956
f41	8,2	131	1461	1592
f42	1,9	115	5841	5956
f43	0,7	5	707	712
f44	3,2	23	689	712
f45	1,2	6	504	510
f46	0,4	2	508	510
f47	0,9	66	7689	7755
f48	0,8	61	7694	7755
f49	6,0	464	7291	7755
f50	1,1	88	7667	7755
f51	1,1	84	7671	7755
f52	2,1	163	7592	7755
f53	2,3	86	3723	3809
f54	1,8	68	3741	3809
f55	2,3	88	3721	3809
f56	1,0	19	1839	1858
f57	6,7	250	3457	3707
f58	3,0	235	7520	7755
f59	4,0	313	7442	7755
f60	1,6	122	7633	7755
f61	1,4	107	7648	7755
f62	1,7	135	7620	7755
f63	1,8	139	7616	7755

APPENDIX 3

Preliminary letter



Appendix 3 – Preliminary letter



Statistiska centralbyrån
Statistics Sweden



Folkhälsomyndigheten

Mars 2015

The Public Health Agency of Sweden is inviting you to participate in a survey on health and sexuality among young people in Sweden.

You are receiving this letter from the Public Health Agency of Sweden as we want to invite you to participate in a survey-based study. In roughly one week a survey will be sent home to you. The questions are about health and sexuality, contraceptive methods as well as knowledge, attitude and behaviour towards HIV and sexually transmitted infections. Statistics Sweden (SCB) is responsible for the dispatch, collection and compilation of responses.

The study aims to monitor work which promotes health, prevents HIV and other sexually transmitted infections and unwanted pregnancy. As a result of the survey, new and up-to-date knowledge of health promotion and prevention work will be compiled. The knowledge will support activities within municipalities and county councils such as, for example, the work at youth health clinics, schools, student health, social services as well as clinics within health and medical care. We hope that you would like to assist us with your participation in the survey!

The results of the survey will be compiled in a report at the Public Health Agency of Sweden. The work will start in September 2015 and is expected to be completed in April 2016. Information on this and publication of the report will appear on the Public Health Agency of Sweden's website www.folkhalsomyndigheten.se/ungkab15

Kind regards,

Johan Carlson
Director-General
Folkhälsomyndigheten

Kontakta oss gärna:

Frågor om att lämna uppgifter
Statistiska centralbyrån
Telefon: 019-17 69 30, e-post: enkat@scb.se
701 89 Örebro
www.scb.se

Frågor om undersökningens innehåll

Folkhälsomyndigheten, Enheten för hälsa och sexualitet
Telefon: 010-2052717
e-post: monica.idestrom@folkhalsomyndigheten.se
171 82 Solna
www.folkhalsomyndigheten.se

APPENDIX 4

Letter for guardians



Appendix 4 – Letter for guardians



Statistiska centralbyrån
Statistics Sweden



Folkhälsomyndigheten

Mars 2015

The Public Health Agency of Sweden would like to inform you about a forthcoming survey-based study on health and sexuality among young people in Sweden.

The Public Health Agency of Sweden will invite adolescents and young adults 15-29 years old to participate in a survey-based study. You are a parent or guardian of one of the 30,000 persons who have been selected randomly from the population register. In order to clarify the purpose of the survey and create understanding of the question areas which your child will receive, we have chosen to send a separate letter to parents of youths who are below the age of 18. The survey is entitled "Knowledge, Attitudes and Behaviour among young people" (UngKAB). The first survey took place in 2009 and is now being repeated in 2015. The study aims to monitor work which promotes health, but also prevents HIV and other sexually transmitted infections and unwanted pregnancy. The survey's questions will address how your child feels, how they currently live, their views and knowledge of contraceptives, the sex and relationship education of schools and experiences of treatment within health and medical care. Statistics Sweden (SCB) is responsible for the dispatch, collection and compilation of responses.

All responses are important

Participation in the survey is voluntary, but your child's contribution will be very useful for us. The Public Health Agency of Sweden is an expert authority which monitors the health of Sweden's population. As a result of UngKAB, new and up-to-date knowledge of health promotion and prevention work will be compiled. The work supports activities within municipalities and county councils such as, for example, the work at youth health clinics, schools, student health, social services as well as clinics within health and medical care.

The questions can be answered through an online link or by sending a paper survey. Your child will receive a personal username and password. In order to respect personal integrity, the username and password can only be administered by the child. If your child has a personal carer, it is advisable for the carer to also receive the information in this letter. It will not be possible to link or present responses in a manner which will enable them to be traced to any specific individual. As a parent/guardian you can read more about the study and access the survey questions through www.folkhalsomyndigheten.se/ungkab15

Kind regards,

Johan Carlsson
Director-General
The Public Health Agency of Sweden

The report is based on a randomised survey-based population study which was conducted in 2015. The point of departure of the study is the Public Health Agency of Sweden's work on the national strategy to combat HIV/AIDS and certain other communicable diseases (Government Bill 2005/06:60) and the work with the prevention group adolescents and young adults.

The survey's main question areas concerned sexual health divided in the following main areas: health, security and social relationships, abusive treatment, discrimination and physical violence, sexuality and relationships, sexual acts, most recent sexual encounter, contraceptives and contraceptive methods, abortion and counselling, sex against your will, sex for payment, sexually transmitted infections, HIV, testing and counselling, measuring knowledge and the need of health promotion initiatives.

The report is mainly intended for employees and decision-makers within county councils, municipalities, civil society organisations as well as relevant authorities and professional associations. The report aims to contribute with knowledge for health promotion and disease prevention work.

The Public Health Agency of Sweden is an expert authority with responsibility for public health issues at a national level. The Agency develops and supports activities to promote health, prevent illness and improve preparedness for health threats. Our vision statement: a public health that strengthens the positive development of society.



Folkhälsomyndigheten
PUBLIC HEALTH AGENCY OF SWEDEN