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Sexual and reproductive health and rights (SRHR) among young people in secure state care and their non-incarcerated peers – a qualitative, descriptive and comparative study

Sexuell och reproduktiv hälsa och rättigheter (SRHR) hos unga i statlig tvångsvård och unga i ett nationellt urval – en kvalitativ, deskriptivt och jämförande studie

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ABSTRACT

Young people in secure state care have impaired general as well as sexual health. Social work practice that addresses SRHR among young people in secure state care is thus called for. Using a qualitative design, this descriptive and comparative paper combines the results of two separate surveys on sexual health with young people 16–29 years old. 7755 young women and men in Sweden and 117 young women and men in secure state care in Sweden participated. The results show large differences in sexual health between the groups. Young women in secure state care are the most vulnerable. Implications for social work are discussed, and a SRHR-affirmative perspective is suggested. This SRHR-affirmative practice is particularly important when social work involving young people is organised in a compulsory fashion.

SAMMANFATTNING

Unga i statlig tvångsvård har nedsatt generell och sexuell hälsa. I socialt arbete med dessa unga måste därför SRHR belysas. Artikeln har en kvalitativ design och beskriver och jämför resultat från två separata enkätstudier om sexuell hälsa där 7755 unga i Sverige, och 117 unga i statlig tvångsvård deltog, alla i åldrarna 16–29. Resultaten visar på stora skillnader i sexuell hälsa mellan grupperna, och unga kvinnor i statlig tvångsvård framstår som mest sårbara. Implikationer för socialt arbete diskuteras, och ett bekräftande SRHR-perspektiv föreslås. Detta bekräftande SRHR-perspektiv är särskilt viktigt när socialt arbete riktat till unga organiseras som tvångsvård.

KEYWORDS

Secure state care; sexual and reproductive health and rights; social work; young people

NYCKELORD

sexuell och reproduktiv hälsa och rättigheter; socialt arbete; statlig tvångsvård; unga och unga vuxna

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Introduction

Sexual and reproductive health and rights (SRHR), as part of human rights, are a global concern and thus important in clinical social work worldwide. In a recent comprehensive report promoting SRHR for all, the authors state that SRHR 'are fundamental to people's health and survival, to economic development, and to the wellbeing of humanity' (Starrs et al., 2018, p. 2642). Accordingly, scholars argue that 'sexuality is a paramount consideration across the life course and needs to be integrated into social work discussions about the care and support needs of individuals, to fully realise a human rights-based approach to practice' (Willis et al., 2016, p. 2171). Focussing SRHR among young people in secure state care in Sweden, we aim to illuminate a constant challenge in contemporary social work. Although departing from a national context, the findings can be relevant in other contexts as well.

SRHR-affirmative social work with young people

Young people in state care within juvenile justice systems or under the care of social authorities have impaired general health (Golzari et al., 2006; Jee et al., 2006; Kling et al., 2016; Rodrigues, 2004; Vinnerljung & Sallnäs, 2008). In addition, they also show impaired sexual health (Ahrens et al., 2010; American Academy of Pediatrics, 2011; Kahn et al., 2005; Svoboda et al., 2012). Sexual health risks and variables predicting adverse sexual health outcomes were compared between young people in secure state care in Sweden and their non-incarcerated same-aged peers in 2013 (Lindroth et al., 2013). Major differences were found. Young people in secure state care had higher rates of Chlamydia, experiences of sexual assault, and unprotected (no hormones or condom) vaginal or anal intercourse the last time they had sex (ibid.).

Social work practices that addresses sexual health among young people in different forms of state care are thus needed. It is also in line with the Convention on the Rights of the Child (CRC, 2013) and the World Health Organization (WHO, 2015), which place an obligation on public and private welfare institutions to ensure that children and young people have the highest attainable standard of health (CRC, 2013; WHO, 2015). Consequently, children and young people have the right to comprehensive sexual and reproductive health services, including knowledge through education or information and a right to sexual privacy (ibid.). Additionally, young people's agency and empowerment to enhance their own well-being needs to be acknowledged (Firmin et al., 2016). In particular, children and young people in prison or other locked facilities are vulnerable, as they are reliant on professionals within the incarcerating authority to access sexual health services (CRC, 2013; WHO, 2015).

Young people in contact with social services describe being left out to judgments made by professionals (Hyde et al., 2016). Professionals working with young people in contact with social services in Scotland tended to share sensitive information about young people's sexual experiences (e.g. STI testing), even when there were no child protection issues from the perspective of the service provider (ibid.). Moreover, personal sexual information about the young persons was circulated among too many professionals. Young people were aware of this and strategically kept quiet about their sexual experiences and sexual-health needs (ibid.). This excessive information-sharing among professionals could be seen as an example of not respecting young people's right to sexual privacy. Similarly, young people subjected to secure state care in Sweden who display non-normative or unconventional sexual behaviours or experiences risk being met with unprofessionalism. It is suggested that young people therefore filter what experiences are societally acceptable to share with professionals, who in turn are not educationally equipped to work with sexual health promotion (Lindroth, 2020).

That young people's sexual health needs are not adequately met could be connected to the low educational levels among staff working at secure state youth institutions, as many lack higher education (The Health and Social Care Inspectorate, 2013). However, having a higher level of social work education does not necessarily imply SRHR competence. In Sweden, higher education in social work, as well as higher education in health care, police work and law, lack in SRHR content (Areskoug–

Josefsson et al., 2019). Swedish students in social work consider themselves uncomfortable and insufficiently prepared to handle issues related to sexual health in their future profession (Areskoug–Josefsson et al., 2019). This may affect the ability to properly address the needs of their future clients.

Sexual health interventions aimed at young people in secure state care do exist. However, they lack a positive approach to youth sexuality and a rights perspective (Hammarström et al., 2018). To better inform social workers that meet young people in secure state care, more knowledge about SRHR-related health outcomes is needed. Such knowledge can address how these outcomes relate to youth in the general population and thereby provide knowledge about how health inequalities should be adjusted. It can also provide information on what areas professional social workers must focus on.

Aim

The main objective of this paper is to describe and compare different aspects of SRHR among young people in secure state care and their non-incarcerated peers. By doing so, we highlight SRHR needs of vulnerable young people, i.e. those in secure state care. This knowledge that can inform SRHR-affirmative social work practice within this and similar populations.

Materials and methods

Two studies – one questionnaire

For the purpose of this paper, a qualitative design is used. Within this flexible design (Robson, 2002), we describe and compare the findings from two published reports on sexuality and health among young people in Sweden. In 2015, a national survey was conducted in Sweden among young people aged 16–29 years (Public Health Agency of Sweden, 2017). In 2016, the same questionnaire was used targeting the same age group who were placed in secure state care (Public Health Agency of Sweden, 2018). Both studies were conducted on behalf of the Public Health Agency of Sweden as part of the work to prevent HIV and promote sexual health among youth and young adults. The first author worked on the national study, and the second author conducted the study concerning young people in secure state care. Both studies were approved by the Regional Ethical Boards in Stockholm (2015/5:4) and Linköping (2016/163–31). The Public Health Agency of Sweden formulated the questionnaire. It was reviewed by the unit for measurement techniques of Statistics Sweden, and tested 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 (Public Health Agency of Sweden, 2017). It covered sexual health in the following areas: health, social support and social relations, violation, discrimination and physical violence, sexuality and relations, sexual practices, last sexual encounter, contraceptives and contraceptive methods, abortion and unplanned pregnancy counselling, sexual abuse, the selling and buying of sex, sexually transmitted infections (STIs) and testing as well as counselling, knowledge and the need for health promotion.

The national survey – sampling, sociodemographics and sexualities

The first sample to be included in our analysis comes from a national, stratified, population-based study. The sampling was carried out by Statistics Sweden, and the sample frame were all 16–29 year olds in Sweden. 7 755 young persons participated (response rate 26%). A non-response analysis showed that the survey was answered to a lower degree by young people with low grades in school year 9, young people without post-secondary education, boys, foreign born persons and young people whose parents had a low level of education. These variables were used to weigh and adjust the non-response impact in order to better portray the conditions among young people 16–29 years old in Sweden (Public Health Agency of Sweden, 2017). The sample was stratified on age, (16–19, 20–24, and 25–29 years). See Table 1.

Table 1 Sociodemographic and sexual variables.

	Young people in secure state care sample (n 117)	Young people in national sample (n 7 755)
Gender identity		
Woman	47%	49%
Man	53%	50%
I do not want to categorise myself (Non-binary gender)	-	1%
Transgender		
Are you or have you been transgender	-	1%
Mean age		
Women	20 years	n.a.*
Men	19 years	
Born in Sweden	80%	90%
Highest education		
Elementary school	70%	25%
High-school	16%	45%
Economic status		
Perceived as good or very good	43%	80%
Sexual orientation		
Bisexual	14%	5%
Homosexual	1%	2%
Heterosexual	80%	83%
Do not categorize my sexual orientation	2%	5%
Do not know	2%	3%
Other	1%	1%
Ever sexually active	97%	81%
Mean age sexual debut age		
Young women	13 years	16 years
Young men	14 years	16 years

*Since the national sample was stratified on age, men age is not presented.

The secure state care survey – sampling, sociodemographics and sexualities

The second sample consist of 117 young persons aged 16–29 in secure state care. All secure state care institutions for young people (24 institutions) and young adults (9 institutions) in Sweden were included. An exact response rate was difficult to establish (estimated to 23%). However, these 117 individuals represent 11% of the approximately 1000 young persons aged 16–29 placed at these secure institutions during one calendar year (Public Health Agency of Sweden, 2018). The reasons for secure placements are psychosocial problems, substance misuse, and criminal behaviour (Swedish National Board of Institutional Care, 2020). Young people (under 21 years) placed at youth institutions have already received non-residential care in their home municipalities or care in a foster home or open residential home. Only when such interventions prove insufficient are young people placed at these secure institutions (ibid.). Care is provided mainly under the terms of the Care of Young Persons (Special Provisions) Act and is planned together with the young person, their family and social services (ibid.). The methods used are cognitive behavioural therapy, Aggression Replacement Training, Relapse Prevention, Motivational Interviewing and individual psychotherapy (ibid.). Some institutions also care for those under 18 years who have committed serious criminal offences and been sentenced to secure youth care under the Secure Youth Care Act (ibid.) In adult institutions, young adults (above 18 years) are placed in secure state care under the Care of Substance Abusers (Special Provisions) Act due to life-threatening substance misuse (ibid.).

Data was collected with help from staff at the secure institutions, predominately nurses. The second author collaborated with the nurses over the phone and by email. It was stressed that the young person should be fully aware that the study was not initiated by the institution or the social services placing them there. If they decided to participate, they were asked to fill out the questionnaire in a private space, seal the envelope and then post it as regular mail. Due to ethical reasons, young persons deemed to be particularly vulnerable (e.g. psychotic, severely depressed, recently out

of severe drug use, migrants with low or no Swedish language skills) where not included. In all, 117 young persons from 25 of the 33 institutions participated. Two thirds were placed at state care institutions for young people (under 21 years), and one third at secure state care institutions for adults with life-threatening substance misuse (above 18 years). See Table 1.

Presentation of results

For the purpose of this paper, answers to a selection of the 64 questions from the aforementioned questionnaire are presented. Sociodemographic data and descriptive statistics from the national survey are described and compared with the findings from the survey conducted with young people in secure state care. The following four areas are in focus: 1) Overall health, mental health, relations, social support, and experiences of violence; 2) Sexual attitudes and experiences; 3) Attitudes and experiences of contraceptives, Chlamydia infection and abortion; and 4) Sexual health knowledge and needs.

As can be seen in Table 1, the two samples match in gender identity (most identify as young women or men) and sexual orientation (two out of ten identify outside the hetero-norm). Due to a stratified sample, mean and median age in the national sample is not available. Respondents in the secure care sample are younger. The samples differ slightly regarding country of birth, a larger proportion of young people in secure state care were born outside Sweden. Young people in secure state care differ from their peers in having a lower educational level, this could be due to their age. Young people in secure state care rate their economic status as poorer, they are more sexually active and have a lower sexual debut age.

The results are presented in percentages. The percentages in the national survey sample represent the likelihood of shares of the total population whereas percentages in the secure state care survey represent shares among the respondents in secure state care. Due to the study design and analysis methods, round-off errors may occur in the national sample. No one chose to gender categorize themselves as other than woman or man, or as transgender, in the secure state care sample. This group is excluded from the national sample in our further presentation (Tables 2–5) in the Results section.

Results

Overall health, mental health, relations, social support, and experiences of violence

As shown in Table 2, young people in secure state care perceive their health as worse than their non-incarcerated peers do. Gender differences occur in both groups, where young women to a lesser

Table 2. Overall health, mental health, relations, social support, and experiences of violence. Percentages.

	Young women in secure state care sample	Young men in secure state care sample	Young women in national sample	Young men in national sample
I have a good or very good health	***13%***	44%	***77%***	82%
I have felt sad almost every day for the last 6 months	***44%***	13%	***13%***	8%
I have tried to commit suicide during the past 12 months	***59%***	32%	***5%***	4%
I have someone to talk to about my innermost emotions	***62%***	61%	***88%***	81%
I can almost always get support if I have practical problems or if I am ill	***78%***	82%	***68%***	65%
I feel happy when I consider my future	***36%***	52%	***61%***	62%
I have been the victim of physical violence in the last 12 months	***65%***	38%	***5%***	7%

Table 3. Sexual attitudes and experiences. Percentages.

	Young women in secure state care sample	Young men in secure state care sample	Young women in national sample	Young men in national sample
I am satisfied or very satisfied with my sex life	***43%***	*62%*	***61%***	52%
In a sexual relation it is important that we decide equally how and where to have sex	***73%***	71%	***83%***	74%
Last time I had sex was in a safe place where I felt safe	***83%***	91%	***96%***	95%
I used alcohol last time I had sex	***29%***	36%	***17%***	22%
I used hashish or marijuana (i.e. cannabis) last time I had sex	***48%***	33%	***1%***	3%
I used other narcotics (amphetamine, cocaine, heroin, ecstasy, LSD spice or other net drugs) last time I had sex	***50%***	34%	***0,5%***	1%
I injected drugs last time I had sex	***28%***	15%	***0,1%***	0,1%
I have against my will been exposed to that someone touched my genitals or breasts	***79%***	19%	***42%***	16%
I have against my will been forced to masturbate on someone else	***49%***	6%	***10%***	6%
I have against my will been forced to have vaginal intercourse	***70%***	16%	***18%***	7%
I have against my will been forced to have oral sex	***56%***	17%	***14%***	7%
I have against my will been forced to have anal sex	***40%***	8%	***7%***	2%
I have given reimbursement /paid for sex	***8%***	29%	***1%***	5%
I have received reimbursement/been paid for sex	***35%***	14%	***3%***	2%

extent state that their health is good compared to young men. Only 13% of young women in secure state care say that their health is good. Similar large differences are found in regard to the statement, 'I have felt sad almost every day for the last six months'. A total of 44% of young women in state care stated this, compared to 13% of young men in state care and young women in the national sample. 8% of young men in the national sample agree to this statement. Regarding having ever tried to commit suicide young people in state care differ from their non-incarcerated peers, especially the young women. 59% of young women in state care and 32% of young men stated this, compared to approximately 5% of the young women and men in the national sample.

Regarding access to someone to talk with about their innermost emotions, young people in state care say they have this to a lesser extent than their non-incarcerated peers. On the contrary, a larger proportion of young people in state care say that they will always get support if they have practical problems or are ill. In answers to the statement of feeling happy when considering one's future, there are differences between groups, and the young women in state care are particularly distinguishable. 36% of young women and 52% of young men in state care state this compared to 62% of young

Table 4. Attitudes and experiences of contraceptives, STIs and abortion. Percentages.

	Young women in secure state care sample	Young men in secure state care sample	Young women in national sample	Young men in national sample
In a sexual relation it is important that we, if we don't want to become pregnant, use contraception	***79%***	*70%*	***91%***	86%
A sex partner that suggests condom use is being responsible and considerate	***49%***	34%	***73%***	66%
A sex partner that suggests condom use might have a STI or think that I have one	***44%***	*36%*	***10%***	10%
I have or have had a Chlamydia infection	***42%***	13%	***15%***	7%
I have been tested for Chlamydia	***94%***	64%	***64%***	35%
I, or my partner, have had an abortion	***30%***	21%	***16%***	15%

Table 5. Sexual health knowledge and needs. Percentages.

	Young women in secure state care sample	Young men in secure state care sample	Young women in national sample	Young men in national sample
If I have Chlamydia I can transfer it to a partner even though I have no symptoms	***95%***	61%	***82%***	71%
One can have Chlamydia for a long time without noticing	***82%***	58%	***86%***	71%
One needs to get tested to know if one has HIV	***86%***	58%	***84%***	74%
In school I learnt enough to take care of my sexual health	***29%***	63%	***41%***	58%
In school I learnt enough about gender, relations and equality	***28%***	50%	***27%***	45%
In school I learnt about STIs	***28%***	51%	***33%***	49%
I would like more knowledge of how to get a functioning relation	***38%***	18%	***31%***	31%
I am in need of possibilities to talk to someone about sexuality and relations	***39%***	13%	***25%***	17%

people in the national sample. The answers to the question of experiences of being the victim of physical violence in the last 12 months show similar differences. 65% of young women in state care and 38% of men in state care state this experience compared to approximately 6% of young women and men in the national sample.

Sexual attitudes and experiences

Table 3 shows that 43% of young women in state care say that they are satisfied or very satisfied with their sex life compared to 62% of young men. Smaller but disparate gender differences were found in the national sample. A larger proportion of young women say they are satisfied or very satisfied with their sex life. Small differences were found between young women and young men in state care regarding their attitudes to the statement that it is important to decide equally on how and where to have sex. In the national sample, a larger proportion of young women than young men agree with this statement. 83% of young women in state care say that the last time they had sex it was in safe place where they felt safe, compared to 91% of the young men. Among young women and men in the national sample, no gender differences were found, and approximately 95% say their last sexual encounter was in a safe place where they felt safe.

Regarding all questions on different forms of substance use in connection with the last time they had sex, young women and men in state care differ from their peers. Young women and men in secure state care have had these experiences to a larger extent. Substance of choice and way of administration differ between young people in state care. Young women say they used cannabis and other narcotics and injected drugs to a larger extent than young men who say they used alcohol. On all five questions on different forms of sexual assault, young women in state care say they have these experiences to a larger extent than young women in the national sample. Additionally, young men in state care have been forced to perform vaginal, oral, and anal sex to a larger extent then young men in the national sample.

Experiences of transactional sex is more common among young people in state care. Receiving money or some other kind of reimbursement for sex is more common among young women in state care (35%) than young women in the national sample (3%). The same applies for young men in state care. 14% say they have been paid for sex, compared to 2% among young men in the national sample. Close to a third of the young men in state care have experiences of buying sex, which differs from the other three groups.

Attitudes and experiences of contraceptives, STIs, unwanted pregnancies and abortion

Table 4 shows that in answers regarding attitudes and experiences of contraception, young people in state care differ between gender and from their peers. 79% of young women in state care say it is important use contraception in a sexual relation if one does not want to become pregnant compared to 91% of young women in the national sample. 70% of young men in state care agree to this statement compared to 86% of young men in the national sample. Even larger differences are found on attitudes towards a sex partner who suggests a condom. 49% of young women in state care consider such a partner to be responsible and thoughtful compared to 73% of young woman in the national sample. 34% of young men in state care agree to the statement compared to 66% of young men in the national sample.

44% of young women in state care agree with the statement that a partner who suggests a condom might have a sexually transmitted infection (STI) or thinks that he has one compared to 36% of young men in state care. 10% of young women and men in the national sample agree to this statement. It is more common among young women (42%) than young men (13%) in state care to have had a Chlamydia infection. Similar gender differences are found among young people in the national sample, but the actual percentages are lower. Young women in state care appear to be those with the most experience of being tested for a Chlamydia infection. 94% say this, compared to 64% of young men in state care, and 64% of young women and 35% of young men in the national sample. Concerning experiences of abortion, there are no gender differences in the national sample, as 16% state this. However, among young people in state care, 30% of the young women and 21% of the young men state that they or their partner has had an abortion.

Sexual health knowledge and needs

Regarding three different true statements concerning Chlamydia and HIV (transmission, symptoms and testing), young women in secure state care display more knowledge than young men in both the state care and the national sample do, see Table 5. Compared to young women in the national sample, young women in secure state care display an equal amount or more knowledge of Clamydia and HIV. Three questions are about whether enough sexual health knowledge has been received in school (about sexual self-care, about gender, relations and equality, and about STIs). Young women in state care report having received less knowledge (except about gender, relations and equality) than young men in state care and young women and men in the national sample. Finally, on two different questions concerning sexual health needs (knowledge on how to maintain a healthy relationship and access to someone to talk to about sexuality and relations) young women in state care say they have these needs to a larger extent than young men in state care and young women and men in the national sample do.

Discussion

In order to show large health inequalities in SRHR between groups, this study describes and compares data from two separate surveys aimed at young people aged 16–29 years. The first study was aimed at the total Swedish population of young people and the second at all young people in secure state care. As a whole, the results illustrate that young people in secure state care have a higher burden of ill health in all areas presented. This inequity is discussed below along with suggestions to counterbalance it with SRHR-affirmative social work practise. However, as a platform for this, we first want to stress the sociodemographic data. It shows that young people in state care have lower educational degrees and perceive their economic status as poorer, and more of them are born outside Sweden. This could be connected to structural barriers that limit their access to health care services, either due to lack of knowledge of them or due to financial reasons. At the same time, young people in secure state care are more sexually active and have a lower sexual debut age. These findings underscore that

individuals can experience social marginalisation through intersections between sexuality, ethnicity, class and location (Hicks & Jeyasingham, 2016).

Another finding worth stressing is that two out of ten young persons in the secure state care sample as well as in the national sample identify outside the hetero norm. This challenges the organisation of secure state care. In Sweden, secure state care is gender segregated, often with an unspoken assumption that this is a way to prevent sexual encounters. Moreover, it points at the need for LGBTQ+ competence among social workers. In an overview of articles in social work journals, a significant decrease in articles addressing lesbian and gay people was observed, with the largest decrease in articles related to HIV/AIDS (Pelts et al., 2014). The authors conclude that this can serve to remind about unmet needs of LGBTQ+ people, and that 'social work scholars and practitioners are well positioned to inform and lead through research, education, advocacy, and direct service' (ibid., p. 137). In this endeavour, it has been suggested that social workers combat 'stigma, shames and hierarchies of value in ways that do not impose new norms or reproduce narrow representations of matters such as sexual practices' (Hicks & Jeyasingham, 2016, p. 2369).

Social work implications in relation to overall health, mental health, relations, social support, and experiences of violence

The results show that young people in secure state care have worse overall health. Specifically, their mental health status differs greatly from their non-incarcerated peers. This warrants action. Routines to screen for adverse life events and mental health among young people in contact with social services have recently been suggested (Tordön et al., 2018). Additionally, experiences of violence (including sexual violence) that young people in secure state have points at the need for trauma-informed social work, including suicide prevention. Trauma-informed counselling, and to receive information about sexuality despite trauma (Fava & Bay-Cheng, 2013; Levenson, 2017), can be seen as a right to sexual health (CRC, 2013; WHO, 2015). It is interesting that young people in secure state care to a greater extent than their peers say they have access to support if they have practical problems. On the one hand, this could signal experiences of having strong and helpful bonds with families and friends. On the other hand, it could be an example of an internalised view on being the recipient of social work. Either way, it can be an opportunity for social workers to add SRHR matters into their existing services.

Social work implications in relation to sexual attitudes and experiences

That young people in secure state care have had experiences of sex under the influence of alcohol or other drugs is not surprising. Substance use is one of the reasons why they are placed in these institutions. However, the findings underscore the need to include support on matters of sexuality in social work when individuals are exiting substance use (Lindroth, 2020; Skårner et al., 2016; Svensson & Skårner, 2014; Wikström et al., 2018). Regarding their most recent sexual experience, young women in secure state care appear to have experienced less power and stated that they were more unsafe compared to the other three groups. This may be connected to experiences of using alcohol and other drugs, as mentioned. It could also be conntected to experiences of selling sex, which is also more commonly reported among young women in secure state care. A review of inequities in accessing health care concludes that whether sex workers use health services involves a wide range of barriers and facilitators at the intrapersonal, interpersonal, institutional, community, and policy levels (Ma et al., 2017). For instance, and of relevance to social workers, stigmatising attitudes among health professionals is regarded as a barrier (ibid.). The possibility of similar stigmatising attitudes among social workers must also be addressed.

Regardless of the form of sexual abuse, young women in state care state experiences of this to a higher extent. Again, this calls for trauma-informed social work practice (Fava & Bay-Cheng, 2013; Levenson, 2017). Given all these experiences, it is not surprising that young women in secure state

care state that they are less satisfied with their sex life compared to the other three groups. In other words, the findings imply that young women in secure state care are in need of sexual health support. In this work, it is vital that social workers, in cooperation with the young women, find the right balance between young women as actors in their own lives and their need for protection. Girls placed in secure institutions in Sweden experience that they are placed in the role of a victim (Vogel, 2017). This is a position they do not recognise and that they oppose (ibid.). These experiences of being regarded as 'victimised' could also be connected to orthodoxies that inform contemporary social work practice concerning sexual abuse (Smith & Woodiwiss, 2016). In an era where Child Sexual Exploitation is emphasised and equated with damage and harm, a discourse exists that 'risks equating all psychological unhappiness with past abuse whilst also writing off victims of such abuse as unfixable or permanently damaged' (ibid., p.2185). Sexually traumatised young women, young men and non-binary gendered youth must be protected from new assaults, but it must also be acknowledged that sexual trauma is experienced differently. Young people with previous negative experiences can be resilient and have current or future positive sexual experiences. It is possible for them to keep or reclaim their sexual agency.

Social work implications in relation to attitudes and experiences of contraceptives, STIs and abortion

That young people in secure state care consider contraception as less important in order to prevent unwanted pregnancy is worrisome, especially given that they have higher rates of abortion. One the one hand, attitudes among young people in secure care on condom use (i.e. that a person suggesting a condom might have an STI or suspect the other person of having one) can appear prejudiced. On the other hand, given that Chlamydia infection rates are higher among young people in secure care, especially the young women, this can also be seen as realistic. Nevertheless, prejudice are found in attitudes toward the person suggesting a condom. Young people in secure state care regard this as responsible and considerate to a lesser extent than their non-incarcerated peers do. This implies that attitudes among young people described by Marston and King (2006) fifteen years ago (e.g. seeing sexual partners as 'clean' or 'unclean', and that condoms are associated with lack of trust) still operate among young people today. These attitudes are possibly even more common among vulnerable young people. This could be because they have not been reached by public sexual health messages about STI prevention. However, this explanation is easily challenged by the finding that young women in secure state care have experiences of using testing services to a higher extent than all other groups. At the same time, young men in secure state care have used this service to a lower extent than young people in the national sample. Given that close to 40% of Chlamydia cases in Sweden occur among a tenth of the youth population (Hammarström et al., 2015), access to testing and health conversations should be offered to those in secure state care. Young men in secure state care appear to be a specific target group in these efforts. These services should be youth-friendly, non-judgmental and entail access to different sexual health-promoting and preventive services such as sexual health counseling, knowledge provision, and testing facilities

Social work implications in relation to sexual health knowledge and needs

Young women in secure state care show more knowledge of STIs, but they also state that they have not received enough sexual health knowledge from school. In addition, they have more experiences of testing for STIs. This implies that they have access to and seek out sexual health services when they are not in secure state care institutions. Again, continued access to these services while placed in institutions is essential. Additionally, four out of ten young women and two out of ten young men in secure state care say they have sexual health needs, i.e. to receive knowledge on how to maintain relationships and access to talk to someone about sexuality and relationships. These needs could be

met in counselling, and again, it is paramount that young women are not victimised. Instead, social workers should avoid a negative discourse on sexuality and what Dodd and Tolman (2017) describes as the 'deficit model of sexuality that runs counter to our holistic, person-in-environment, life span and strengths-based perspective, as well as to our commitment to social justice' (p. 227). In other words, a SRHR-affirmative approach to all young persons in secure state care is needed. Following these recommendations could lead to a social work practice where well-being includes sexuality as a resource and a source of strength. A sexual rights-based perspective is needed in social work in general and with vulnerable young people in particular (Lindroth, 2020; Smith & Woodiwiss, 2016). This is especially important when social work is organised in a compulsory fashion and when young people are incarcerated. A placement in a secure state care institution hinders them from seeking the sexual health services they want. In short, in these institutions, SRHR become social work issues.

This is the second study of its kind in Sweden, using the same questionnaire, which illuminates that young people in secure state care have sexual health needs that are both alike and different from their non-incarcerated peers (Lindroth et al., 2013). As such, it underlines the need to focus on SRHR in social work with vulnerable young people generally and young people in secure state care in particular. The results confirms previous findings and demonstrates that sexual health inequalities persist. Social work need to address this gap on both policy and practice levels. Future studies on sexual health among young people in secure state care is needed, but even more essential is to raise SRHR competence levels among social work professionals working in these institutions. SRHR competence in social services in municipalities applying for a placement at a secure state institution is also necessary. To evaluate how SRHR-affirmative social work practices are perceived by young people is another future endeavour.

Study limitations and strenghts

One large limitation of this study is the different sampling strategies, the different sample sizes and low response rates. This inevitably affect study trustworthiness. Therefore, it is worth mentioning again that the results presented in this paper are not derived from analytical statistics but rather from describing and comparing. Comparative studies describing SRHR among young people in secure state care and their non-incarcerated peers are rare. One reason can be that young people in secure state care are a hard-to-reach group. Even though the study design in the national sample enabled correction for drop-out, it is still not likely that it could adjust all aspects. Therefore, it is possible that the national sample has a tendency to describe young people who have a relatively good socioeconomic status and are relatively active in society. The secure state care sample can be seen as filling this gap. In the secure state care sample, it is likely that the young persons excluded from participating due to ethical reasons, and the unknown number of individuals who chose not to participate are even more vulnerable. Another limitation is that questionnaires tend to produce blunt results with no possibility for clarification. Some of our operational choices can be debated. For instance, can a question about a partner who suggests a condom measure a young person's attitude towards condoms? Nevertheless, bearing these limitations in mind, we suggest that the results can be of interest to social workers meeting vulnerable young people.

Although studies like this risk underscoring and perhaps negatively reinforcing the marginalised position of vulnerable young people, they also offer opportunities for social workers to discover areas within SRHR in need of policy and practice action. The transferability of the findings is limited to countries where young people are in secure state care under similar conditions as well as to countries with similar societal views on youth sexuality, sexual health as a human right, and gender equality. Young people and social workers in countries with other forms of secure state care, and views on youth sexuality and equity between genders may face different adversities and challenges.

Conclusion

The results provide a broad and extensive insight into SRHR issues and needs in a vulnerable group: young people in secure state care in Sweden. The findings underscore that health inequities among young people persist and that SRHR-affirmative social work is needed.

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