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Availability, Accessibility, Acceptability, and Quality of SRHR related health care for unaccompanied minor girls in VGR

A qualitative study based on the perceptions of health care professionals.

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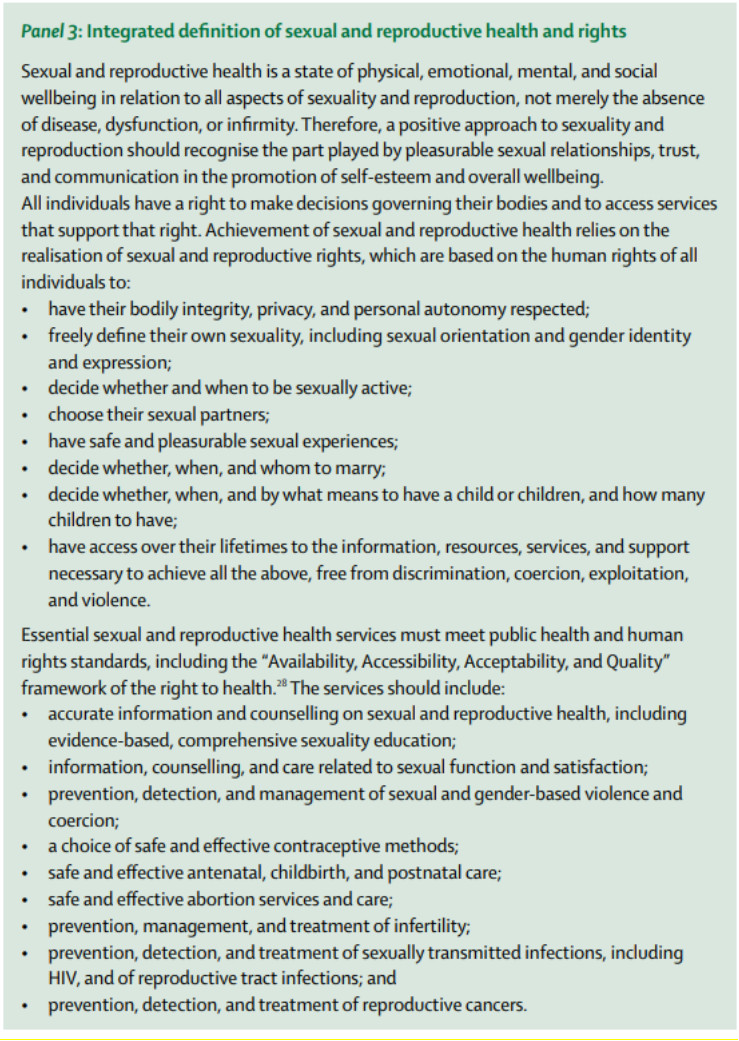
PART A

Introduction

Sexual and reproductive health (SRH) has been identified as one of the most important fields within public health, particularly regarding women and girls. Sexual and reproductive health and rights (SRHR) are also universal human rights that play an important role in the field of human rights and development, and it is established that empowering women and girls is one of the most reliable pathways to improved well-being for all (UNFPA, 2014). Suffering due to SRHR related issues is still a large part of the global ill health, and sexual and reproductive ill health accounts for one-third of the global burden of disease among women of reproductive age and one-fifth of the burden of disease among the population overall (UNFPA, 2014). According to the World Health Organization (2008), SRHR is essential for women's health, therefore countries should empower women to have control over all aspects that relate to their SRHR as well as prevent those traditional practices that girls are exposed for such as female genital mutilation and early marriage. The definition of SRHR has been evolving the last decades and it has been a process of both advances and setbacks, therefore the literature the definitions are often combined or overlapping. In 2018, a new comprehensive definition of SRHR proposed by the Guttmacher–Lancet Commission (Starrs et.al. 2018) includes sexual health, sexual rights, reproductive health and reproductive rights, but does also reflect a consensus on what services and interventions that are needed to achieve the sexual and reproductive health needs of all individuals. Furthermore, it addresses related issues such as violence, stigma and respect for bodily autonomy, which profoundly affect individuals' psychological, emotional and social well-being.

The new integrated definition of sexual and reproductive health and rights, from the Guttmacher–Lancet Commission building on agreements, WHO publications, international human rights treaties and principles is presented below in figure 1:



Panel 3: **Integrated definition of sexual and reproductive health and rights**

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing.
All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health.[28] The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

Figure 1. *The new integrated definition of SRHR, from Guttmacher–Lancet Commission (Starrs, et al. 2018:2646)*

The right to the enjoyment of the highest attainable standard of physical and mental health, is one of the human rights and was first formulated in the 1946 Constitution of the World Health Organization. Health being a human right implies countries to ensure access to health care that is both accessible, available and acceptable as well as of good quality (WHO, 2008), this is the conceptual framework called AAAQ framework.

2030 Agenda for Sustainable Development is the UN´s action plan, with 17 goals that aim to achieve universal peace, eradicating poverty, gender equality and realize human rights for all as well. The two goals that relate to this study is goal 3 "Ensure healthy lives and promote

well-being for all at all ages" and goal 5 "Achieve gender equality and empower all women and girls.". They include targets regarding universal access to SRHR services, integration of SRHR in policies and programs and eliminating harmful practices such as female mutilation. The European action plan for SRHR (WHO, 2016) states that there is a lack of information on SRHR, and it also highlights the fact that inequity in SRHR is closely related to social determinants and structures imbedded in society, this makes the accessibility for everyone to relevant health education and information extremely important. The opportunities for a good SRHR depend on access to information, knowledge about risks, access to good quality health care as well as a health promotive environment.

Background

During 2020, approximately 13,000 people applied for asylum in Sweden, 3566 of them were children and 500 of them were unaccompanied minors. Of them 157, were girls, most of them with an origin from Afghanistan, Iraq or Somalia (Migrationsverket, 2020). According to Swedish law, the concept of unaccompanied minors includes asylum-seeking children under the age of 18 who, on arrival in the receiving country, are separated from both their parents or any other adult who can be considered to have taken the place of the parents, or children who, on arrival, are without such a person (SBU, 2018).

Unaccompanied minor girls are more likely to have suffered gender-based violence as well as restrictions regarding their right to health. According to Abubakar et al. (2018) there is a particular risk for migrants of sexual violence, coercion, and sexual exploitation at all stages of their migration journey. The study highlights the fact that women and children are at even higher risk when they migrate without their family, and that "…unaccompanied boys and girls who move in ways that are not readily detected by potential support mechanisms are particularly vulnerable to neglect, trafficking, abuse, and sexual exploitation." (Abubakar et al. 2018:2610). Unaccompanied minors generally also have a low level of awareness

regarding the issue of SRHR and might have experience of fear, deprivation of liberty and abuse. Regarding experiencing a traumatic past, research shows that certain background factors are closely associated with sexual risk-taking, such as low self-esteem, previous exposure to sexual abuse, previous sexually transmitted infections, and experience of having given or received compensation for sexual services (Tikkanen et al. 2011).

The report *Stöd till ensamkommande barn och unga – effekter, erfarenheter och upplevelser* [Support for unaccompanied children and young people - effects, experiences and experiences] (SBU, 2018), concludes that there is a knowledge gap regarding unaccompanied girls' special situation and need for support. This as there are few studies on unaccompanied minors' experiences of migration and their health situation in Sweden, especially when it comes to SRHR, and none focusing specifically on unaccompanied minor girls and SRHR. The need for research is furthered as these girls are unaccompanied as well as minors, which make them extremely vulnerable and places high demands on the regulation of their rights and the way that different authorities and institutions that they encounter act.

Aim

The aim of this literature review is to present scientific and grey literature on sexual and reproductive health and rights of unaccompanied minor girls and analyse its usefulness for policy and programs aiming to support this group in Region Västra Götaland, Sweden.

The research questions are:

1. Which are the SRHR needs of unaccompanied minor girls and in what way, if any, do they differ from other groups?
2. What special policies and programs to address the SRH needs and rights of girls and, specifically, unaccompanied minor girls are described in the literature?

Method

A total of 206 articles were identified in a systematic literature search that was conducted using the databases Scopus, PubMed and Cinahl (see *Appendix 1*) for complete details of the search strategy) using search terms such as “sexual and reproductive health and rights”, “unaccompanied minors”, “girls”, “women”, “females”, “young migrants”, “young refugees etc. Abstracts were screened using following inclusion criteria; (a) mention unaccompanied minor girls; (b) target women and SRHR; youth migrants and SRHR; or migrants and SRHR. Exclusion criteria were articles with a focus specifically on STDs, sex work, gender-based violence, humanitarian crises, or very contexts specific. This was the same for both the systematic and manual search.

Since the systematic search within the databases did not result in any research specifically focusing on unaccompanied minor girls and SRHR, the search method was also extended beyond databases, to a manual search that was done to include grey literature such as SRHR government reports, policy documents and reports from relevant authorities.

Results

Thirteen (13) articles were included from the systematic search and fifteen (15) documents from the manual search (see table in *Appendix 2)*. When reviewing this literature to identify topics related to unaccompanied minor girls and SRHR, three themes were identified:

1. Strategic perspective on SRHR (nr:1,13,16,21,28)

2. SRHR for young people and other vulnerable groups (nr: 2,3,5,8,9,25,26)

3. Health and migration (nr: 4,6,7,10,11, 12,14, 15,18, 19,20, 22, 23, 24,25, 27)

1. Strategic perspective on SRHR

This theme will include literature concerning strategic perspectives on SRHR, that was identified through the research. Both the Swedish national and international policy on SRHR as well as frameworks regarding the topic on an EU level will be addressed.

According to Keygnaert et.al. (2014), both academic, as well as grey literature conclude that the health needs of EU-migrants from a third country differ from the general European population, and particularly so, their SRH needs. They are less often screened, have lower access to family planning and use less health care services related to their SRH. These special needs and the vulnerability of theses migrants should be considered within the EU, but still seem to be somewhat ignored. Unclear legal and policy frameworks, and what is described as "patchy practices" creates a discrepancy between the documents that the member states have ratified such as the International Bill of Human right, the right to health and the actual current situation. To increase EU -migrants access to SRH related health care, new ways of making health policies that include a mutual way between the EU and its member states of upholding human rights and to reconsider SRH as a right for all, should be considered (Ibid, 2014).

The report of the Guttmacher–Lancet Commission (Starrs, A. et al. 2018) points at the work that is left within the SRHR field and formulates a challenging and evidence-based vision for SRHR based on human rights. The Commission proposes a new definition of SRHR and recommends basic actions in the SRHR field that covers a broader view and more aspects than the usual definition. The new definition integrates the full spectrum of individual needs and services that are rarely recognized in global discussions, including sexual well-being and personal self-determination. It provides a framework that can guide stakeholders in designing guidelines, services and action programs that consider all aspects of SRHR in an effective and equitable manner.

SRHR work is also crucial for the work on sustainable development due to the relation to gender equality and women's health. The effect of SRHR on the female life course perspective on health, including maternal, child and adolescent health influences the future economic development, and environmental sustainability (Starrs, et al. 2018).

In Sweden this has resulted in the Swedish international policy on SRHR, *Sweden's international policy on sexual and reproductive health* (Regeringskansliet, 2006) that aims to compile the work and the strategic areas within the field. It has it´s starting point in the international documents such as the ICPD report from 1994 and the UN World Conference on Women in Beijing in 1995, as well as national documents such as the *Shared Responsibility – Sweden's Policy for Global Development* (PGD) from 2003. The international policy has a strong emphasis on the rights perspective which focus on the individual as a potent actor and bearer of rights and that the work of SRHR should be based on human rights, democracy, and gender equality. This means that the government are obliged to provide knowledge and tools for people to exercise their rights. The policy has highlighted strategic areas for the international work, one of those areas that concerns the unaccompanied minors girls is "Empower women and girls to shape society and their own lives",(p.14, Regeringskansliet, 2006) were it is stated that a precondition for moving SRHR work from theory to practice is gender equality, and that states have the responsibility of "guaranteeing that everyone's rights are protected, and that women have access to knowledge about their rights as well as the power to exercise them" (Regeringskansliet, 2006:15).

Another area that also concerns the unaccompanied minor girls is the area "The health and rights of young women and young men" (Regeringskansliet, 2006:15) where it is stated that specific vulnerable groups such as youth migrants lack information and services regarding SRHR. According to the Swedish government, information about access and availability to healthcare concerning SRHR is of great importance if people are to be able to take

responsibility over their SRH. It is also clear that Sweden consider SRHR related ill health to be a result of lack of access to information and knowledge, and that the government supports increased knowledge about SRHR as well as gender-based power structures, sexual orientation and gender identity as a way of strengthening the populations SRHR (Regeringskansliet, 2006).

During 2019 the Public Health authorities got commissioned to develop a national strategy for SRHR, aiming on equality regarding SRHR within the whole population, which requires equal conditions and terms for all. The strategy is structured in four sub-goals, based on human rights principles, and they are interdependent, long term goals of what is called a "visionary nature". The knowledge and information that the strategy builds on is *SRHR2017* (FHM, 2019), a representative population study on SRHR in Sweden 2017, that was done by the Public Health Authorities. The results from that study showed that SRHR was relatively good but unevenly distributed within the population, it also showed differences in SRHR between groups based on gender, age, socioeconomic conditions, and sexual identity, which was found to be because of inequal conditions. The strategy builds on the rights perspective, a life course perspective as well as the knowledge of prerequisites for equal SRHR. In the strategy it is pointed out that certain group's SRHR needs to be strengthen and one of those groups are migrants, since their health often is worse than the general population, and public health intervention reaches this group to a lower extend, they have less knowledge about the Swedish health care system, they encounter cultural and language barriers and might have a low confidence in institutions and authorities. This means that efforts are needed to identify and address barriers in order to increase access and availability for this group. Seven areas of action are highlighted in the strategy, which should contribute to the work of reaching the four sub goals, these are" to create structural preconditions for SRHR, make SRHR visible as part of public health work, ensure competence in the relevant professional groups, secure the right

to knowledge and information, promote SRH throughout life, prevent sexual and reproductive illness throughout life, create equal and accessible care, support and treatment" (FHM, 2020:22).

2. SRHR for young people and other vulnerable groups

The literature identified in this theme was interpreted to primarily discuss the theme SRHR for young people and other vulnerable groups. The main focus are challenges and facilitators regarding SRHR for vulnerable groups, and the specific needs that they might experience.

Barriers and facilitators for SRHR of young migrants that were resettled in a new country were identified by Tirado et.al (2020) as either individual, social, institutional, or structural. Examples of the barriers that were identified were lack of knowledge and information, gender-based violence, sociocultural norms, stigma and shame, lack of social support, and lack of infrastructure and security. These barriers are barriers that are common even for other groups of youths, but the review of Tirado er al (2020) indicates that many barriers are exacerbated by the refugee context. Individual barriers were the lack of information on SRHR, poor risk perception, fear over abortions due to knowledge about unsafe procedures that they experienced during their migration and transit. Social barriers were relationship power, gender-based violence or norms, and common institutional barriers were education or provider support. Structural barriers were identified as infrastructure, policies, or enforcement of laws. Some of these barriers could in certain contexts act as either a barrier or a facilitator, norms are an example of that. Facilitators on the other hand, were identified as social support and trust, provision of appropriate services, provider support and tools, improved safety.

According to Ivarsson (2017) girls often migrate due to different reasons than boys. Reasons to escape the country of origin can be the lack of bodily autonomy, that they are controlled by men in the family, fear of being forced to marry, or being victims of gender-based violence and/or female mutilation. Regarding the need of health care in Sweden, the girls in the study

express that they would like to have access to different health care service but do not know how to access or what is available. They also express the need for education regarding SRHR since they have very little knowledge of their own body and their rights, and that the information given in Sweden has been inadequate.

The report from Socialstyrelsen (2016), does also highlight the areas of care that has been discovered and need attention, and some of these areas are trauma from sexual abuse, unwanted pregnancies due to abuse, lack of knowledge regarding SRHR and low knowledge about self-care and health promotion. A specific challenge that is mentioned is that children from this group do not access care as much as other children, and that unaccompanied minors are extra vulnerable due to the lack of a parent or other adult during the health care encounter, and which is seen to cause more demanding interventions and could also complicate assessment and treatment.

There is also mentioned (Socialstyrlesen, 2017) certain concern regarding female mutilation, how to encounter that and how many of the girls that have been exposed to that. The ongoing violations of vulnerable groups such as unaccompanied minors SRHR, despite all international policies and guidelines point at the lack of enough attention that this matter gets (Endler et al.2020).

3. Health and migration

The theme health and migration capture different barriers to health care and risk factors due to migration such as traumas, lack of networks or language barriers.

According to Endler et.al (2020) barrier to health care such as language barriers, fear of reprisal upon seeking care and cultural beliefs lead to a high mortality among refugees. To increase the access to care for refugee's context specific interventions and a possibility to care in their own language is highly needed.

This is related to what is stated in the project plan of the city of Gothenburg's reception of unaccompanied minors (Göteborgs Stad, Stadsrevisionen, 2014) it is described how unaccompanied minors have experiences of breaking up from family, home and informal networks as well as suffering from migration traumas, which is regarded as risk factors for ill health. The National Board of Health and Welfare highlights the fact that the need of unaccompanied minor girls has not gotten enough attention, compared to the situation of the boys. It also appears to be clear that asylum seekers and newly arrived people receive less health care than the rest of the population, and that they mostly receive primary care and less specific health care (Socialstyrelsen, 2016). Some of the challenges that are mentioned are their large need for information, communication difficulties, specific challenges regarding unaccompanied minors and a lack of cultural competence. Some of the suggestions for change are to develop guidelines for how specific healthcare areas such as maternal and maternity care should adapt interventions for certain groups and to improve the support of unaccompanied children within the health care system.

In the guidelines of Göteborgs Stad regarding unaccompanied minors (Göteborgs Stad, 2013) there are two questions regarding health, but nothing specifically on SRHR. One is where the initial health check-up should be done and who is responsible and the second one is regarding who should help the child if it is suffering from ill-health. A survey conducted by Socialstyrelsen (2013) highlights the fact that several professionals within the social services and health care personnel mention that unaccompanied minor girl's health does not get as much attention as the boys and that they lack special efforts for unaccompanied minor girls that are pregnant or have their own children. In 2017, Socialstyrlesen did an analysis of their work with a focus suicide risk, partly on unaccompanied minor girls, it is mentioned the difficulties of the unaccompanied minor girls that are married or have their own children regarding their living situation and education. Regarding their access to care the regions

consider the girls to have access to the care they need, but it is also expressed that it means that they have access to the care they ask for, not necessary what they actually need. According to the analysis the girls do not have the habit of being asked about their needs, which make it difficult for them to express their needs.

Theoretical context

The right to health, Article 12 in ICESCR includes four core elements: availability, accessibility, acceptability, and quality, also referred to as the AAAQ framework. Availability refers to sufficient, functioning health care services for all. Accessibility has four different aspects: non-discrimination, physical accessibility, affordability, and information accessibility, and requires that everyone should have access to health care facilities and its services. To gain accessibility it is needed to understand what barriers that may exist for vulnerable groups, such as examine norms that may exist and that may hinder certain groups from accessing adequate health care. Acceptability concerns the encounter between the individual and the health care services provided, in regard to gender, ethnicity, age, socio-economic status or similar. Quality refers to the standard of the health care and should be safe, effective, people-centred, timely, equitable, integrated and efficient (WHO, 2017). This framework examines access to health care from a human rights perspective, and that could highlight that being an unaccompanied minor and a girl could affect the possibilities to access the available health care services that exist, due to language and cultural barriers and a lack of knowledge regarding the health care system.

Ethical considerations

Regarding ethical considerations within the field of SRHR and unaccompanied minor girls, there are several aspects that are of interest. The first one is the fact that these girls are a very exposed and vulnerable group due to the combination of being minors in a new country, being girls, being migrants and presumably bearing the trauma of the migration process. This might

be a reason for the lack of research done specifically on this group, but at the same time it highlights the need for more knowledge and information regarding their health and SRHR.

Another ethical consideration regarding health in general, could be the idea of holding people responsible for their own health, which could be argued from different perspectives. If individuals are given the right circumstances the idea of being held responsible for one's own health could strengthen the efforts to make healthy choices, the problem here would be that the target group are not given the right circumstances, they lack knowledge, information and agency to be able to make the "right" choices regarding their SRH. The theory of luck egalitarianism argues that it is to be seen as inequity if the ill-health isn't caused by free decisions but a result of brute luck, and if so, one should not be held responsible for one's own ill- health. Within the field of SRHR and regarding vulnerable groups such as unaccompanied minor girls, their ill-health is often due to external factors such as structural factors and norms, rather than making the "wrong "choice. Interventions in public health that focus on lifestyle choices or on increasing knowledge of a certain issue, are based on the idea of holding people responsible for their own health. This is often seen to increase inequalities in society and could also create stigma which is ethically doubtful. Stigma could cause harm and is considered to be an independent social determinant of health. Since stigmatized group do have a lower life expectancy than others, it seems to be a strong reason not to expose people of that (Goldberg, 2017).

Conclusion

Based on the results from this literature review, there seem to be a knowledge gap regarding unaccompanied minor girls and SRHR, both in Sweden and globally. The findings include literature regarding SRHR both nationally and globally, SRHR regarding other vulnerable groups, literature regarding the health of migrants in different contexts and literature regarding unaccompanied minors in Sweden but nothing specifically unaccompanied minor

girls and SRHR. The most relevant finding that target these girls, and where their experiences are highlighted, is the report of Ivarsson (2017) where the need for knowledge and education regarding SRHR as well as how to navigate a new health care system are emphasized. Knowledge prevents ill-health, promotes integration, contributes to positive future possibilities, and teaches young people what is socially accepted, which in turn can contribute to increased self-esteem. That is why Part B of this study will focus on examining what SRHR related needs, health care professionals perceive unaccompanied minor girls in Region Västra Götaland, Sweden, to have, as well as how existing health care services address these needs. It will also try to identify areas for improvement regarding the availability, accessibility, acceptability, and quality of above-mentioned health care services, in accordance with the AAAQ framework.

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Reference list

Abubakar I, Aldridge RW, Devakumar D, Orcutt M, Burns R, Barreto ML, et al. (2018). *The UCL–Lancet Commission on Migration and Health: the health of a world on the move.* Lancet. 2018. The UCL–Lancet Commission on Migration and Health: The health of a world on the move. The Lancet (British Edition), 392(10164), 2606-2654.

Endler, M., Al Haidari, T., Chowdhury, S., Christilaw, J., El Kak, F., Galimberti, D., . . . Danielsson, K. (2020). *Sexual and reproductive health and rights of refugee and migrant women: Gynecologists' and obstetricians' responsibilities*. International Journal of Gynecology & Obstetrics, 149(1), 113–119.

Folkhälsomyndigheten. (2019). *Sexuell och reproduktiv hälsa och rättigheter i Sverige 2017 Resultat från befolkningsundersökningen SRHR2017*, Retrieved 2021-02-25 from https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/s/sexuell-och-reproduktiv-halsa-och-rattigheter-i-sverige-2017/?pub=60999

Goldberg, Daniel S. (2017). On Stigma & Health. *The Journal of Law, Medicine & Ethics*, 45(4), 475-483.Schmidt, H. (2016) Chronic Disease Prevention and Health Promotion. In: H. Barrett D., W. Ortmann L., Dawson A., Saenz C., Reis A., Bolan G. (eds) Public Health Ethics: Cases Spanning the Globe. Public Health Ethics Analysis, vol 3. Springer, Cham

Göteborgs Stad, Stadsrevisionen. (2014). *Projektplan Göteborgs Stads mottagande av ensamkommande barn.* Retrieved 2021-02-25 from https://goteborg.se/wps/wcm/connect/3316379b-5555-44e7-aaf9-9b1cb2586af0/2014+Projektplan+G%C3%B6teborgs+Stads+mottagande+av+ensamkommande+barn.pdf?MOD=AJPERES

Göteborgs Stad. (2013). *Ensamkommande barn och ungdomar i Göteborg25 frågor och svar.* Retrieved 2021-02-25 from https://goteborg.se/wps/wcm/connect/79b07d3b-855f-4111-a594-

82d4654f07c3/Ensamkommande+V%C3%A4gledningen.Ensamkommande+barn+och+ungdomar+i+G%C3%B6teborg.+25+fr%C3%A5gor+och+svar.pdf?MOD=AJPERES.

Keygnaert, I., Guieu, A., Ooms, G., Vettenburg, N., Temmerman, M., & Roelens, K. (2014). *Sexual and reproductive health of migrants: does the EU care*? Health policy (Amsterdam, Netherlands), 114(2-3), 215–225. https://doi.org/10.1016/j.healthpol.2013.10.007

Migrationsverket. (2020). *Asylsökande till Sverige 2000–2020,* Retrieved 2021-02-12 from https://www.migrationsverket.se/download/18.4a5a58d51602d141cf41003/1611313758766/Asyls%C3%B6kande%20till%20Sverige%202000-2020.pdf)

Närhälsan Kunskapscentrum för sexuell hälsa. (2017). *SRHR på HVB, Att arbeta med sexuell och reproduktiv hälsa och rättigheter på hem för vård och boende. Metodbok med utgångspunkt i projektet SRHR på HVB 2013 – 2016.* Retrieved 2021-02-21 from https://www.srhr.se/sites/default/files/hvb.pdf.

Regeringskansliet. (2006). *Swedens international policy on sexual and reproductive rights and health.* Retrieved 2021-02-25 from https://www.government.se/49b74f/contentassets/184b53554f8448a3a8ebde6fe41f3da1/swedens-international-policy-on-sexual-and-reproductive-health-and-rights.

SCB. (2020). *Ensamkommande flyktingbarn efter kön, ålder och medborgarskap. År 2002 – 2020.* Retrieved 2020-12-22 from https://www.statistikdatabasen.scb.se/pxweb/sv/ssd/START__BE__BE0101__BE0101P/Ensamkommande/table/tableViewLayout1/.

Schramme, T. (2018). *Theories of Health Justice: Just Enough Health*. Rowman & Littlefield International.

SBU. (2018). *Stöd till ensamkommande barn och unga – effekter, erfarenheter och upplevelser.* Stockholm: Statens beredning för medicinsk och social utvärdering (SBU); SBU Bereder 294/2018: 2018. Retrieved 2020-12-22 from https://www.sbu.se/294

Socialstyrelsen. (2013). *Ensamkommande barns och ungas behov, En kartläggning.* Retrieved 2021-02-25 from https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2013-11-37.pdf.

Socialstyrelsen. (2016). *Hälso- och sjukvård och tandvård till asylsökande och nyanlända.* Retrieved 2021-02-11 from https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2016-10-13.pdf

Socialstyrelsen. (2017). *Analys av situationen i socialtjänsten våren 2017 Fokus på ensamkommande flickor, yngre barn, nätverksplaceringar samt suicidrisk – delrapport 3* Retrieved 2021-02-25 from https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2017-6-14.pdf

Starrs, A., Ezeh, A., Barker, G., Basu, A., Bertrand, J., Blum, R., . . . Ashford, L. (2018). *Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission*. The Lancet (British Edition), 391(10 140), 2642–2692.

Tikkanen, R., Abelsson, J., Forsberg, M., & Göteborgs universitet. Institutionen för socialt arbete. (2011). *UngKAB09: [kunskap, attityder och sexuella handlingar bland unga]* (Skriftserien / Göteborgs universitet, Institutionen för socialt arbete, 2011:1). Göteborg: Inst. för socialt arbete, Göteborgs universitet.

Tirado, Chu, Hanson, Ekström, & Kågesten. (2020). *Barriers and facilitators for the sexual and reproductive health and rights of young people in refugee contexts globally: A scoping review.* PLoS One, 15(7), E0236316.

United Nations General Assembly. (1966). *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, United Nations, Treaty Series, vol. 993, Retrieved 2021-03-18 from https://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=3ae6b36c0%20.

United Nations. (2015). *Transforming our World: The 2030 Agenda for Sustainable Development.* UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1. Retrieved 2021-03-05 from https://sdgs.un.org/2030agenda

United Nations Population Fund. (2014). *Sexual and Reproductive Health is a Fundamental Human Right.* Retrieved 2021-01-27 from https://www.unfpa.org/press/sexual-and-reproductive-health-fundamental-human-right-unfpa-executive-director-addresses

United Nations Population Fund. (2014). *ADDING IT UP*. Retrieved 2021-02-13 from https://www.unfpa.org/adding-it-up.

Unicef. (2020) *Barn på flykt i Sverige.* Retrieved 2020-12-22 from https://unicef.se/fakta/barn-pa-flykt-i-sverige.

World Health Organization. (2008). *Gender, equity and human rights, The right to health Factsheet 31,* Retrieved 2021-01-23 from https://www.who.int/gender-equity-rights/knowledge/right-to-health-factsheet/en/?

World Health Organization. (2016). *Action Plan for Sexual and Reproductive Health Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind.* Retrieved 2021-03-05 from https://www.euro.who.int/__data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf.

World Health Organization. (2017). *Human rights and health*. Retrieved 2021-01-02 from https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

Appendix 1

Search strategy for the systematic search

Cinahl search:

- Search terms: “sexual and reproductive health and rights) AND unaccompanied minors AND (girls or women or females or young woman or girl or female or young women), zero (0) articles where found, then a search with the terms (sexual and reproductive health and rights) AND unaccompanied minors was conducted and still no articles where found. Using only the term “sexual and reproductive health and rights” 207 articles where found.
- Limitations: Published Date (20110101-20211231); Source Types (Academic Journals); Language (English); Gender (female): 85 articles remained.
- Screening: abstract using following exclusion criteria’s: articles with a focus on STDs, sex work, gender-based violence, humanitarian crises, or very context specific research (such as research in countries very different from the Swedish setting unless it was targeting the group unaccompanied minor girls and SRHR in a different country), and two (2) articles remained.

PubMed search:

- Search terms: “sexual and reproductive rights and health”, and 1079 articles were found; advanced search using the terms “sexual and reproductive health rights and rights” AND (“young migrants” OR unaccompanied OR refugees)
- Limitations: years (2011-2021), test (full text), age (Child: 6-12 years, Adolescent: 13-18 years, Adult: 19+ years), sex (female), language (Swedish and English) this resulted in 45 articles.
- Screening: abstracts eliminating using following exclusion criteria’s: focus on STDs, sex work, gender-based violence, humanitarian crises, or very context specific research (such as research in countries very different from the Swedish setting unless it was targeting the group unaccompanied minor girls and SRHR in a different country), eight (8) articles remained.

Scopus search:

- Mesh terms and search words: TITLE-ABS-KEY ("sexual health" OR "reproductive health") AND TITLE-ABS-KEY (migrant* OR refugee*) AND TITLE-ABS-KEY (rights), this resulted in 230 documents.
- Limitations: years 2021-2011, resulted in 81 articles remaining, limiting to language made 76 articles remain.
- Screening: the abstracts using exclusion criteria’s: articles with a focus on STDs, sex work, gender-based violence, humanitarian crises, or very context specific research (such as research in countries very different from the Swedish setting unless it was targeting the group unaccompanied minor girls and SRHR in a different country, three (3) articles remained.

Appendix 2

Table 1: Publications included in the systematic review and in the manual search of grey literature.

	Author	Year	Title	Publisher	Datasource
1	Hallgarten, L. Starrs, A; Ezeh, AC; Barker, G; Basu, A; Bertrand, J T; Blum, R; Coll-Seck, A M; Grover, A; Laski, L; Roa, M; Sathar, ZA; Say, Lale; S, I; Singh, S; Stenberg, K; Temmerman, M; Biddlecom, A; Popinchalk,; Summers, C;	2018	Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission.	The Lancet (British Edition)	Cinahl
2	Braeken, D., & Rondinelli, I	2012	Sexual and reproductive health needs of young people: Matching needs with systems	International Journal of Gynecology & Obstetrics	Cinahl
3	Tirado, V., Chu, J., Hanson, C., Ekström, AM., Kågesten, A.	2020	Barriers and facilitators for the sexual and reproductive health and rights of young people in refugee contexts globally: A scoping review	Journal POne	PubMed
4	Endler M, Al Haidari T, Chowdhury S, Christilaw J, El Kak F, Galimberti D, Gutierrez M, Ramirez-Negrin A, Senanayake H, Sohail R, Temmerman M, Danielsson KG;	2020	Sexual and reproductive health and rights of refugee and migrant women: gynecologists' and obstetricians' responsibilities	International journal of gynecology and obstetrics	Pub Med
5	Botfield JR, Newman CE, Kang M, Zwi AB	2018	Talking to migrant and refugee young people about sexual health in general practice	Australian Journal of General Practice	Pub Med
6	Mason-Jones AJ, Nicholson P	2018	Structural violence and marginalisation. The sexual and reproductive health experiences of separated young people on the move. A rapid review with relevance to the	Public Health	Pub Med

			European humanitarian crisis		
7	Svensson P, Carlzén K, Agardh A.	2016	Exposure to culturally sensitive sexual health information and impact on health literacy: a qualitative study among newly arrived refugee women in Sweden	Culture, Health & Sexuality An International Journal for Research, Intervention and Care	Pub Med
8	Botfield JR, Newman CE, Zwi AB	2017	Drawing them in: professional perspectives on the complexities of engaging 'culturally diverse' young people with sexual and reproductive health promotion and care in Sydney, Australia	Culture, Health & Sexuality An International Journal for Research, Intervention and Care	Pub Med
9	Svanemyr J, Amin A, Robles OJ, Greene ME	2015	Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches	Journal of Adolescent Health	Pub Med
10	Byrskog U, Olsson P, Essén B, Allvin MK.	2014	Violence and reproductive health preceding flight from war: accounts from Somali born women in Sweden	BMC Public Health	Pub Med
11	Inci, M.G., Kutschke, N., Nasser, S., Kurmeyer, C., Sehouli, J.	2020	Unmet family planning needs among female refugees and asylum seekers in Germany - is free access to family planning services enough? Results of a cross-sectional study	Reproductive Health	Scopus
12	Cevirme, A., Hamlaci, Y., Ozdemir, K.	2015	Women on the other side of war and poverty: Its effect on the health of reproduction	International Journal of Women's Health and Reproduction Sciences	Scopus
13	Keygnaert, I., Guieu, A., Ooms, G., Vettenburg, N., Temmerman, M., Roelens, K.	2014	Sexual and reproductive health of migrants: Does the EU care?	Health Policy	Scopus

14	Abubakar I, Aldridge RW, Devakumar D, Orcutt M, Burns R, Barreto ML, et al	2018	The UCL–Lancet Commission on Migration and Health: the health of a world on the move.	The Lancet	
15	Ivarsson, C. Sexuell hälsa, Malmö Stad	2017	En kartläggning över ensamkommande unga och unga vuxna migranters kunskaper och utbildningsbehov gällande hiv/STI, SRHR, könsidentitet och könsuttryck.	Arbetsmarknads- och socialförvaltningen, Malmö stad	
16	Folkhälsomyndigheten	2019	Sexuell och reproduktiv hälsa och rättigheter i Sverige 2017 Resultat från befolkningsundersökningen SRHR2017	FHM	
17	Folkhälsomyndigheten	2020	Migration, sexuell hälsa och hiv- och STI-prevention En kartläggning av unga migranters sexuella och reproduktiva hälsa och rättigheter i Sverige	FHM	
18	Stadsrevisionen, Göteborgs Stad	2014	Göteborgs Stad, Stadsrevisionen (2014) Projektplan Göteborgs Stads mottagande av ensamkommande barn.	Göteborgs Stad	
19	Göteborgs Stad	2013	Ensamkommande barn och ungdomar i Göteborg, 25 frågor och svar.	Göteborgs Stad	
20	Närhälsan Kunskapscentrum för sexuell hälsa	2017	SRHR på HVB, Att arbeta med sexuell och reproduktiv hälsa och rättigheter på hem för vård och boende. Metodbok med utgångspunkt i projektet SRHR på HVB 2013 – 2016.	VGR	
21	Regeringskansliet	2006	Swedens international policy on sexual and reproductive rights and health	Regeringen	
22	SBU	2018	Stöd till ensamkommande barn och unga – effekter, erfarenheter och upplevelser.	SBU	
23	Socialstyrelsen	2013	Ensamkommande barns	Socialstyrel	

			och ungas behov, En kartläggning.	sen	
24	Socialstyrelsen	2016	Hälso- och sjukvård och tandvård till asylsökande och nyanlända.	Socialstyrelsen	
25	Socialstyrelsen	2017	Analys av situationen i socialtjänsten våren 2017 Fokus på ensamkommande flickor, yngre barn, nätverksplaceringar samt suicidrisk – delrapport 3	Socialstyrelsen	
26	Tikkanen, R., Abelsson, J., Forsberg, M., & Göteborgs universitet. Institutionen för socialt arbete.	2011	UngKAB09: [kunskap, attityder och sexuella handlingar bland unga]	Göteborgs Universitet	
27	VGR	2017	Asylsökandes vårdkonsumtion i Västra Götaland 2011–2016	VGR	
28	UNFPA, Guttmacher Institute	2014	Adding It Up 2014 The Costs and Benefits of Investing in Sexual and Reproductive Health	UNFPA	
29	Unicef	2020	Unicef, (2020) Barn på flykt i Sverige	Unicef	

PART B

Abstract

Sexual and reproductive health and rights (SRHR) are fundamental to both the individual's health as well as to public health. Despite that, SRHR are still only a desire and an ambition for millions of women and girls around the world, and the suffering due to SRHR related issues continues to be a large part of the global ill health. This study aims to examine what SRHR related needs, health care professionals perceive unaccompanied minor girls in Region Västra Götaland, Sweden, to have and, how existing health care services address these needs. Furthermore, the aim is to identify areas for improvement regarding the availability, accessibility, acceptability, and quality of these health services, in accordance with the AAAQ framework. The data for this study was collected through six semi-structured interviews with professionals working at SRHR related health care services and analysed in accordance with established standards for thematic analysis and the theoretical framework AAAQ. Through the process of analysing the data, twelve sub themes were identified as barriers and needs, to reach the enjoyment of the right to health. The findings of the study are in line with previous research which conclude that unaccompanied minor girls have different health needs than the general public and that their right to health and specifically their SRHR is not being fulfilled. The findings of this study do also reveal inadequacies and constraints in the provision of an accessible SRHR related care for these girls and provide directions for recommendations to address these inadequacies.

Keywords: *SRHR, unaccompanied minors, young migrants, AAAQ*

Introduction

SRHR and the right to health

Research from the last decades conclude that sexual and reproductive health and rights (SRHR) are fundamental to both the individual's health as well as to the public health. Investing in SRHR is, in addition to that, shown to be beneficial for both sustainable and economic development. Despite this, the progress of SRHR related work is insufficient due to inadequate resource allocation, lack of political will and a continuous discrimination against women and girls (Starrs, et. al, 2018).

The right to health has been a fundamental part of human rights since it was stated in the 1946 Constitution of the World Health Organization (WHO, 2017), and it is recognized in international human rights law. Several treaties recognize the right to health, some of them concerning unaccompanied minor girls are “The 1979 Convention on the Elimination of All Forms of Discrimination against Women” and “The 1989 Convention on the Rights of the Child”, which also have added annotations and recommendations on the right to health and health-related issues. However, certain countries have added restrictions to some of the articles in order to elude their responsibilities and obligations concerning SRHR and others lack a strong enough legal framework to keep up to standards (WHO, 2008). Considering health as a human right requires specific attention, and creates obligations of action for states, particularly to different individuals and groups of individuals in society, living in vulnerable situations, such as unaccompanied minor girls.

In 1994 during the ICPD (International Conference on Population and Development) in Cairo, sexual health was included within the definition of reproductive health, and this highlighted the sexual and reproductive right as a fundamental human right as well as emphasizing that the health of women and girls is a way to improve wellbeing for all. The conference played a major role in shifting the political focus from the rapid growth of the world’s population to the right and needs of the individual. It also became clear that there was not enough focus on sexual and reproductive medical and health care which hindered the development of societies, which made the conference to focus on the individual, in its action programme (Regeringskansliet, 2006).

1995 the Fourth UN World Conference on Women in Beijing, China, was held and the Beijing Declaration as well as the Beijing Platform for Action became important documents to strengthen the position of women at social, economic, and political levels. The Platform for

Action stated that SRHR, are essential for women's participation in all the different areas of society (Regeringskansliet, 2006).

In 2014 the UN General Assembly held a meeting on the follow-up of the Programme of Action of the International Conference on Population and Development (ICPD) Beyond 2014, which was the ICPD 20-year review following up and evaluating the interventions of the programme. The ICPD Global Review Report showed large improvements in many areas, but it also highlighted persistent inequalities and discrimination that undermined human rights. Women's health and status showed very little progress the last two decades, maternal mortality rates had not improved, and safe abortion and sexual orientation were issues that still were considered controversial. The report further emphasis that young people, particularly adolescent girls, are prevented from accessing SRH related health services due to discriminatory laws, practices and attitudes.

The findings of the report clarify the urge for states to enforce laws to eliminate inequalities and protect human rights and that non reliable accountability systems as well as limited access to them by the marginalized groups sustain this. SRHR are still only a desire and an ambition for millions of women and girls around the world (UNFPA, 2014).

As stated in part A, there are few studies on unaccompanied minor's health and none on unaccompanied minor girls and SRHR in Sweden. The report *Stöd till ensamkommande barn och unga – effekter, erfarenheter och upplevelser* [Support for unaccompanied children and young people - effects, experiences and experiences] (SBU, 2018), concludes that there is a knowledge gap regarding unaccompanied girls' special situation and need for support. The need for research is furthered as SRHR are fundamental to people's health and survival and these girls are particularly vulnerable being unaccompanied as well as minors. This places high demands on the regulation of their rights and the way that different authorities and institutions that they encounter act.

2030 Agenda

2030 Agenda for Sustainable Development is the UN´s action plan based on 17 Sustainable Development Goals and 169 targets, two of those concern SRHR and women's health. Sustainable development has three dimensions; economic, social, and environmental, and the action plan has a rights-based approach that depend on health policy and programs to focus on prioritizing those with the greatest need, to be able to reach equity. Ensure universal access to SRHR as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (UN, 2015).

Health care in Sweden

Sweden has a parliamentary system of government, and the government is divided into different ministries, whereas the ministry of social affairs, (Socialdepartementet), is responsible for issues concerning the welfare of the society, promoting public health as well as ensuring that the adequate care is given to the citizens (Regeringen,2020). The Swedish health care system is a version of the Beveridge model, i.e., the financing source is national, regional and municipal taxation (Tulchinsky, & Varavikova, 2015).

The overall goal of the Swedish public health policy is to create social conditions for good health on equal terms for the entire population. The work of SRHR aims to improve societal and social conditions for increased sexual and reproductive health and to strengthen the possibility for individuals to assimilate their rights. The starting point for this work is the equal value of all and the principle of non-discrimination in relation to sexual and reproductive health (FHM,2020).

In Sweden SRHR interventions must meet the general standard of public health and human rights, as well as following the AAAQ framework, and the Public Health Agency has the task of working for national coordination in this area. This is done, among other things, through

the Government Cooperation for SRHR and HIV / STI prevention, which includes twelve authorities with various assignments within the SRHR area (FHM, 2020).

The hospitals, the primary care, the maternity care, and the youth clinics are organised on a regional level, and the regions are responsible for the health care according to the Swedish health care act (" hälso- och sjukvårdslagen") as well as other laws such as the Communicable Diseases Act, the Discrimination Act and the Patient Safety Act. The responsibility includes ensuring equal access to health promotion, prevention and target specific efforts. According to the Swedish health care Act, the health care is obliged to extend the responsibility of care further than to diagnose and perform treatments, it also includes health prevention work. (SFS. 2017:30).

The municipalities have the ultimate responsibility for the individual to receive the support and help it may need, according to several different laws/ act such as the health care act mentioned above. The work of the social services should build on supportive and preventive actions to increase people's health and life quality, which means that the work of SRHR should be integrated in their work.

Theoretical background

The theoretical context for this study is the AAAQ framework that provides the framework to structure and analyse the results of this study. The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights, a committee of experts, responsible for overseeing adherence to the Covenant. The right includes the following core components availability, accessibility, acceptability and quality, also referred to as the AAAQ framework (UN, 2000). The framework recognizes these four interrelated and overlapping elements as necessary for implementation of the right to health.

According to the AAAQ framework access to health care is regarded from a human rights perspective, this framework provides a way to analyse how the concept of the right to health can be analysed.

The right to health is an inclusive right, that includes various factors that help humans to live a healthy life such as safe drinking water, sanitation, health-related education and information and gender equality. It includes freedom from certain aspects such as being free from non-consensual medical treatment and medical experiments, but it also includes entitlements like the right to a system of health protection, providing equality of opportunity for everyone to enjoy the highest attainable level of health, maternal, child and reproductive health and equal and timely access to basic health services (WHO, 2008). Another aspect of the right to health is non-discrimination, which is essential when aiming for the right to the highest attainable standard of health to all. Considering that, certain group requires special attention to increase their possibilities to exercise their right to health, examples of these groups are women and children, due to the discrimination that they face and the extra vulnerable situation these groups are in. Women are considered a vulnerable group due to their economic dependence, poverty, exposure to violence, and lack of power over their SRHR, and some women such as unaccompanied minor girls, face many different forms of discrimination and marginalization as well as being discriminated due to gender (ibid). Another vulnerable group are certain groups of children such as migrants and adolescent girls" …who might not access health care the way they need due to availability, norms, or other context specific matters" (WHO, 2008:14).

Aim

The aim of this study is to examine, what SRHR related needs, health care professionals perceive unaccompanied minor girls in Region Västra Götaland, Sweden, to have, as well as

how existing health care services address these needs. Further, the aim is to identify areas for improvement regarding the availability, accessibility, acceptability, and quality of above-mentioned health care services, in accordance with the AAAQ framework.

The research questions are:

1. How do health care professionals perceive the SRHR needs of unaccompanied minor girls and the capacity of existing SRHR related health care services, to address these needs?

2. What are the perceived challenges and opportunities for improving the availability, accessibility, acceptability, and quality of SRHR services relevant to unaccompanied minor girls in Region Västra Götaland?

Material and Methods

This study has a qualitative and explorative approach, where the experience of health care professionals is examined through interviews. A thematic analysis as well as the AAAQ framework are used to analyse and interpret the results.

Data collection method

The chosen data collection method of this study is semi-structured interviews, since the aim of the study is to understand what SRHR needs public health professionals perceive unaccompanied minor girls to have, and to identify ways to improve their accessibility, availability, acceptability, and quality of the services that deliver SRHR related health services.

Six interviews have been conducted, one of them was an informal interview with a key informant, and all of them identified through snowball sampling. Based on the informal interview with the key informant, ten different SRHR related health care services were

contacted regarding participation in the study. The email contained information about the aim of the study, how the research was to be carried out, as well as which questions were to be asked during the interviews. Five SRHR related health care services responded and agreed to participate in the study. The only inclusion criteria were that they worked at a SRHR related health services in VGR. The actual workplace of the respondents that participated in the study will not be disclosed due to anonymity and confidentiality, but their professions were midwife at a hospital, midwife at a youth clinic, social worker at a youth housing for girls, psychologist and public health worker at an NGO.

The interviews were conducted over ZOOM due to the pandemic, during March 2021, in Swedish, recorded through an iPhone and lasted between 35 min to 55 min. An informed letter of consent was obtained from all participants (see *Appendix 1,* for the letter of consent). The letter of informed consent was email to the respondents, which was printed out by them, signed, scanned, and then emailed back.

A semi- structured interview is organised around different relevant themes, and an interview guide is used as a point of departure, this interview guide was developed by the author specifically for this purpose, with the aim and research questions of the study in mind (see *Appendix 2*, for the interview guide). The interview guide was based on structured, but open questions and did include a question regarding the theoretical framework (see *Appendix 1,* for the interview guide).

The aim of the semi- structured interview is to capture the respondents' own understandings and experiences with a possibility for spontaneous thoughts and ideas to rise. The semi-structured interview gives the respondents the possibility to describe the topic from their perspective, in their own personal way. As a researcher and a practitioner in the field of health care, there might be certain ideas concerning health that are obvious, taken for granted and/ or preconceived, while other things might go unseen if not explicitly communicated (Mason,

2004). Reflexivity: the idea of recognizing one's understanding is always very important when conducting research and perhaps especially important in qualitative research when interpreting qualitative data. Our perceptions, preconceptions and understandings of the world we live in affects both our choice of area to research, or methods and our analysis. My own background in health promotion and SRHR related education with minors in Gothenburg, have made me interested in the field of SRHR and the positive health effects that knowledge and empowering interventions can give, especially to vulnerable groups in society, such as unaccompanied minor girls. Through the description of my background and my preconceptions as well as continuously reflecting on how that would influence my research, I will try to deal with the requirements of neutrality and objectivity in the best possible way. This is further discussed under the heading Methodological considerations.

Reflexivity when using the method of interviewing, is important to consider since the situation imposes a power asymmetry. The semi-structured interview is similar to a conversation, but between a professional researcher and a respondent. In this case though, since the respondent is interviewed in his/her profession it might not affect the power structure, but if the respondents would have been unaccompanied minor girls it probably would have. This is still important to bear in mind, when conducting interviews, since it could have an effect on the result (Kvale, 2007).

Data analysis

The conducted interviews were transcribed verbatim and analysed through a thematic analysis, a method that analyses and identifies themes in qualitative data. The quotations in the result section were translated by the author.

Both an inductive as well as a deductive approach were used. For this process, the model of "Steps in thematic analysis" by Braun and Clarke (2006) was used. As pointed out by Braun and Clarke (2006:5): "Through its theoretical freedom, thematic analysis provides a flexible

and useful research tool, which can potentially provide a rich and detailed, yet complex account of data". The first step of the analysis was done inductively, reading through the transcribed interview several times before identifying relevant meaning units. This was done manually using an Excel document for organizing the meaning units, the condensed meaning units, the descriptive codes, the interpretive subthemes, and the interpretive themes.

Figure 1 *Extract from the analysis document*

Source	Authentic meaning unit	Condensed meaning unit	Descriptive code	Interpretive subtheme	Interpretive theme
Interview nr 1	Yes, the cultural difference and the knowledge. But also all the trauma they have been through during their trip to Sweden. They do not trust adults so much, their own parents have let them down by sending them away, at such an early age. That you then should trust an adult if you have a problem with an area on your body that is absolutely forbidden to talk about in your own culture…	The cultural difference, being sent away at an early age and all the trauma that occurred during the trip to Sweden means that they do not trust adults so much. It is difficult to trust adults when it comes to parts of the body that have been forbidden to talk about.	Lack of trust in adults after being sent away from their home country and experiencing trauma during migration.	Lack of trust as a barrier for accessing Health Care.	Accessibility

Seventy-four meaning units were identified as relevant in relation to the aim of the study to examine what SRHR related needs health care professionals perceive unaccompanied minor girls to have. Furthermore, how existing health care services address these needs, and to identify areas of improvement regarding the availability, accessibility, acceptability, and quality of above-mentioned health care services, in accordance with AAAQ framework. The meaning units were identified through reading the transcribed data repeatedly, which also

highlighted repetitions and similarities between the interviews that later formed the subthemes. These meaning units were descriptively condensed and then descriptively coded.

This part of the analysis was inductive since the process of coding was data driven, without having the theoretical framework in mind, and focusing on what the respondents wanted to highlight and what they thought were important regarding the topic. The analysis was conducted on a semantic level, emphasizing on what had been explicitly stated during the interviews, and searching for semantic patterns to later organize and summarize the data based on that.

During the second phase of the data analysis the results from the first phase were interpreted in relation to the AAAQ framework. This phase of the analysis was deductive, driven by the theoretical framework, when developing descriptive subthemes as a bridge between the data and the theoretical framework. The four themes are the four concepts of the AAAQ framework, and twelve sub themes were identified through the analysis process.

The AAAQ framework is a tool for analysing how the right to health is fulfilled and therefore suitable when examining how right to SRHR of the target group is met.

Results

Through the process of analysing the data, seventy-four (74) meaning units, twelve (12) sub themes and fifty-six (56) codes were identified. These are listed in the table below, the table below shows the different themes, subthemes and the number of codes related to each subtheme.

Table 1. *Results of identifies themes, sub themes and numbers of codes.*

Theme	**Subtheme**	Nr of codes
Availability	A need of specialized HC	3
	A need of a more mobile HC	4
Accessibility	Economic hardship	1
	Lack of trust as a barrier for seeking HC	3
	A need for information regarding SRHR	4
	A need for knowledge regarding the Swedish HC system	5
	Cultural shame and guilt regarding SRHR	5
	Barriers for accessing SRHR education in school	6
	Norms regarding gender or culture as barriers for seeking HC	8
	A need for basic knowledge regarding SRHR	13
Acceptability	A need of culturally adapted care (female staff, interpreters, separate waiting rooms etc.)	4
	A need of cultural competence within the HC personnel	9
Quality	Specialized needs that are difficult to meet within the current HC system	9

Availability

The theme availability has two sub themes and a total of seven codes. To assess the availability of the health care provided, the quantity of facilities and services should be examined. During the interviews all of the respondents estimated the availability as good in regard to the quantity of services, but they expressed the lack of a special unit for this target group and a need for a mobile unit.

Subtheme: A need for specialized HC

The need for a specialized unit or health care centre, focusing mainly on the target group and gathering different professions such as counsellors, gynaecologists and physicians, all trained specifically to meet this group.

"So, we need a specific unit that you apply to or sign up for if you want to work there and get the knowledge and education needed. If you want to help build and secure these young people" (Interview 1)

One of the respondents stated the need for professionals with a keen interest in the target group, to work in a specific unit, aiming at gathering competence and knowledge to meet the specific needs of the target group.

"There are definitely initiatives and projects linked to it (SRHR) from both the municipalities and idea-driven sectors. But what we discovered was that it is quite clear that these efforts that are made in this area, mainly focus on produce material, for example to produce knowledge-based information, that may be used to train staff and so on, but it is very, very few, if even any interventions that I know of, that are directly aimed at newly arrived young girls." (Interview 3)

Most of the work within this field has focused on developing material for education and similar, and very few interventions specifically focus directly on these girls, according to one of the respondents.

<u>Sub theme: A need of a more mobile HC</u>

The other subtheme highlighted the need of a more mobile health care, that there might be enough services, but they need to be more available in the sense of meeting the target group where they are, having facilities in the areas where they live and go to school.

"I can think that here at the youth clinic we reach out very badly to those who need us. We have been a few, who have fought for that we should be in young people's arenas, that they should find us easily and that we cannot just work at youth clinique in the city, it is difficult to get access to care if you do not know that it exists. I think that is our biggest problem, at least

we are pretty bad at reaching out with information about that we exist to newly arrived youths and migrants." (Interview 5)

The importance of having youth friendly SRHR related health care services in the suburbs and need for letting these girls know about what types of services are available was expressed by one of the respondents, and a mobile unit could facilitate this.

"On paper, it looks good, and it is also available, but I still think that the problem is that we do not work on reaching out enough. We are ready to receive them, but on the other hand, we are not really that, we have to work harder to actively reach out with our services and what is available. Thinking on how to get closer to them, instead of expecting them to come to us." (Interview 3)

To reach out and to be mobile was something that several respondents expressed as important, the health care services are not used effectively enough, and a mobile unit could be a solution to that.

Accessibility

The theme with the greatest number of codes related to it, was "Accessibility", with eight themes, and forty-five codes. Accessibility is used as a measure of how physically accessible the health care services are for everyone, but it also implies "…. the right to seek, receive and impart health related information in an accessible format…" (WHO, 2008:8), this was mentioned by all the respondents as an area of great possibilities for improvement.

Sub theme: Economic hardship

"Contraceptives cost money so…, then it can be very frustrating, many take for granted that anyone can buy a treatment for something but there are many who cannot afford it." (Interview 5)

One respondent highlighted the fact that many of the girls she met did not afford contraceptives, which affects the economical accessibility even if the health care services are free of costs.

Sub theme: Lack of trust as a barrier for seeking HC

Due to the trauma of being sent away from home at an early age in seek of a better future or having to escape war, gender violence or poverty, a lack of trust on adults was usual according to the respondents. This was often seen as a barrier for seeking care or for trusting the health care personnel.

"But also, all the trauma they have been through during their trip to Sweden. They do not trust adults so much; their own parents have let them down by sending them away, at such an early age to another country. Because we are talking about very young girls who have migrated.... That you should then trust an adult if you have problems with an area on your body that is absolutely forbidden to talk about in your own culture… So, it is definitely a target group that is being exploited and is not getting the care they need." (Interview 1)

The difficulties to trust health care professional with issues concerning sexual or reproductive health was seen as a barrier to seek adequate care according to one respondent, specially for the youngest girls.

"You have to be careful and take time, it is important to build a relationship before you just start asking questions, they try to encourage us that the first time you meet someone you should dare to ask about their sexual health, but I think with this group you should be a little careful. Build a relationship and offer several meetings before you start poking at specific stuff. Because they are very…they have so much trauma that they have no confidence. And I think that once you have built a professional relationship with them, you can give them so much that will help them for so long." (Interview 1)

To take time to develop a relation was highlighted during several interviews as important in regard to building trust, and to be able to book several appointments with the same care provider seemed important when aiming at building trust.

Sub theme: A need for information regarding SRHR

Closely related to the sub theme of a need for knowledge regarding SRHR, there is a need for information regarding SRHR, which this sub theme captures. These girls lack information regarding their rights and possibilities within the health care system.

"It was actually very clear that it was unaccompanied girls who lacked this information about SRHR, and that it was they who least could absorb this information. When we started digging into that, and saw what it looked like in this group, then we clearly understood that there was a great need for information. (Interview 5)"

One respondent referred to how an organisation had examined what information regarding SRHR different groups of youths had, and how it was clear that unaccompanied minor girls where those who had least access to information, and how had the most difficulties embracing the information.

... it is important that the information has been provided and received, that they know that it is possible to have an abortion, that no one will be shamed about their choice… (Interview 4)

One midwife mentioned the importance of informing on the choices in regard to pregnancy, such as the possibility of abortion or the use of contraceptives.

Sub theme: A need for knowledge regarding the Swedish HC system

Not knowing which health care service that are available or not knowing how to book an appointment was mentioned as factors for not accessing the health care needed. According to

one of the respondents, the patients she met did not know about the clinic for female mutilation which in many cases would be relevant, due to their own experiences of that.

"The Vulva center does a great job, but when I meet young asylum-seeking girls then they have no idea that they exist." (Interview 3)

The lack of knowledge regarding the Swedish health care system seems to create barriers to seek care due to the fear of consequences or interventions that it might imply.

".. she was abused and a victim of sexualized violence by her husband and this was incredibly heavy for her, it took time for her to ask for help. It's not always about culture, sometimes it's about fear, about what we should do, will the social services intervene? Yes, there is a lot of knowledge gap about our system, if you let someone in, what does that mean? "(Interview 2)

Not having enough information about the Swedish health care system, such as duty of confidentiality, could hinder women and girls to seek care, in fear of the authorities to interact according to one of the respondents.

<u>Sub theme: Cultural shame and guilt regarding SRHR</u>

Shame and guilt regarding their own feelings, their sexuality and their bodies was mentioned by all respondents as a barrier for seeking and receiving care as well as information and knowledge regarding SRHR.

"When it comes to sexual relationships, there is an incredible cultural clash. They come from cultures, where it is shameful and very related to guilt. They are in very anxious circumstances when they come to Sweden and become very anxious about their bodies. Very…But they do not know where to go for help. They have a very hard time opening up to talk about it. "(Interview 1)

According to one respondent these girls often have a background in cultures where sexuality and sexual and reproductive health is associated with guilt and shame, and they are not accustomed to seeking care regarding those issues or even talk about it.

"But the ones I met in general, were poor people from a very patriarchal structure, Afghans, Somalis, Arabs from Syria where they are not allowed to explore their sexuality at all or get a picture of their own… yes well I still think when it comes to people who are very religious regardless of religion, there was a lot of shame and guilt about one's own body, and very little knowledge about the body and so ..." (Interview 2)

Religion was also found by the respondents to inhibit the possibilities to explore and express sexuality.

Sub theme: Barriers for accessing SRHR education in school

In Sweden the sexual education in school is statutory and mandatory, but the context of the education might not be appropriate for the target group due to lack of knowledge in the field of SRHR, the fact that boys and girls are thought together, or the contrast of cultural norms regarding SRHR.

"It is way too..hm … I can experience that it is… well, I would think it will be a shock. It is way too Swedish culturally oriented, for many of these girls it is "haram" to talk about it, as it is done in a Swedish school." (Interview 1)

One respondent perceives the Swedish education regarding SRH to be "chocking" for these girls, far too adapted to the Swedish culture.

"Maybe one should just start with the fact that you can seek help for certain things, that you can start carefully, around rights and so on. If we are to reach them, we should try to avoid a frontal collision! "(Interview 2)

The need for education that starts off emphasizing the rights related to SRHR and information on what one may seek help for, as well as a slower pace; taking it step by step to not scare the girls of, was articulated by one of the respondents.

Sub theme: Norms regarding gender or culture as barriers for seeking health care

The accessibility seemed to be restricted due to norms regarding SRHR. The principle of non-discrimination and equality implies that each country should provide for the differences and specific needs that certain groups such as women, or children, might have due to being marginalized and suffering from structural inequalities in health.

"But accessibility can also be about daring to go to a youth clinic, and that is probably where the problem is." (Interview 4)

Norms and restrictions regarding sexual habits and the use of contraceptives appear to limit the target group to access health care. One of the respondents described the restrictions that her patients had regarding sexual habits as very strong and limiting the possibilities to sexual pleasure. The fact that the problem of not seeking care sometimes was related to not daring to, was also mentioned.

"There are many restrictions regarding girls, they are not allowed to decide for themselves. Who do they want to meet, how they should dress, or if you are going to have sex before marriage. There are very clear ideas about how girls should be, so from an SRHR perspective it is very clear that there are norms about girls' bodies and how girls are supposed to behave, that they are expected to form a family. And that there is very little focus on sexual pleasure and personal desire. It has of course affected them in many different ways. We see it, for example, in genital mutilation, when it comes to bans on abortion in several countries or bans on contraceptives, and these are things that affect girls to a very high degree". (Interview 3)

According to one respondent, norms seem to discriminate these girls from accessing the health care they might need, and work towards making these norms visible and informing regarding the right to bodily autonomy, appears to be needed.

Subtheme: A need for basic knowledge regarding SRHR

The subtheme "A need for basic knowledge regarding SRHR" focuses particularly on the lack of basic knowledge as a barrier for accessible SRHR related care. This was frequently highlighted as an area of relevance during the interviews, all the respondents mentioned the lack of basic knowledge regarding SRHR within the target group. This was mentioned as a barrier to seek health care, due to not knowing what symptoms that are normal or what symptoms that might need health care, but also the issue of not knowing one's own right to health and sexuality.

"They have almost no education from primary school about this, they… in their home country they have not received that kind of information. They know almost nothing about their bodies, about their genitals and sexual health. They do not know how it should work, what is normal, what is not normal. How to handle a menstrual period or how to handle the emotions. "(Interview 1)

One respondent shared her experiences of meeting girls with almost no education regarding SRHR, and with very little knowledge regarding their own bodies and how to take care of basic issues such as menstruation.

"I think that if you have a low education, you know very little about sexual rights and you may not know what contraceptives are, you may be unsure of how to get pregnant, or how to take care of your own sexual health…. I have experienced that many girls do not do it, the body is… not always even their own and that is very difficult". (Interview 4)

Another respondent mentioned that some girls did not take care of their sexual health due to that fact of not relating to their own body, that they perceived their body to belong to someone else.

Acceptability

The theme acceptability has two subthemes and thirteen codes related to it. To be acceptable the health care provided should not only respect medical ethics, but also be gender-sensitive and culturally appropriate.

Sub theme: A need of culturally adapted care

The lack culturally adapted care in the meaning of having female staff available or having the possibility to wait for help in witing rooms only for women/girls was expressed throughout the interview as important.

"You are ethical but then, culturally adapted isn't the health care really, and that's it. You must be… or be lucky enough to see a doctor or nurse who has the right background. If you come to a health center and meet a doctor from your own home country, it can go very wrong. Or an interpreter, a male interpreter from your home country, that is not quite ok. I do not think many people think of that in Sweden, because we do not understand what they say in their own language, we do not know what their prejudices are, how they will interpret back, I think it is under all criticism. "(Interview 1)

According to one of the respondents it is by chance that the patients meet health care professionals with the right cultural competence. Sometimes a doctor, a nurse or an interpreter from the same country as the patient can be devastating due to prejudices they might have.

"And to have female staff, many do not want to meet men in healthcare, and I absolutely do not think they would like to meet a Swedish male gynaecologist. So, there are little things that could have been done to make it easier." (Interview 2)

Being able to choose a female gynaecologist or doctor are things that could facilitate the health care encounter according to one respondent.

Sub theme: A need of cultural competence within the HC personnel

The interviews highlight the lack of health care personnel with cultural competence, that have knowledge about cultural differences, that can be sensitive and understanding regarding different perspectives and ideas regarding health care.

"It is probably a bit arbitrary who gets involved and who does not, so it depends on who you meet within the health care. I think that the employer is pretty bad at demanding that you should have a certain cultural knowledge or be well-read on certain things, but it probably looks very different in different workplaces I think" (Interview 5)

According to one respondent the employer doesn't require cultural competence even if the personnel experience the need for it.

"Sometimes I actually think that it exists racism with in the health care services, especially the genitally mutilated girls and women can sometimes be afraid to do a gyn examination because they do not know what kind of reactions that can occur." (Interview 4)

One respondent says that she believes there exist racism within some of the SRHR related healthcare services. The fear of being exposed to racism, might hinder girls that have suffered from female genital mutilation to do a gynaecological examination according to her.

"... there are certain notions in healthcare about how people with a foreign background express their pain. That you should ignore people who scream very loudly, and that you miss something because you have ideas about how some people express their pain very dramatically and it is not taken seriously." (Interview 3)

It was put forward by one respondent, that health care professionals not knowing about differences in how pain and sorrow are articulated can lead to patients not receiving the care they might need.

Quality

The theme quality has one sub theme and nine codes identified. To achieve quality there is a need of both medical equipment of good quality, as well as trained health care personnel, this has been pointed out as difficult to achieve due to the special needs that the target group might have. Their needs related to SRHR are often complex and many of the barriers mentioned above, such as a lack of trust, shame and different norms complicates the situation and it is highlighted that they often need more time than what is available, both mental support as well as medical care and the possibility to come several times to meet with the same person. In the Swedish health care system this is difficult to achieve and might result in lower quality of care.

Sub theme: Specialized needs that are difficult to meet within the current HC system

"I get the feeling that the sexually mutilated young people need quite a lot of support in how sex should be for it to be good, that sex is something you choose yourself, it should feel nice, not hurt. We have those who come to us who have sex, even though they are sewn together, and it is very painful for them, and not always do we manage to persuade them that an opening operation is better for them than continuing the way they do." (Interview 4)

One respondent put forward that, girls who suffer from female genital mutilation do need a lot of support to achieve a healthy sexuality, they might need a combination of counselling and meeting a midwife several times before deciding for an opening surgery. Some girls still have penetrating sex even though they are sewn together, which is very painful and cause a lot of harm on several levels.

"The problem with female genital mutilation is very big also for many girls, it is an incredibly big problem that spills over into a lot of other things such as physical health, as well as mental health. The risk of HIV is much greater for these women and also other sexually transmitted infections, but also the physical and mental part can be very stressful" (Interview 3)

According to one respondent the risk for STDs, mental ill-health as well as problems related to female genital mutilation are special needs that need to be addressed together, and this can be difficult to meet due to time constrain and the lack of a specialized unit.

Ethical reflections on the study

Regarding the ethical reflections of this study, the criteria of "Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning" from The Swedish Research Council (Vetenskapsrådet ,1990) were used as a reference. Their perspective is that the purpose of research ethical principles is to protect the individual by preventing conflicts between participants and researcher. This is done by following the four ethical requirements which are the information requirement, the consent requirement, the confidentiality requirement and the utilization requirement. In this particular study the data collection method are interviews, hence the importance of an informed consent from the respondents, to ensure them confidentiality as well as participating voluntarily. The informed consent does also make sure that the respondents are well informed of the purpose of the study and their possibility to withdraw their participation at any time. The participants might find the interviews burdensome in regard to time spent, however, the expected benefits that might shed light on this topic through their help is considered to outweigh the potential burden. If this study was to examine the personal experiences and perceptions of unaccompanied minor girls, it would

probably impose further aspects to consider regarding the ethical aspects, due to their age and their vulnerable situation.

Discussion

The findings of this study suggest that unaccompanied minor girls might not get their right to health fulfilled according to the AAAQ framework. It is however the results of the chosen data and method, and the findings might have been different if the target group themselves had been interviewed or another method would have been applied. Due to ethical considerations, it is reasonable to believe that it would have been difficult to interview unaccompanied minor girls within the scope of this study. There is a lack of informants within this area, and it is not entirely easy to find the ways to them, to build the trust and confidence needed for them to take part in this study during this short time, thus the professionals within the different SRHR related health care services seemed to be a better choice. The consensus of the obtained data indicates that even if only six interviews were conducted, a certain saturation in the results is achieved.

According to the Swedish Public health authority the work of SRHR in Sweden aims to improve societal and social conditions for an increased sexual and reproductive health as well as to strengthen the possibility for individuals to assimilate their rights (FHM, 2020). The findings of this study might be able to contribute with suggestions on how that work can be performed, regarding this specific target group.

In relation to the study's aim to examine what SRHR related needs, health care professionals perceive unaccompanied minor girls to have, the findings of the study highlight the need of specialized care due to complex traumas such as sexual violence or female genital mutilation, and the need for time to build trust before seeking and receiving care.

The aspect of accessibility appears to be the most difficult to meet. Within the scope of accessibility several areas were emphasized as relevant such as a need for basic knowledge regarding SRHR and a need for a more culturally adapted care, in order to be able to meet the specific needs and create the prerequisites that this target group might require. This need could be met through competence-enhancing initiatives for health care professionals and greater flexibility within the Swedish health care system. The need for interventions aiming at strengthening the knowledge regarding SRHR within the target group was frequently mentioned by the respondents. The girls seem to lack fundamental education regarding their own bodies, their right to sexuality and to take decisions regarding their reproductive health. According to WHO (2008:15) "…adolescent girls are likely to experience early and/or unwanted pregnancies and their right to health is therefore dependent on health care that respects confidentiality and privacy and includes appropriate mental, sexual and reproductive health services and information."

All of the respondents put forward that the education in the Swedish school regarding SRHR, is not adapted to meet the needs of the girls due to the different norms and cultural backgrounds regarding SRHR. This education would better meet their needs if the girls and boys were thought separately, and if it were adapted to their previous knowledge. Health being a human right, means that states should enable women and girls to, not only have control over their SRH, but also to be able to make responsible choices and decisions concerning their sexuality and their reproductive health and to do that, they need to have appropriate knowledge and information (WHO, 2008). To make responsible choices and to be able to make informed decisions regarding one's own health, one need to have knowledge and information regarding the subject, therefore an adapted education regarding SRHR seem like an important intervention.

Economic hardship is a sub theme with only one code, within the dataset, but is still considered as important due to the socioeconomic situation these girls often are in, and thus included in the analysis. Braun& Clarke (2006), describes how importance is more relevant than frequency in thematic analysis, as "…the 'keyness' of a theme is not necessarily dependent on quantifiable measures but rather on whether it captures something important in relation to the overall research question." (Braun& Clarke, 2006:82).

The AAAQ framework has been a useful framework to analyse how the right to health is fulfilled, since it has shed light on areas and perspectives that might not have been made visible without it. It is however important to mention that the four concepts of the framework are overlapping and intertwined, which could have affected the results. Some of the subthemes could have been placed under more than one theme and could often be a combination of these themes.

To summarize the results and the discussion, the findings of this study are in line with previous findings such as the results of Keygnaert et.al. (2014), which conclude that migrants right to health and, particularly their SRHR is currently not ensured throughout the EU. They also conclude that the health needs of EU-migrants from a third country differ from the general European population, and particularly so, their SRH needs.

Methodological considerations

There are certain limitations regarding the use of the chosen method, thematic analysis, as a method of analysis. It is sometimes referred to as a method that has not been clearly defined and demarcated, and that its flexibility might affect the quality of the analysis. This can be met by following the structured guidelines of Braun& Clarke (2006) and by explicitly account for how the analysis is done and that the theoretical framework and methods match what the

researcher wants to know, and that they acknowledge these decisions, and recognize them as decisions" (Braun &Clarke, 2006 :80).

Advantages of the method are the possibility to highlight similarities and differences across the data set, generate unanticipated insights, be useful for producing qualitative analyses suited to informing policy development (Braun & Clarke, 2006).

For this study to reach trustworthiness, the criteria of Lincoln and Guba is used. The criteria emphasis on credibility; the truth value, transferability; how the findings of this study relate to a broader context, dependability; the logic and structure of the study and confirmability; reflexivity or the ability of disclosure of bias (Lincoln, 2004). Credibility: referring to the question if the findings of the study are believable, the description of method will strive to be as transparent and accurate as possible. The interviews have been audio recorded and transcribed verbatim, and the interview guide is included as an appendix. The range of variety between the respondents that might occur due to data sampling being done with only one criterion, increase the possibility of finding different perspectives that answers the research question, which could strengthen the credibility of the study and its findings. Transferability: the possibility of the findings in this study being transferable to other context or settings is, as mentioned by Lincoln (2004) up to the "receiving context". Referring to if people are interested in applying the findings in their own context. Due to the rather broad (even though it is small) data sampling, with the only criteria of the respondents working at SRHR related health services in VGR, the findings might be relevant in many different situations concerning migrants and SRHR.

To achieve transferability, the context of the study, the collection of data as well as the analysis is presented thoroughly and with suitable quotations. Dependability: the criteria of dependability will be achieved by a clear description of the methods applied and by being stringent and transparent in the data analysis. Confirmability: to achieve confirmability

reflexivity is discussed (as done above) and the data should be easy to follow and track. The only data in this study are the interviews which facilitates the possibility to achieve confirmability.

It might have facilitated the interview if some of the concepts and ideas around health would have been discussed and explained before, but that could also have steered the interview to a certain direction and not captured the essences of the respondents' own experiences.

Conclusions and Implications

Previous studies as well as this one, conclude that unaccompanied minor girls and young migrants have different health needs than the general public and that their right to health and specifically their SRH are not being fulfilled. Findings from other studies also highlight the fact that they are extra vulnerable due to their complex situation of being minors, migrants and girls, with experiences of trauma and unmet needs. Despite these complex needs the findings indicate that this groups do not access the SRHR related health care services in accordance with their needs. These needs should be addressed effectively to increase their possibilities to resettle and to increase their possibilities to a healthy life.

This qualitative exploratory study examined the perceptions of health care professionals through interviews, and identified challenges and opportunities for improving the availability, accessibility, acceptability, and quality to meet the SRHR needs of unaccompanied minor girls in Region Västra Götaland. The results of this study can provide a point of departure for future guidelines or policies in order to address these inadequacies, when planning interventions aiming at increasing SRHR or in strategic public health work in the region.

There is a knowledge gap regarding unaccompanied minor girls in Sweden, and this study can point out specific areas for further research aiming at securing the right to health for this group. Interventions aiming at enhancing the cultural competence of health care professionals, increasing the knowledge and information regarding SRHR within the target group and creating flexibility within the healthcare system to better meet the specific needs would improve the availability, accessibility, acceptability and quality of the SRHR related health care for this group.

References

Braun, V. and Clarke, V. (2006). *Using thematic analysis in psychology*. Qualitative Research in Psychology 3 (2). pp. 77-101

Folkhälsomyndigheten. (2020). *Sexuell och reproduktiv hälsa och rättigheter (SRHR).* Retrieved 2021-03-25 from https://www.folkhalsomyndigheten.se/livsvillkor-levnadsvanor/sexuell-halsa-hivprevention/srhr/

Keygnaert, I., Guieu, A., Ooms, G., Vettenburg, N., Temmerman, M., & Roelens, K. (2014). *Sexual and reproductive health of migrants: does the EU care*? Health policy (Amsterdam, Netherlands), 114(2-3), 215–225. https://doi.org/10.1016/j.healthpol.2013.10.007

Kvale, S. (2007). *Doing Interview (Qualitative Research Kit).* London: SAGE Publications

Mason, J. (2004). *Semi-structured Interviews* in Lewis- Beck, M. S, Bryman, A., & Futing Liao, T. The SAGE Encyclopedia of Social Science Research Method. Thousand Oaks: SAGE Publications.

Lincoln, Y. S., (2004), *Trustworthiness Criteria*, in Lewis-Beck M.S, Bryman, A & Futing Liao, T (2004). The SAGE Encyclopedia of Social Science Research Methods. Thousand Oaks: SAGE Publications.

Regeringen. (2020). *Socialdepartementet, Folkhälsa och Sjukvård.* Retrieved 2021-02-25 from https://www.regeringen.se/regeringens-politik/folkhalsa-och-sjukvard/

Regeringskansliet. (2006). *Sweden's international policy on sexual and reproductive rights and health.* Retrieved 2021-02-25 from https://www.government.se/49b74f/contentassets/184b53554f8448a3a8ebde6fe41f3da1/swedens-international-policy-on-sexual-and-reproductive-health-and-rights.

SFS 2017:30. *Hälso- och sjukvårdslag*. Stockholm: Socialdepartementet

Starrs, A., Ezeh, A., Barker, G., Basu, A., Bertrand, J., Blum, R., . . . Ashford, L. (2018). *Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission*. The Lancet (British Edition), 391(10 140), 2642–2692.

Tulchinsky, T H. & Varavikova, EA (2014). *The new public health*. Third Edition. Elsevier, Academic Press, San Diego

United Nations. (2015). *Transforming our World: The 2030 Agenda for Sustainable Development.* UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1. Retrieved 2021-03-05 from https://sdgs.un.org/2030agenda

United Nations, Committee on Economic, Social and Cultural Rights (CESCR). (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4. Retrieved 20121-01-01 from https://www.refworld.org/docid/4538838d0.html.

United Nations Population Fund. (2014). *Sexual and Reproductive Health is a Fundamental Human Right.* Retrieved 2021-01-27 from https://www.unfpa.org/press/sexual-and-reproductive-health-fundamental-human-right-unfpa-executive-director-addresses

Vetenskapsrådet. (1990*). Forskningsetiska principer inom humanistisk-samhällssvetenskaplig forskning*. Vetenskapsrådet.

World Health Organization. (2008). *Gender, equity and human rights, the right to health Factsheet 31*, Retrieved 2021-01-23 from https://www.who.int/gender-equity-rights/knowledge/right-to-health-factsheet/en/?

World Health Organization. (2016). *Action Plan for Sexual and Reproductive Health Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind.* Retrieved 2021-03-05 from

https://www.euro.who.int/__data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf.

Appendix 1 – Letter of informed consent

Samtyckte till deltagande i studie

- Jag, ……samtycker till att frivilligt delta i denna studie, som är del av en masteruppsats med fokus på ensamkommande flickor och SRHR i VGR.

- Jag förstår att även om jag samtycker till att delta nu, kan jag när som helst dra mig tillbaka eller vägra att svara på några frågor utan några konsekvenser av något slag.

- Jag har fått syftet med av studien förklarat för mig och jag har haft möjlighet att ställa frågor om studien.

- Jag accepterar att min intervju är ljudinspelad.

- Jag förstår att all information som jag tillhandahåller för denna studie kommer att behandlas konfidentiellt.

- Jag förstår att jag är fri att kontakta Carolina Lodeiro, för att söka ytterligare förtydligande och information.

.

……

Namnteckning, respondent Namnteckning, intervjuare

Göteborg 2021-04-01

Appendix 2 – Interview guide

1. What is your profession? Where do you work? What is your mission?

2. Do you meet migrants, unaccompanied minors/unaccompanied minor girls within your work?

3. What is your experience of the SRHR needs that unaccompanied minor girl´s might have?

4. Do you think these needs differ from other girls in Sweden? If so why and how?

5. Do you know of any special policies and programs that address these SRH needs, that exist in the Västra Götalands Region?

6. With your experience, what is your opinion about unaccompanied minor girls needs for SRHR related services?

7. In Sweden, we have a statutory SRH education in school, what do you think about that education in relation to unaccompanied minor girls' needs?

8. AAAQ is a framework with four key concepts used to assess whether the right to health is met. The AAAQ stands for Availability, Accessibility, Acceptability and Quality. This could be defined as:

Availability, of services requires that public health and healthcare facilities are available in sufficient quantity, taking into account a country's developmental and economic condition.

The health system has to be accessible to all. Accessibility has four overlapping dimensions:

-Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable.

-Physical accessibility: health facilities, goods and services must be within safe physical reach of all parts of the population.

-Economic accessibility (affordability): health services must be affordable for all.

-Information accessibility: accessibility includes the right to seek, receive, and impart information concerning health issues. For example, governments must ensure that young people have access to sexual and reproductive health education and information presented in an unbiased manner.

Acceptability requires that health services are ethically and culturally appropriate, i.e. respectful of individuals, minorities, peoples, and communities, and sensitive to gender and life-cycle requirements.

Quality requires that health services must be scientifically and medically appropriate and of the highest quality.

What are your reflections regarding unaccompanied minor girls' access to SRHR related services? What about Availability? Accessibility? Acceptability? Quality?

9. What do you think about how their right to health is met, in relation to this framework? If you do not think it is met, why do you think it is not? Which are the barriers for these services?

10. Is there anything else that you think of regarding SRHR and unaccompanied minor girls?