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An in-depth analysis of the sexuality needs of Barcelona's youth: a holistic view using mixed method

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Abstract: *A positive experience of sexuality during youth is key to good sexual health later in life. Addressing young people's sexual health needs and sexual and reproductive rights is thus essential. This study aimed to identify unmet sexual health needs among youth in the city of Barcelona (Spain) through mixed methods research. We analysed the narratives of young people (*n = *50) aged 14–24 years with different genders, origins, sexualities and socioeconomic backgrounds, collected from January to April 2019. A descriptive statistical analysis was also conducted on the records of visits to sexual health services and reasons for consultation. We found that 21% (*n = *32,161) of young people aged 14–24 years had used sexual healthcare services in Barcelona between 2015 and 2017, while the reasons for consultation differed across sex, gender and socioeconomic background. Young people declared that they needed more information to enjoy their sexuality, to know where to go in case of an unexpected situation and to learn how to combat gender-based violence. They stated that the sexuality education they had received was sparse and focused on risks. We found that formal sex education is scarce, with informal sex education thus acquiring a major role. Current services can be improved by expanding coverage, training professionals and reducing acceptability and accessibility barriers. Sexism is ubiquitous in young people's sexual, dating and personal relationships. We recommend planning sexual health care services and formal sexual education, in which a strong gender strategy is embedded, as part of the same strategy.* DOI: 10.1080/26410397.2022.2135728

Keywords: qualitative research, young adult, sexual health, reproductive health services

Introduction

Sexuality is a central aspect of a person's life, which manifests itself in all stages of the life cycle.[1] A positive experience of sexuality during youth contributes to good sexual health later in life. Sexual health is defined as a complete state of physical, emotional and mental well-being in relation to sexuality.[2] Good sexual health is achieved through a positive approach to sexuality, and the possibility of having pleasurable affective sexual relationships based on respect for and the guarantee of the sexual rights recognised by the Cairo Declaration.[3]

The experience of sexuality is determined by both contextual and individual levels. At the contextual level, the construction of sexualities maintains a close relationship with the social, historical, cultural and political context, with two significant elements. On the one hand, in Spain, as in many other societies in the global North, today's postmodern vision of sexuality combines the values of individualism and

hedonism with inherited religious values.[4] This impacts on constructions of sexuality during youth with phenomena such as the hook-up culture[5] and pornography at the same time as the perpetuation of sexualities as taboo. On the other hand, contemporary societies in the global North are also characterised by a set of factors and mechanisms that configure social hierarchies through the axes of inequality.[6] Through the mechanisms of gender binarism, and the institutionalisation of heterosexuality, romantic love and monogamy, the patriarchal system contributes to inequalities and reinforced gendered experiences of sexuality.[7] Thus, patriarchy generates and reproduces social inequalities and punishes dissidents.[8] Other axes of inequality also affect the experience of sexualities, such as social class,[9] ethnicity,[10] diverse capabilities[11] and age.[12]

These factors have a particular impact on adolescence and youth. During adolescence, the foundations of affective sexual relationships are acquired and these adolescent experiences will have an impact on later stages of life.[13] For this reason, it is essential to understand the needs that adolescents and young people identify with respect to their sexualities, within the framework of sexual and reproductive rights.[14] Understanding what is happening in adolescence will help to develop interventions that guarantee young people's positive affective sexual development and experience of their sexualities. Existing public policies and services can contribute to the experience of a positive sexuality,[15] especially through sex education, reproductive counselling and contraception, prevention and treatment of sexually transmitted infections (STIs), combating sexism and the prevention and treatment and sexual violence.[16] Despite the recognised importance of psychosocial aspects in the positive experience of sexuality, the current dominant model for the study and approach to sexualities during youth is biomedical, focused on identifying and avoiding risks.

At the international level, the effectiveness of socio-educational actions, such as counselling or sex education, has been demonstrated through a psychosocial paradigm to improve sexual health in youth.[17] Sex education and education for respectful relationships have been shown to be effective in empowering young people to manage their own risks and improve their sexual health.[18,19] Furthermore, including a gender perspective can increase the effectiveness of sex education.[20] With regard to sexual healthcare services, quality criteria have been established for the care of young people,[21] to determine whether services are youth-friendly. The following barriers to their use have also been identified: availability of services, accessibility and acceptability of services for youth and quality of services.[22] Studies have also identified the role and attitudes required by professionals caring for young people in order to provide high-quality care.[23]

At the individual level, sexualities are constructed based on a person's individual experience and social interactions with other people. The construction of an individual's sexuality begins at the same time as his or her socialisation. Sexual socialisation is the process by which certain behaviours are reinforced or rejected according to the expectations held of the individual by the agents of socialisation (the family, the educational centre, the media and the peer group). Through this process of sexual socialisation, individuals assimilate codes of conduct and normative social and cultural values of quality.[24] In addition, sexual socialisation is deeply linked to gender socialisation, such that the constructions of femininity and masculinity are parallel to the configuration of sexual beliefs, expectations and desires.[7] An individual's gender trajectories will combine with his or her sexual experiences and determine his or her beliefs and behaviours. These will be modulated throughout an individual's lifetime by the accumulation of positive and/or negative experiences related to sexuality.

The context of the city of Barcelona

Barcelona is a city of 1.6 million inhabitants located in Spain, southern Europe, on the Mediterranean coast. The sexual behaviour of youth in Barcelona is well documented through the sexual health information system. Information is collected on the percentage of youth who have had sexual intercourse (at the age of 17 years, 54% of women and 53% of men), young people who have used an effective contraceptive method during their last sexual intercourse (83% of women and 89% of men) and on the use of post-coital contraception (40% of women). In Barcelona, only 37% of girls and 32.7% of boys aged 15–19 feel satisfied with their sexual relationships.[25] The effect of social determinants of sexual health, especially gender, has also been studied: there are clear differences in sex-gender patterns with respect to the reasons for first sexual relations and inequalities in pregnancy prevention. In addition, in Barcelona, people from

disadvantaged socioeconomic backgrounds have worse sexual health indicators,[26] LGBTI people have worse indicators of self-perceived health,[27] and immigrants from low-income countries have markedly high abortion rates.[28]

As in other similar social contexts, the predominant model of young people's sexualities is more biomedical than psychosocial. Comprehensive sexuality education is not mandatory in Spain. Schools can decide whether to schedule sex education, and when and how to deliver it. The main public sex education programme in Barcelona had a coverage of 36% of secondary school students in the 2019–2020 academic year.[25] On the other hand, sexual healthcare services for young people are not youth-friendly as a whole, although specialised care for young people has been specifically incorporated into the portfolio of public sexual healthcare services[29] and there are public services specialised in youth care. These are called the *Tarda Jove*, which consists of a weekly slot reserved for young people in public sexual health centres, and the *Centre Jove d'Atenció a les Sexualitats (CJAS),* which specialises in sexual health care for young people.

The current study

Although various interventions have been carried out to improve the sexual health of young people, in Spain, there is no evidence until now as to whether these interventions have resolved adolescents' and young people's concerns about their sexuality. We do not know if they can access the most appropriate, or timely sexual health services to cover their needs. However, it is not our intention in this study to conduct a comprehensive evaluation of any sexual health intervention, as these interventions have been widely evaluated in the past few years.[30]

The aim of this research is to understand the narratives of adolescents and young people in Barcelona regarding their sexual health from a sexual and reproductive rights perspective. In this regard, our study addresses the research question: "Is the support adolescents and young people receive in relation to their sexualities adequate?" This question is particularly relevant for policy decision-making in Barcelona, establishing the changes that need to be implemented in interventions and services to suit young people's needs and determining the resources that should be allocated. To answer this question, our study raises the three following research questions:

- What are the sexual needs of youth in Barcelona?
- What are the sociodemographic characteristics of youth using sexual healthcare services?
- What barriers do youth experience to making use of sexual health services?

Methods

This mixed methods study combined data collection techniques and quantitative and qualitative analysis methods to provide more knowledge on the topics under investigation than would be gained with separate analyses.[31] The relationship between our research questions, the data collection techniques used and the methods of analysis are shown in Table 1. For each research question, a main data collection technique was employed, with its corresponding method of analysis. The answers to the first and third questions were sought through the narratives of young people in the city, whether or not they were users of sexual healthcare services. Information from the records of sexual health services was used to answer the second research question, which aimed to categorise youth accessing the services. Finally, quantitative and qualitative data were interpreted together and conclusions were drawn.

Qualitative part

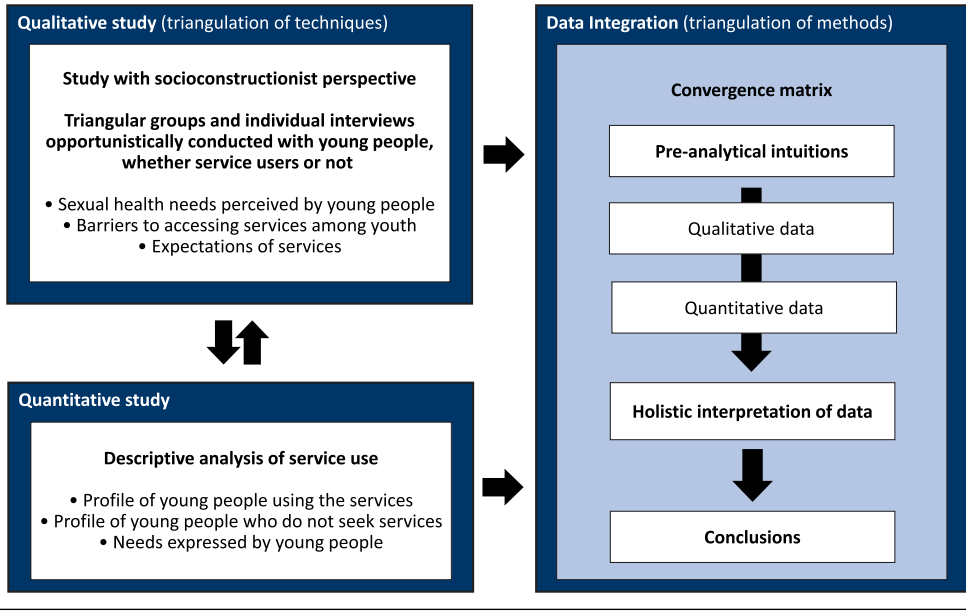
To answer the first and third research questions, we used mainly methods specific to qualitative research (Table 1). We designed a qualitative study using a socio-constructionist perspective that holds that the realities and phenomena experienced by a person or group of people are embedded in a social and historical context.[32] These realities are deeply marked by the unequal distribution of power, rights and resources along axes of power. The qualitative part aims to identify the barriers faced by young people when attempting to use public sexual healthcare services and the needs perceived by these young people in Barcelona regarding their sexualities in 2019 (Figure 1).

Intentional stratified sampling was carried out[33] with a selection of young people according to gender (male or female), age (14–17; 18–21 or 22–24) and country of origin (native or immigrant). Participants were recruited in the waiting rooms of sexual healthcare services. It was agreed with the young people whether they wanted to be interviewed while waiting, when leaving the clinic, or at another time. Participants who were

Table 1. Relationship between research questions and study methods

	Research question 1: What are the sexual needs of youth in Barcelona?	Research question 2: What are the sociodemographic characteristics of youth using sexual healthcare services?	Research question 3: What barriers do youth have to making use of sexual health services?
Contribution of the question to the global understanding of the phenomenon	To understand the perceived, normative and expressed needs of young people regarding sexualities	To identify the profiles of youth accessing sexual health services and those of young people excluded from them	To identify barriers to the availability, access and quality of sexual health services
Main data collection technique and method of analysis used to answer the question	Use of triangular groups with young people and individual interviews, a descriptive-interpretative analysis was carried out to capture the needs perceived by the young themselves	From the register of users of sexual healthcare services, a descriptive and cross-sectional analysis was carried out to typify the profiles of youth using the services	Use of triangular groups with young people and individual interviews, a descriptive-interpretative analysis was carried out to identify barriers perceived by the young themselves
Strategy for a holistic interpretation of data and drawing of conclusions	Based on a convergence matrix in which both the data collected to answer research questions 1, 2 and 3 and the conclusions of the analyses of these questions were integrated, an interpretative analysis was again carried out to determine which needs - if any - of youth's sexual health are not sufficiently met by public services.		

Figure 1. Methodological design of this study



not service users were recruited using a snowball strategy. The snowball started from the young users, who were asked if they knew of any young people who did not use these services who might be interested in participating. The majority of conversations took place in empty consultation rooms at the health services. However, some of them were conducted in other public spaces where young people could feel comfortable.

Data collection techniques consisted of an individual interview[34] and triangular groups.[35] Previous studies have previously combined these techniques in the study of sexualities.[36] In-depth interviewing was used when the young people chose to conduct the interview alone, and the triangular group when they preferred to be interviewed together. In all the triangular groups, the young people already knew each other. In the triangular groups, the issues were introduced in general terms and the young people were invited to share their vision. The interviewer balanced the young people's participation and cross-examined to clarify issues. The person who conducted the interviews and the triangular groups was an experienced interviewer who received specific training for the current study.[37] Data were collected from January to April of 2019.

A list of the topics covered in the conversations is shown in Table 2, including sexualities, sexual health needs, relationships, experiences in services and barriers to the use of services. Both users and non-users were asked about barriers to access: in users, the ones they had experienced, and in non-users, the ones they think they would face. Narratives were recorded with 50 young people between the ages of 14 and 24 years. Pre-recording contact lasted about 10 minutes and included an explanation of the project, the topics of conversation to be addressed, the

Table 2. Guide to talking points for obtaining data from young people in individual interviews and triangular groups

Category	Subcategory	Examples of issues raised
Concept of sexualities	Concept of sex; Concept of sexuality; Concept of sexual health.	For you, do the terms sex and sexuality have the same meaning? For you, what does sexuality include? What do you identify with sexual health?
Sexual health needs	Sex education; Risk of pregnancy and STIs; Reasons for consulting services; Role of the internet; Role of pornography.	What do you think youth need in terms of sexuality? How do you rate the sex education you have received? What concerns do you have about your own sexuality? What would be a reason for you to go to a sexual health service?
Relationships and sexualities	Sexuality and relationships with friends; Sexuality and affective sexual relationships; Sexuality and family relations.	In your group of friends, is it taboo to talk about sexuality? What aspects of your sexuality would you talk about comfortably in a classroom? What sexuality concerns would you share with your mother? Are they the same ones you would talk about with your father?
Experiences in services	Experiences in services	Can you identify what you value most highly and what you would improve in your practice? How did you feel during your time in the practice?
Barriers to the use of services	Availability barriers Entry barriers Quality barriers	How long did it take you to come to the service? How did you learn about the service?

collection of individual data and the signing of the informed consent form. Discussions lasted between 8 and 33 minutes. The shortest conversations were conducted while the young people were waiting to be seen. The young people were invited to participate further after the visit, but they declined. In these short conversations, the young people could not be questioned about all the topics and priority was given to delving into one or two topics. Recruitment lasted until data saturation was achieved. Conversations were transcribed verbatim and completed with a contextualisation and summaries of the conversations held before and after the recording.

A descriptive-interpretative analysis of the narratives was carried out through a sociological discourse analysis.[38] The process of category generation was mostly inductive, performed with the help of Atlas.Ti software. The researchers individually performed the repeated reading of the texts, as well as the coding and analysis of the discourse, and the points of view were triangulated. An explanatory framework was developed, and summaries of the analyses were produced.

Quantitative part

To answer the second research question, we mainly used quantitative research methods (Figure 1). A descriptive, cross-sectional analysis was carried out. The study population was the 32,161 users of Barcelona's public sexual healthcare services, aged 14–24, between 2015 and 2017. Using the registers of visits from the public sexual healthcare system centres as a source, the sociodemographic profiles of users were categorised from their first visits. These profiles were compared with the young population of the city as a whole based on information from the 2016 municipal census, provided by the City Council itself.[39]

The dependent variable of our analysis was services use, operationalised as the first visit made by persons aged between 14 and 24 years to a public sexual healthcare service in the city of Barcelona between 2015 and 2017. The reasons for visits were grouped into 10 categories: (a) sexuality care for non-medical sexuality concerns, (b) psychological counselling, (c) non-communicable diseases, (d) sexually transmitted infections, (e) reproductive counselling, (f) pregnancy testing, (g) post-coital contraception, (h) abortion request, (i) pregnancy and postpartum care, (j) other and non-relevant consultations. Information for reason of visit was unavailable for 5,714 (17.8%) users.

Explanatory variables were sex (women and men), age (14–17, 18–21 and 22–24 years), nationality (Spanish, immigrants from high-income countries and those from low-income countries)[40] and socioeconomic background (favourable or unfavourable, depending on whether the available family income in the district of residence was above or below that of the city as a whole).[41] The second dependent variable was the reason for consultation. There was no information on nationality in 12,537 (39%) users and none on socioeconomic background in 15,065 (47%).

A descriptive statistical analysis was carried out on the use of public sexual healthcare services in Barcelona by young people. Measures of the coverage of services use were obtained according to variables (sex, age, nationality, socioeconomic background), taking the young population of Barcelona as the denominator. The analysis was carried out with the STATA v12 software.

Ethical concerns

The study was approved by the Clinical Research Ethics Committee of Parc de Salut Mar (approval number CEIm-PSMAR 2020/9354) on 1 February 2021. The study was explained to participants before informed consent was obtained, it was emphasised that they would be free to answer questions or not, and the confidentiality of the conversations held was stressed.

Results

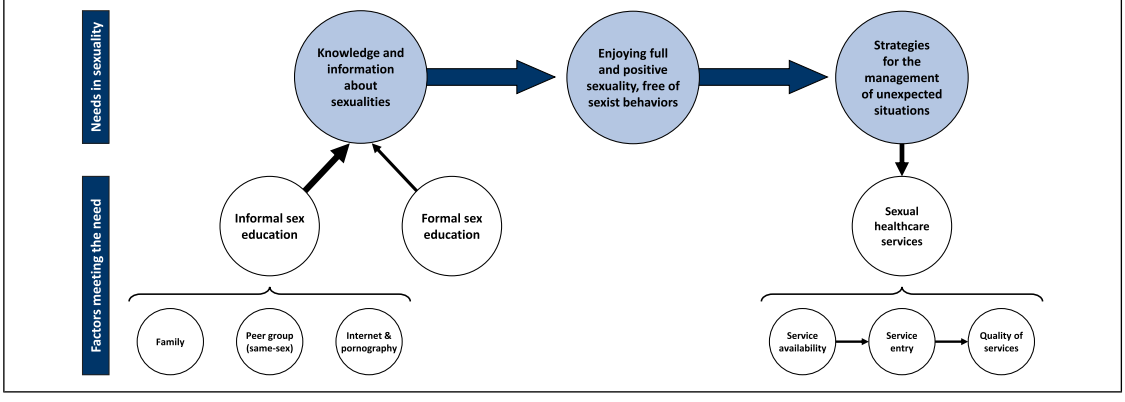
Responses from 50 young people (35 girls and 15 boys) were analysed. The mean age of participants was 18.1 years (range 14–24). Most participants were from disadvantaged socioeconomic backgrounds ($n = 32$). The majority had normative sexualities ($n = 41$) and were native ($n = 36$).

Key themes identified during the analysis are explored below.

Perceived needs of youth regarding their sexuality

Young people declared they had a positive experience and view of sexuality and enjoyed it. They also considered they had good sexual health. They identified three needs related to their sexual health (Figure 2). First, they needed knowledge and information about sexuality, appropriate to

Figure 2. Narrative configurations of young people's discourse



their diverse contexts and experiences. This information could be drawn from both formal and informal contexts. Secondly, they reported they wanted to live a sexuality free of sexist attitudes and behaviours. Thirdly, youth stated they needed strategies for the management of unexpected situations. Although all young people mentioned these three needs consecutively, the narrative configurations of their discourse were strongly influenced by age and gender.

Formal sex education

All the young people considered sex education in the school context was essential to have the information and knowledge necessary to make decisions on their own sexuality. None of the young people were satisfied with the formal sex education they had received, and many pointed out that informal sex education had a stronger influence (Figure 2). Young people reported that they either had no or little sex education, and 14- and 17-year-olds and young women especially were left with doubts.

"When they do it [sex education], they do it too late, and they do it very little, very badly. I mean, everything they've taught to us about sex education is the craziest thing I've ever seen in my life." (Woman, 23 years)

For youth, formal sex education should be participatory and imparted in small groups. Young informants of both sexes indicated that sex education should be provided by people they trust and with whom they felt safe.

"You can't really ask in class what you like, can you? Because maybe you're also afraid of being told something later." (Man, 16 years)

Among young people who had had some formal sex education, there was general agreement that its contents consisted of moralistic talks focusing on the risks of heterosexual sexual relations, especially the need to use condoms for pregnancy prevention. Young people with dissident sexualities reported that the formal sexual education received was not adapted to sexual and gender diversity in sexually transmitted infection (STI) prevention.

"When you talk about having relationships with protection and all these things, I think people focus on heterosexual relationships and not getting pregnant. […] There are also diseases and sometimes they are not given their real importance." (Man, 23 years, dissident sexuality)

Young people stated that there were taboos that needed to be addressed. Knowledge of one's own body, pleasure and intercourse were not mentioned in sex education, except in highly valued exceptions. In general, informants considered that the sexuality education they had received did not discuss consent, sexist behaviours and attitudes, violence against women in relationships, or the myths of romantic love. Women reported speaking more about sexuality and the female body and, especially those older than 18 years, believed taboos needed to be broken about female masturbation and menstruation:

"If you have to have four assholes [boys] there, taunting you that 'you've got your period!', and you're ashamed to [get a friend to] pass [you] a tampon … I don't know, I wish that could be changed." (Woman, 18 years)

Informal sex education

Young people recognised that family, internet and pornography, as well as their peers (Figure 2) played a key role in providing information about sexuality, as they allowed them to resolve doubts that formal sex education had not addressed. Informants believed that their family did not play an important role in their sex education. They distinguished between the paternal and maternal roles: the father played no role and the mother was the person to turn to as a last resort. Most young people stated they had searched the Internet for information on sexuality, such as the appearance of the genitals, sexual positions, the G-spot and contraceptive methods. A few men stated that their personal experience was enough for them, and they had never searched the Internet. Young people said they had had doubts about the reliability of the pages consulted, looked for sites validated by institutions and avoided forums:

"There are situations where you say … you're embarrassed to ask, you know? So, it's easier to find, although what you can find on the internet can be very relative. You may not be able to find the information you're looking for, or you may be given the wrong information." (Man, 23 years)

Few women reported they had viewed pornography. They mentioned that they had been alarmed that people could be sexually excited by content that they described as violent, vulgar, sexist and misogynistic. They said it fostered a culture of rape and was intended for individual male pleasure. They said they were concerned that the issue of consent did not appear.

"There are so many things that porn instils in you. It's sexist, rape. It's totally … I was shocked." (Woman, 18 years)

In contrast, many men reported having viewed pornography from a very early age, for entertainment and pleasure, and perhaps to learn about sexual practices and positions. They agreed with women that pornography influenced men's sexual expectations and practices, although all believed themselves to be an exception and that they personally had not been influenced by it:

"I don't think it has any influence on the way I have sex, or anything, or how I experience it. Because it's accepted that it's unrealistic. For me it's entertainment, as if I were watching a series." (Man, 17 years)

According to informants, conversations about sexuality among peers were segregated by gender and, regardless of age, only took place within the most intimate friendships. Women exchanged secrets and intimacy as well as concerns and problems. Menstruation and masturbation were taboo, and some considered it unhygienic:

"It was embarrassing, and we dealt our pads in class as a drug. Like, you know, don't let anyone see it, sneaky." (Woman, 19 years)

"A girl says: I've jerked and everyone [her friends]: 'oh, gross', 'what are you saying', I mean, 'you've fingered your… you know?'" (Woman, 15 years)

Among men, friends served to reflect back and demonstrate virility. This was true for both heterosexual and non-heterosexual men. Topics evolved with age. Younger men reported they discussed the number of times they masturbated, while older men reported they commented on who they masturbated with and on how and where they had sex. However, men stated that they did not reveal certain aspects of their sexual encounters that were considered as strictly private.

"[Who I fuck] That's right, you tell your good friends. But, for example, if I left here with a wart or … I don't know, syphilis or that candidiasis, I might not tell many people." (Man, 18 years)

Sexist behaviours occurred both during and outside sexual relations. Women said that for men the central practice was penetration and they put their pleasure before that of their partners.

"They're fucking and he takes off the condom, the girl tells him to stop but he keeps going on. This happens, and a lot." (Woman, 19 years)

Women described the sexist behaviours, both psychological and sexual, exerted by men through control and emotional blackmail, which undermined the women's self-esteem. Virtually all the women participating in the study, regardless of their age, had experienced this phenomenon at first hand.

"What abounds is psychological abuse, especially between couples. In other words, yes, making the other person feel bad. Jealousy could be an aspect of psychological abuse. […] That you can't do anything but spend time with that person, that you can't go out or go about your life. They make you feel bad, they make you feel inferior. […] The relationship can turn into one person being in charge and the other obeying. And you don't even realise it." (Woman, 18 years)

However, no particular man reported that he considered himself to be sexist. Nor did any man admit a sexist attitude or behaviour on his part.

"There are macho attitudes, actions. I think there is this, but there are no machista people." (Man, 24 years)

Use of services

Of 14–24–year-olds, 32,161 (21%) used public sexual healthcare services in Barcelona between 2015 and 2017. Of these, the majority were women (95%), aged 18–21 years (52%), of Spanish nationality (69%) and disadvantaged socioeconomic backgrounds (72%) compared with the total number of users (Table 3). Services had 40% coverage in women, compared with 2% in men ($p < 0.01$). Young people aged 18–21 years were over-represented ($p < 0.01$). There were no differences in nationality between the general population and services users. Significant differences were found in socioeconomic background of public sexual health service users according to sex ($p = 0.03$): women from disadvantaged backgrounds were slightly over-represented while men from advantaged backgrounds were over-represented.

The reasons for consultation differed by sex, age and socioeconomic background (Figure 3 (a)). Women attended mainly for reasons related to non-communicable diseases (30%) and reproductive counselling (23%). By age group, women aged 14–17 stood out for the percentage of visits for post-coital contraception (24%), which dropped in the other groups (9% in 18–21 and 4% in 22-24). Visits for sexual transmitted infections (STI) and delivery and postpartum care increased progressively with age: 4%, 9% and 13% for STI, 2%, 6% and 8% for delivery and postpartum care. In contrast, requests for pregnancy tests decreased with age by 11%, 9% and 5%. Visits for abortion remained stable at around 2–3% in all age groups. We found disparate percentages in some age groups between socioeconomic backgrounds: post-coital contraception visits were significantly higher in young people from advantaged socioeconomic backgrounds (15%) compared to disadvantaged (6%), and this difference increased in the 14–17 age group (33% in advantaged, 15% in disadvantaged). On the other hand, the request for abortion was slightly higher in young people from disadvantaged backgrounds, although this difference was not significant. In the 14–17 age group, users from advantaged backgrounds were less likely to seek reproductive advice (16%) than those from disadvantaged backgrounds (25%), but there was no difference in other age groups.

The most frequent reason for consultation among men was related to STI (52%), as seen in Figure 3(b). The percentage of visits for STIs increased with age: 20% in ages 14–17, 51% in ages 18–21 and 71% in ages 22–24. In the 14–17 age group, the main reason for their visit was post-coital contraception (24%). This percentage differed according to socioeconomic background, being 33% in advantaged and 15% in disadvantaged backgrounds.

Access to sexual healthcare services and barriers identified

Young people needed services to support them in coping with the circumstances that could arise, which varied according to gender and age, and were related to the reasons for consulting the services. Among female informants, especially girls aged 14–17 years, these circumstances lay in reproductive health: demand for free contraceptives, menstruation, pregnancy testing, post-coital contraception and abortion. Among male informants, concerns were related to difficulties in intercourse: erection problems, premature ejaculation and difficulties with condom use. Men aged between 22 and 24 years were especially concerned about STIs, regardless of their sexual orientation, although they reported they knew how to protect themselves. In women with dissident sexualities aged 22–24, STIs were also a main concern. These women indicated that they were not satisfied with the preventive strategies they were aware of.

However, there were barriers to accessing services (Figure 2). Some informants did not know where to go, especially those aged 14–17 years.

Table 3. Youth aged 14–24 years using public sexual healthcare services. Barcelona City, 2015–2017

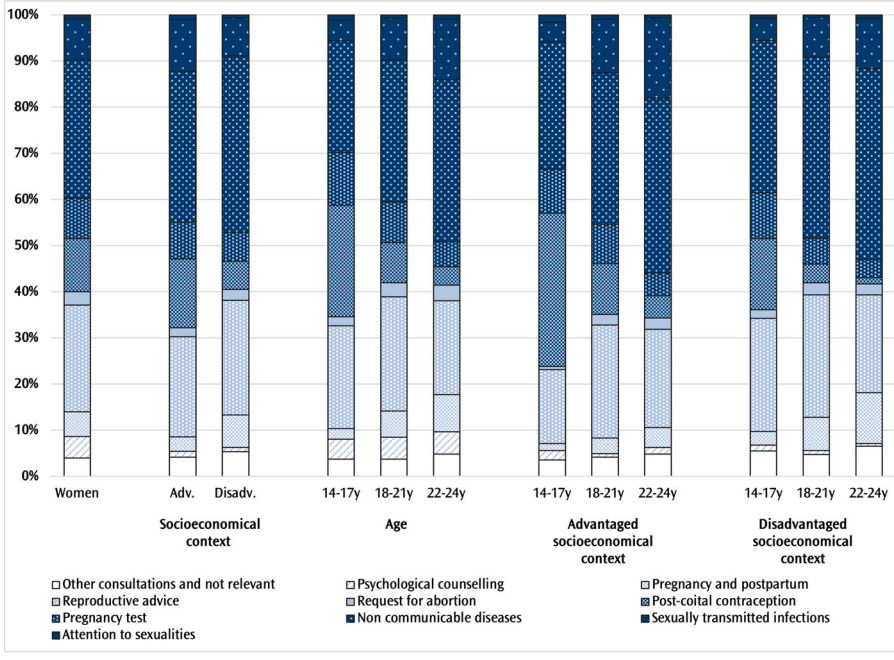
	Women					Men				
	Users		Population[a]		% Coverage over 3 years (2015–2017)	Users		Population[a]		% Coverage over 3 years (2015–2017)
	N	%	*N*	%		*N*	%	*N*	%	
Barcelona	30,693		76,202		40.3%	1,467		78,541		1.9%
Age (years)										
14–17	7,761	25.3%	25,025	32.8%	31.0%	306	20.9%	26,377	33.6%	1.2%
18–21	15,990	52.1%	26,314	34.5%	60.8%	680	46.4%	27,837	35.4%	2.4%
22–24	6,940	22.6%	24,863	32.6%	27.9%	481	32.8%	24,327	31.0%	2.0%
No data	2		N/A			0		N/A		
Origin										
Spanish	12,777	69.0%	53,856	70.7%	N/A[b]	848	76.6%	55,901	71.2%	N/A[b]
High-income countries	1,031	5.6%	5,431	7.1%	N/A[b]	57	5.1%	4,669	5.9%	N/A[b]
Low-income countries	4,708	25.4%	16,915	22.2%	N/A[b]	202	18.2%	17,971	22.9%	N/A[b]
No data	12,177		N/A			360		N/A		
Socioeconomic background										
Advantaged	4,445	26.9%	29,955	39.3%	N/A[b]	289	49.1%	29,706	37.8%	N/A[b]
Disadvantaged	12,061	73.1%	46,247	60.7%	N/A[b]	300	50.9%	48,835	62.2%	N/A[b]
No data	14,187		N/A			878		N/A		

[a]Population refers to young people registered in Barcelona's City Census in 2016.
[b]Estimates of coverage could not be computed due to high levels of missing data.

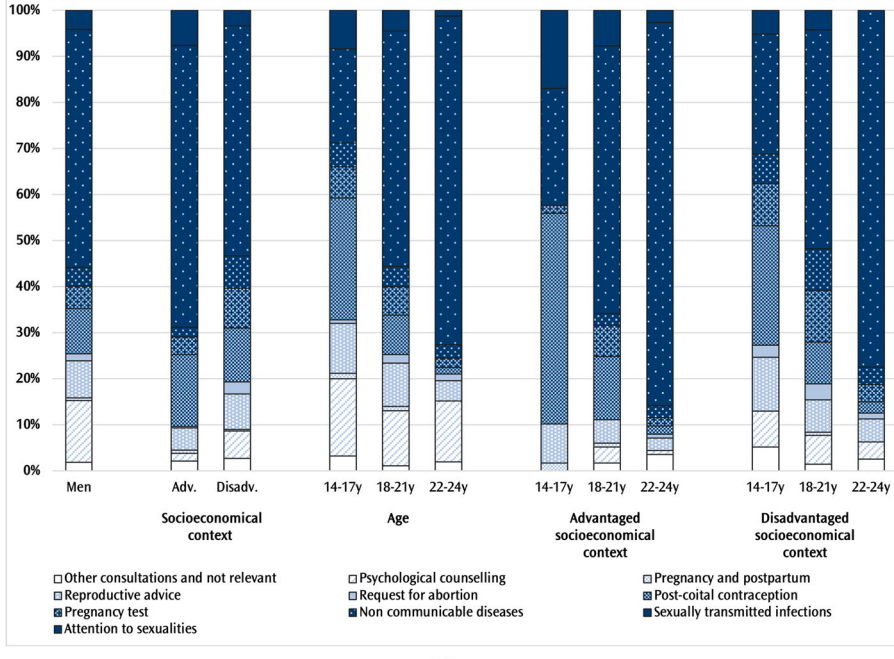
They admitted that they were not well informed and that their knowledge was garnered through friendships. If they needed post-coital contraception or a pregnancy test, many women would prefer to go to a pharmacy rather than a sexual healthcare centre. With the exception of some women between the ages of 22 and 24 years, most were unaware of their abortion rights: although they would go to a health centre, they did not know that it is free. Women from advantaged socioeconomic backgrounds said they would prefer to undergo an abortion in the private sector. Many of them said they did not know about abortion procedures. Women, in particular younger ones, reported that this was a cause of concern.

"Typical of a period delay, what do you think: Shit, what if I got pregnant for whatever? What the fuck do I do now? I would have liked someone to have explained it to me, what you have to do. And what solution is there? Because I don't know, if there's a pill or if they really have to put something in there. I don't know." (Woman, 18 years)

Figure 3. Reasons for consultation reported by young people between the ages of 14 and 24 years using public sexual healthcare services. Barcelona, 2015–2017. (a) Women, (b) Men



(a)



(b)

The barriers of access to sexual healthcare services were grouped in: availability barriers, entry barriers and quality barriers (Figure 2).

Barriers to availability

The main barrier was opening hours: young people reported they were concerned about the management of emergencies arising on weekends or evenings. They placed a high value on services being close to their place of residence. They also reported they attached importance to being able to drop in without an appointment. Many young people, especially 14–17-year-olds and men, mentioned they were unaware of the existence of services, consultation procedures and appropriate reasons for attendance. They pointed to sex education as an opportunity to advertise these services and stressed the importance of keeping websites up to date and with easily accessible information.

"I have no idea if I have to go to the gynaecologist. Where to go to the gynaecologist, how to ask for an appointment. Like … in the normal health centre, right?" (Woman, 17 years)

Accessibility and acceptability barriers

Young people described that they were embarrassed to share their concerns about sexuality. They said it was, therefore, very uncomfortable for them to discuss the reason for consultation at the reception desk. In the waiting room, they were stressed by long waits and by both sepulchral silence and commotion. In addition, women repeatedly mentioned that they felt judged by adults if the waiting rooms were shared, especially the younger ones. They reported meeting known peers in the waiting room was not a problem for them, as there was shared understanding. In the consultation, the young people declared they assumed they would not be judged and trusted that confidentiality would be respected. Throughout the visit, young people said the main concern for them was that their parents did not learn of their attendance, especially in the case of women aged 14–17 years:

"You leave your name, but that's it. You don't have to tell your parents or do anything. So I think your privacy is very much respected." (Woman, 17 years)

Quality barriers

In the public services specialised in the sexual health care of young people, users rated their experiences very positively, although their initial expectations were low. Young people liked the fact that the service was free, that they had enough time to resolve their doubts and that their waiting times for a further consultation were relatively short. The treatment received, characterised by empathy, active listening and respect, was rated highly. For example, they said they appreciated that any procedures being carried out were explained and that the health professionals did not make assumptions about their sexuality and asked if the companion is a friend or partner, whatever the sex. Young people reported that specialised youth care solved their concerns.

"I got there and I said [to the professional]: well, I'll start from scratch because I have no idea, and I want you to explain everything to me. […] I felt super comfortable, and the treatment I received was … wow! I mean, I got out of there very happy. I wasn't even ashamed to ask her for a pregnancy test. I wasn't going to, but I felt so comfortable that I asked her and she told me to do it right there, to go to the bathroom and we would look at it together." (Woman, 18 years)

In contrast, experiences in public gynaecological services were repeatedly reported as negative. Young informants said they felt judged by gynaecologists, who dismissed their concerns, did not empathise with them and treated them paternalistically. Young people attributed many of their complaints to gynaecologists, while they valued the work of midwives positively.

"I went to ask her to explain to me what contraceptive methods there are. In other words, different from condoms. I wanted information and, of course, [the gynaecologist] asked me why, and I told her that, that many times I had had sex without a condom. And I don't know, I felt a little bad because … I don't know, I think she judged me a lot for that and she was very unpleasant all the time. And she didn't give me that much information either. […] I left there thinking that I would never go back to a gynaecologist again." (Woman, 19 years)

Discussion

In this study, we used quantitative and qualitative methods to explore the sexual health needs of young people in Barcelona. Young people need

sufficient information to allow decision-making, to experience their sexuality pleasurably and free of sexist attitudes and behaviours, and to have the resources to manage situations satisfactorily, like knowing how to respond in the event of encountering a possible unwanted pregnancy or STI. These needs correspond to sexual and reproductive rights[3] and, therefore, the barriers and shortfalls detected in our study represent a violation of young people's sexual rights in Barcelona.

To address these needs in accordance with young people's views, two complementary interventions are required: formal sex education and sexual healthcare services. In these two interventions, it is essential to incorporate the gender perspective in a comprehensive manner and to raise awareness of the need to eradicate sexist attitudes and behaviours.

Relationship between the need for information and formal sex education interventions

Although the information is one of the main requirements for sexual health, young people stated they had little information about sexuality, irrespective of whether they had participated in any sex education programme or not. Those youth that had received sex education described it as scarce, too risk-centred, heteronormative and coito-centric. When young people did not find answers to their concerns in formal sex education, they resorted to informal contexts, with the consequent spread of myths and rumours.

Formal sex education interventions have been shown to be effective in improving sexual health and in preventing sexism in affective sexual relations.[16] However, most international studies indicate that sex education does not really exist in Spain.[41] Sex education has not yet been mandatorily included in the school curriculum and no national guide has been published by the government. In Barcelona, despite attempts to include formal sex education programmes in schools, they are carried out on an *ad hoc* basis and have unequal coverage. The main formal sex education programme has 36% coverage and consists of six one-hour sessions.[25] Although the content has been recently diversified in order to include LGBTI sexualities, it is still largely focused on risks and how to avoid them.

This contrasts with the established criteria,[19] which propose focusing interventions on knowledge of the body, pleasure and emotion management. It is also necessary to break down the myths about sexuality and romantic love.[36] Some of the reasons that would explain this incoherence, in addition to the lack of political will, could be the lack of specialised professionals to provide sex education from non-biomedical perspectives in Spain,[42] or a hypothetical fear of the objections that might be raised by some families, teachers and educational centres if sex and pleasure were discussed explicitly in the classroom without adequate legal regulation.[43]

Approaches to delivering sex education also need to be reviewed. Although the most effective and highly rated interventions applied participatory and experiential methods, it should be remembered that school classrooms are not always safe spaces.[44] Sexist attitudes and structural LGBTI-phobia inhibit young people, who reported they preferred to remain in doubt rather than be exposed to harmful comments from the group. An effective means of correcting this situation is to normalise existing sexual and gender diversity.[45]

We recommend that the Spanish government introduce sex education into the mandatory curriculum at all stages of education in schools nationwide, as part of a holistic sexual health strategy for young people. Meanwhile, in Barcelona, a socio-educational intervention to promote healthy and equitable relationships should be designed which must necessarily have a gender perspective.[20] This should go beyond the biomedical model and address gender-based violence and sexual and reproductive rights.[18,19]

Relationship between the need to manage situations and sexual healthcare services

The young participants in our study identified public sexual healthcare services as a place to go in case of need. Sexual health care has been shown to be effective in preventing sexual health problems.[46] However, we offer the following three reflections.

First, our results show that there are three gaps in public service coverage: men; women from advantaged socioeconomic backgrounds; and the 14–17-year-old age range. The under-representation of men should be understood in the context of the patriarchal system, which makes women responsible for sexual health. However, the percentage of users in Barcelona (5%) is much lower than for Europe as a whole, where

men account for 25% of users.[47] Some strategies that could increase the percentage of men seeking services would be making them equally responsible for sexual health through sex education interventions with a gender perspective.[48] Involving men in service design and communication strategies could reduce acceptability barriers.

The scarce presence of women from favoured socioeconomic backgrounds contrasts with the situation elsewhere, where the cost of services can become one of the main barriers to access for young people from disadvantaged backgrounds.[49] In Barcelona, where free public services coexist with private services, the underrepresentation of women from favoured backgrounds may be linked to the use of private gynaecological services, as can be seen from the interviews with young people from these more advantaged backgrounds. Low service coverage among 14- to 17-year-olds may be related to a lack of knowledge of services and lack of privacy. Our results agree with those of other studies that have previously reported that young people were discouraged from attending services if they required family authorisation[50] or doubted their confidentiality.[51]

The second reflection relates to the reasons for using public sexual health services. Quantitative data show that women attend mostly for reasons related to contraception while men do so for STIs and difficulties in intercourse. Although these findings were reflected to some extent in the qualitative data, during conversations, men found it harder to admit to difficulties, as doing so would mean questioning their virility,[52] and women found it easier to attend services when the reason was reproductive health than when it concerned their sexual health. However, although young people did not attend consultations for information on sexual pleasure, they were concerned about the issue, as shown by the fact that, on the institutional website of the services, the most frequently visited sections are those related to pleasure and sexuality.[53]

A third reflection is that, in our study, all young users of public sexual healthcare services specialised in young people rated these services positively; while users of services not specialised in young people, such as gynaecological care, were almost always rated poorly. This may be because specialised services, unlike gynaecological care, fit perfectly the criteria established by the WHO for youth-friendly services.[21] Young people appreciate, above all, rapport with health professionals,[54] and the perception of services as safe spaces where they can open up and find answers to their questions due to fast, free, person-centred care. Unlike other studies, in which young women did not want their peers to know that they were using services,[22] in our study, the concept of privacy generally related to parents not being aware of the content of the consultations, and young people in Barcelona trusted that their confidentiality would not be breached.

We propose the expansion of the youth-friendly sexual healthcare model as part of the sexual health strategy for young people. This involves training all personnel who work in youth sexuality and ensuring comfortable and safe spaces. Sexual health care for men needs to be urgently addressed. On the other hand, the information system that collects data from young people should be improved, as it currently has a very high percentage of missing data. Furthermore, this would allow more in-depth analyses of the use of services by young people of nationalities other than Spanish and with dissident sexualities, for whom there is currently no information.

Strengths and limitations of the study

Limitations of the present study include the use of visit records as an information source, with many missing data on the nationality of persons receiving assistance: this does not allow the exploration of associations and correlations in quantitative analysis. In addition, the availability of data exclusively from public services may imply a selection bias in relation to the socioeconomic backgrounds of the people included in the study. The composition of the sample in the qualitative analysis was not intended to be statistically representative but rather to be socially representative. Finally, the type of study carried out did not allow us to extrapolate what happens in other contexts, such as smaller municipalities or those in non-urban contexts with fewer services.

The main strength of the study is that, due to the use of mixed methods, quantitative and qualitative data were integrated to offer results that help to deepen knowledge of the sexual health needs of young people and to identify those not being covered. While discourse saturation was sought for the objectives of the study, we were also able to delve deeper into aspects such as the role of pornography, the role of parents and

men's access to services. In addition, two aspects of sexual health appear in this work that, although complementary, are usually studied separately: sexual education and sexual health care. By incorporating both aspects, this study allows us to obtain a global vision of the phenomenon.

Conclusions

Youth positively rated the public sexual healthcare services specialising in young people in the city of Barcelona and wanted this to be the model, in line with proposals in international guidelines. Sex education for young people is partially covered by interventions in public schools but is insufficient: quality sex education should be imparted by trained personnel and introduced in the curriculum at all stages of compulsory education. Sex education and sexual healthcare services should be approached as part of a single strategy: comprehensive sexual health policies. Furthermore, given that experiences of sexualities are gender-specific, it is essential to incorporate feminist and sexual affective diversity perspectives to all matters related to the sexuality of young people.

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References

1. Foucault M. Histoire de la sexualité 1: La volonté de savoir. Paris: Éditions Gallimard; 1976.
2. WHO. (2006). Defining sexual health: Report of a technical consultation on sexual health. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf.
3. UNFPA. (1994). The state of world population.
4. Fandiño Pascual R, Rodríguez Pousada V. La lucha sexual de los adolescentes en la hipermodernidad. Barcelona: Editorial UOC; 2018.
5. Duerto P. Cuerpos acelerados: un análisis de los efectos de la temporalidad neoliberal en la subjetividad. Res Publica Revista de Historia de Las Ideas Políticas. 2021;24 (3):505–517. DOI:10.5209/rpub.79248.
6. Viner RM, Ozer EM, Denny S, et al. Adolescence and the social determinants of health. The Lancet. 2012;379 (9826):1641–1652. DOI:10.1016/S0140-6736 (12)60149-4.
7. Carpenter LM. Gendered sexuality over the life course: A conceptual framework. Sociol Perspect. 2010;53 (2):155–178. DOI:10.1525/sop.2010.53.2.155.
8. Preciado P. (2000). Manifeste contra-sexuel. Au Diable Vauvert.
9. Despentes V. King Kong Théorie. París: Edicions Grasset & Fasquelle; 2006.
10. Puar JK. Terrorist assemblages: homonationalism in queer times. Durham, NC: Duke University Press; 2007.
11. Kafer A. Feminist, queer, crip. Bloomington, IN: Indiana University Press; 2013.
12. World Health Organization. (2014). Health for the world's adolescents. A second chance in the second decade. www.who.int/adolescent/second-decade.

13. World Health Organization. (2018). WHO recommendations on adolescent sexual and reproductive health and rights. https://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf?ua=1.
14. Engel DMC, Paul M, Chalasani S, et al. A package of sexual and reproductive health and rights interventions – what does It mean for adolescents? J Adolesc Health. 2019;65(6):S41–S50. DOI:10.1016/j.jadohealth.2019.09.014.
15. Bearinger LH, Sieving RE, Ferguson J, et al. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. Lancet. 2007;369(9568):1220–1231. DOI:10.1016/S0140-6736(07)60367-5.
16. Goldfarb ES, Lieberman LD. Three decades of research: the case for comprehensive Sex education. J Adolesc Health. 2021;68(1):13–27. DOI:10.1016/j.jadohealth.2020.07.036.
17. Tolman DL, Striepe MI, Harmon T. Gender matters: constructing a model of adolescent sexual health. J Sex Res. 2003;40(1):4–12. DOI:10.1080/00224490309552162.
18. Flood M, Fergus L, Heenan M. (2009). Respectful relationships education: Violence prevention and respectful relationships education in Victorian secondary schools. https://eprints.qut.edu.au/103414/1/__qut.edu.au_Documents_StaffHome_staffgroupB%24_bozzetto_Documents_2017000497.pdf.
19. UNESCO. (2022). Evidence gaps and research needs in comprehensive sexuality education: technical brief. UNESCO. https://unesdoc.unesco.org/ark:/48223/pf0000380513.
20. Haberland NA. The case for addressing gender and power in sexuality And HIV education: a comprehensive review of evaluation studies. Int Persp Sexual Reprod Health. 2015;41(1):31–42. DOI:10.1363/4103115
21. WHO. (2012). Making health services adolescent friendly. Developing national quality standards for adolescent-friendly health services. http://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf.
22. Bender SS, Fulbright YK. Content analysis: a review of perceived barriers to sexual and reproductive health services by young people. Eur J Contracept Reprod Health Care. 2013;18(3):159–167. DOI:10.3109/13625187.2013.776672.
23. Haberland NA, Rogow D. Sexuality education: emerging trends in evidence and practice. J Adolesc Health. 2015;56(1 Suppl):S15–S21. DOI:10.1016/j.jadohealth.2014.08.013.
24. Shtarkshall RA, Santelli JS, Hirsch JS. Sex education and sexual socialization: roles for educators and parents. Perspect Sex Reprod Health. 2007;39(2):116–119. DOI:10.1363/3911607.
25. Carrere J, Sánchez E, Serral G, et al. (2022). La salut i els drets sexuals i reproductius a la ciutat de Barcelona. Any 2020. https://www.aspb.cat/salut-drets-sexuals-reproductius-barcelona-2020.
26. Ruiz-Muñoz D, Wellings K, Castellanos-Torres E, et al. Sexual health and socioeconomic-related factors in Spain. Ann Epidemiol. 2013;23(10):620–628. DOI:10.1016/j.annepidem.2013.07.005.
27. Pérez G, Martí-Pastor M, Gotsens M, et al. Salud y conductas relacionadas con la salud según la atracción y la conducta sexual. Gac Sanit. 2015;29(2):135–138. DOI:10.1016/j.gaceta.2014.07.013.
28. Malmusi D, Pérez G. Aborto legal en mujeres inmigrantes en un entorno urbano. Gac Sanit. 2009;23(S1):64–66. DOI:10.1016/j.gaceta.2009.05.006.
29. Cartera de Serveis de les Unitats d'Atenció a la Salut Sexual i Reproductiva de Suport a l'Atenció Primària,. (2007). Testimony of Generalitat de Catalunya. Departament de Salut. & Generalitat de Catalunya). http://salutweb.gencat.cat/web/.content/_ambits-actuacio/Linies-dactuacio/Serveis-sanitaris/Salut-sexual-reproductiva/Model_cartera_de_serveis/placarte.pdf.
30. Juárez Martínez O. (2015). Programas de prevención del embarazo, las infecciones de transmisión sexual, incluida la infección por el VIH/SIDA, entre jóvenes escolarizados de Barcelona ciudad (1992-2014). Universitat Autònoma de Barcelona.
31. O'Cathain A, Murphy E, Nicholl J. The quality of mixed methods studies in health services research. J Health Serv Res Policy. 2008;13(2):92–98. DOI:10.1258/jhsrp.2007.007074.
32. Berenguera Ossó A, Fernández de Sanmamed Santos MJ, Pons Vigués M, et al. (2014). Escuchar, observar y comprender. Recuperando la narrativa en las Ciencias de la Salud. Aportaciones de la investigación cualitativa (1a edición).
33. Patton MQ. Qualitative research and evaluation methods. integrating theory and practice. Saint Paul, MN: SAGE Publications, Inc; 2014.
34. Kvale S. Las entrevistas en investigación cualitativa. Madrid: Ediciones Morata; 2011.
35. Andreucci P, Guajardo Soto G. El potencial creativo de los grupos triangulares: una aproximación intersubjetiva y dialógica. Revista Akadèmeia. 2016;7(2):65–76. http://revistas.ugm.cl/index.php/rakad/article/view/129/123.
36. Saura S, Jorquera V, Rodríguez D, et al. Percepción del riesgo de infecciones de transmisión sexual/VIH en jóvenes desde una perspectiva de género. Atención Primaria. 2019;51(2):61–70. DOI:10.1016/J.APRIM.2017.08.005.
37. Forcadell–Díez L, Baroja J, Pérez G. Overcoming the difficulty of recruiting young people. keys to obtaining qualitative data in a study of sexualities. Gac Sanit. 2020;34(5):524–527. DOI:10.1016/j.gaceta.2019.08.002.

38. Conde Gutiérrez del Álamo F. (2009). Análisis sociológico del sistema de discursos. Centro de Investigaciones Sociológicas.
39. Ajuntament de Barcelona. Departament d'Estadística i Difusió de Dades. (2019). Característiques de la població de Barcelona segons el Padró Municipal. https://www.bcn.cat/estadistica/catala/dades/tpob/pad/padro/index.htm.
40. World Bank. (2019). World Bank country and lending groups – World Bank Data Help Desk. Country Classification. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519.
41. Oficina Municipal de Dades. (2018). Distribució territorial de la Renda Familiar Disponible per Càpita a Barcelona, any 2017. http://barcelonaeconomia.bcn.cat.
42. Ketting E, Ivanova O. (2018). Sexuality education in Europe and Central Asia. State of the art and recent developments. https://oegf.at/wp-content/uploads/2021/09/BZgA_Comprehensive-Country-Report_online_EN.pdf.
43. Martínez JL, Carcedo RJ, Fuertes A, et al. Sex education in Spain: teachers' views of obstacles. Sex Educ. 2012;12(4):425–436. DOI:10.1080/14681811.2012.691876.
44. Bucchianeri MM, Eisenberg ME, Neumark-Sztainer D. Weightism, racism, classism, and sexism: shared forms of harassment in adolescents NIH public access. J Adolesc Health. 2013;53(1):47–53. DOI:10.1016/j.jadohealth.2013.01.006.
45. Gegenfurtner A, Gebhardt M. Sexuality education including lesbian, gay, bisexual, and transgender (LGBT) issues in schools. Educ Res Rev. 2017;22:215–222. DOI:10.1016/J.EDUREV.2017.10.002.
46. Anderson JE, Lowen CA. Connecting youth with health services: systematic review. Can Fam Phys. 2010;56(8):778–784.
47. Baltag V, Mathieson A. (2010). Youth-friendly health policies and services in the European Region. http://www.euro.who.int/__data/assets/pdf_file/0017/123128/E94322.pdf.
48. Hardee K, Croce-Galis M, Gay J. Are men well served by family planning programs? Reprod Health. 2017;14(1):14. DOI:10.1186/s12978-017-0278-5.
49. Mazur A, Brindis CD, Decker MJ. Assessing youth-friendly sexual and reproductive health services: a systematic review. BMC Health Serv Res. 2018;18(1):216. DOI:10.1186/s12913-018-2982-4.
50. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. J Am Med Assoc. 2002;288(6):710–714. DOI:10.1001/jama.288.6.710.
51. Carlisle J, Shickle D, Cork M, et al. Concerns over confidentiality may deter adolescents from consulting their doctors. A qualitative exploration. J Med Ethics. 2006;32(3):133–137. DOI:10.1136/jme.2004.011262.
52. Ruane-Mcateer E, Amin A, Hanratty J, et al. Interventions addressing men, masculinities and gender equality in sexual and reproductive health and rights: an evidence and gap map and systematic review of reviews. BMJ Global Health. 2019;4(5):e001634. DOI:10.1136/bmjgh-2019-001634.
53. Falguera G, Lluch MT, Costa D, et al. GRASSIR Anàlisi del web sexe joves: www.sexejoves.gencat.cat. Annals de Medicina. 2014;97:150–154.
54. Thomée S, Malm D, Christianson M, et al. Challenges and strategies for sustaining youth-friendly health services – a qualitative study from the perspective of professionals at youth clinics in northern Sweden. Reprod Health. 2016;13(1):147. DOI:10.1186/s12978-016-0261-6.

Résumé

Une expérience positive de la sexualité pendant la jeunesse est déterminante pour une bonne santé sexuelle plus tard dans la vie. Il est donc essentiel de répondre aux besoins de santé sexuelle des jeunes et à leurs droits sexuels et reproductifs. Cette étude visait à identifier les besoins de santé sexuelle non satisfaits parmi les jeunes dans la ville de Barcelone (Espagne) au moyen d'une recherche à méthodes mixtes. Nous avons analysé les récits de jeunes (n = 50) âgés de 14 à 24 ans de différents genres, origines, sexualités et milieux socioéconomiques, recueillis de janvier à avril 2019. Une analyse statistique descriptive a aussi été réalisé sur les dossiers des visites aux services de santé sexuelle et les raisons de la

Resumen

Una experiencia positiva de sexualidad durante la juventud es clave para una buena salud sexual más adelante en la vida. Por consiguiente, es esencial atender las necesidades de salud sexual y derechos sexuales y reproductivos de las personas jóvenes. El objetivo de este estudio era identificar las necesidades no satisfechas de salud sexual de jóvenes en la ciudad de Barcelona (España) por medio de la investigación de métodos mixtos. Analizamos las narrativas de jóvenes (n = 50) de 14 a 24 años con diferentes géneros, orígenes, sexualidades y condiciones socioeconómicas, recolectadas entre enero y abril de 2019. Además, se realizó un análisis estadístico descriptivo de los registros de consultas a servicios de

consultation. Nous avons constaté que 32 161 (21%) jeunes, âgés de 14 à 24 ans, avaient utilisé des services de soins de santé sexuelle à Barcelone entre 2015 et 2017, alors que les raisons de la consultation variaient selon le sexe, le genre et l'environnement socioéconomique. Les jeunes ont déclaré qu'ils avaient besoin de davantage d'informations pour jouir de leur sexualité, pour savoir où aller en cas de situation inattendue et pour apprendre comment combattre les violences sexistes. Ils ont affirmé que l'éducation à la sexualité qu'ils avaient reçue était insuffisante et axée sur les risques. Nous avons observé que l'éducation sexuelle formelle est lacunaire et que l'éducation sexuelle informelle assumait donc un rôle majeur. Les services actuels peuvent être améliorés en élargissant la couverture, en formant des professionnels et en réduisant les obstacles à l'acceptabilité et l'accessibilité. Le sexisme est omniprésent dans les rapports sexuels, les fréquentations et les relations personnelles. Nous recommandons de planifier des services de soins de santé sexuelle et une éducation sexuelle formelle dans laquelle une solide stratégie de genre sera intégrée, comme élément de la même stratégie.

salud sexual y las razones para la consulta. Encontramos que 32,161 (21%) jóvenes, de 14 a 24 años, habían usado servicios de salud sexual en Barcelona entre 2015 y 2017, mientras que los motivos para las consultas difirieron entre sexos, géneros y condiciones socioeconómicas. Las personas jóvenes declararon que necesitaban más información para disfrutar su sexualidad, para saber a dónde ir en caso de una situación inesperada y para aprender a combatir la violencia de género. Dijeron que la educación en sexualidad que habían recibido era escasa y centrada en riesgos. Encontramos que la educación sexual formal es escasa, por lo cual la educación sexual informal adquiere el rol principal. Los servicios actuales pueden mejorarse ampliando la cobertura, capacitando a profesionales y reduciendo las barreras de aceptabilidad y accesibilidad. El sexismo es ubicuo en las relaciones sexuales, románticas y personales de la juventud. Recomendamos planificar los servicios de salud sexual y educación sexual formal, en los que se incorpore una sólida estrategia de género como parte de la misma estrategia.