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Knowledge, Attitudes and Perceptions regarding modern  
contraceptive methods  
**A qualitative study of young men**

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## Abstract

**Background:** Since 1994 the need for joint sexual and reproductive health (SRH) responsibility between men and women to achieve gender equality and reduce health inequalities has received more attention. The focus has been on young people as they transition into adulthood and are vulnerable to the negative consequences of early pregnancy and childbirth, STIs and early parenthood. Traditionally, contraception has often been regarded as a women's responsibility however recent efforts have pushed for men's involvement to improve contraceptive use and reduce unwanted pregnancies and STIs, including HIV.

**Aim:** The overall aim of this study was to understand modern contraceptive use among young men in Sweden. With the objective to identify and explore the knowledge, attitudes, and perceptions of contraceptives and to explore the experiences of decision-making of male contraceptive methods among young men.

**Method:** Qualitative content analysis was used as the method of analysis. This study used semi-structured interviews with six young men in Southern Sweden. Interviews were conducted in the fall of 2017, and a gatekeeper was used to identify suitable participants between the ages of 20-30.

**Findings:** Within the context of the young men transitioning into adulthood, contraceptives played an important role in growing up particularly in long-term relationships. Although, they idealized contraceptives to be of equal responsibility between men and women. The findings showed contraceptives were seen as a woman's responsibility. Between condoms and vasectomy, the men felt they lacked options and their role in contraceptives was limited. Young men in this study displayed difficulties in expressing emotions, and recognized a need for men's care where they can go for help.

**Conclusions:** The young men's attitudes and perceptions needs to be considered in order to understand their health needs. Within public health, this has huge repercussions for interventions involving men and adopting gender-transformative programming. An important step forward would be to increase men's sense of responsibility and involve them in taking preventative measures. Further research is needed on how to effectively involve men in already existing SRH clinics/spaces.

*Keywords: reproductive health, men's health, youth, contraceptives*

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## 1. Introduction

### 1.1 Sexual and Reproductive Health among young men: a global perspective

Traditionally Sexual and Reproductive Health (SRH) has been regarded mainly as ‘women’s issue’ and the responsibility of women (Hoga et al., 2014). In the past, men were only partially involved or not at all, and the vast majority of studies focus on men as partners and supporters alongside women (Edwards, 1994). In the 1980s, the Demographic Health Survey collected standard data on women’s SRH and for the first time it added men as partners and husbands (Varga, 2001). Since the International Conference on Population and Development, men have become more involved in SRH programs on the premise that men who are educated on SRH issues are more likely to support their partners’ decisions on contraceptives and family planning with the aim to improve women’s health (Guttmacher Institute, 2003; UN, 1995). Since then men have been increasingly involved in fatherhood and childrearing as a means to increasing men’s participation in gender equality (Sonenstein, 2000). More recently, efforts to push for more gender-equitable behaviour and attitudes<sup>1</sup> has been linked to men’s involvement in SRH.

Several studies point to the importance of capturing the transition from adolescence to adulthood with regards to sexual behaviours, contraceptive use and its impact later in life (Dariotis et al., 2008; Sonenstein, 2000; WHO, 2000). Although there is an abundance of literature on women’s SRH throughout the life-course, less is known about young men’s sexual health concerns and needs (Barker, 2003; UNFPA, 2017; Varga, 2001; WHO, 2000). The more recent international policy debate emphasizes the need to provide information and services for young people in order to safeguard their health and rights (UN, 1995). Despite efforts made on an international level, a majority of young people today still lack adequate information about sex, relationships and sexual responsibilities and access to SRH care services (UNFPA, 2016; WHO, 2000).

There is general agreement that men’s reproductive health concerns are not being met. These include family planning, prevention and treatment of STIs, sexuality and sexual dysfunction,

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<sup>1</sup> For a better understanding of gender-equitable, see Barker, 2003 and Sonenstein, 2000. One of the four indicators for defining gender-equitable men focuses on assuming responsibility for SRH that includes discussing SRH issues with a partner, condom use, or assisting a partner in using a contraceptive method or seeking abortion (Barker, 2003).

psychosexual problems, infertility, prostate and testicular cancers, and urologic conditions (Cohen & Burger, 2000). Acknowledging that men need sexual and reproductive services for themselves has been a factor in building partnerships with men in SRH (ibid). The World Health Organisation published a report on the health needs of adolescent boys, emphasizing the need for gender-specific sexual health interventions during the period of transition into adulthood (WHO, 2000). As men transition into adulthood having little to no contact with health care professionals (WHO, 2000). Even when specific SRH services are available for young people, the majority of clients are young women. Still today, young men regarded reproductive health as a 'female' issue and clinics to be 'women's spaces' (Bender & Fulbright, 2013; Sonenstein, 2000). The persistence of traditional perceptions on masculinity among men create reluctance to seek sexuality education and health care (WHO, 2010). Furthermore, recent reports (Hoga et al., 2014; Schalet et al. 2014; WHO, 2010) indicate a gap between health policy-level of developed countries and research findings when addressing gender-specific needs. Today, many intervention policies aimed at SRH services focus heavily on women, particularly on contraceptive use, whilst ignoring the importance of gender roles and attributing equal responsibility among men and women in questions relating to SRH and the decision-making process of contraceptives use (Hoga et al., 2014).

## 1.2 Contraceptive use among young men: public health relevance

Globally, the use of modern contraception has marginally increased over the last two decades, from 54% in 1990 to 57.4% in 2015 (WHO, 2017). The various programs aimed at promoting contraceptive use and awareness among young people reinforce a rights-based approach to SRH and family planning. Further, contraceptives reduce the need for emergency contraceptives and abortion. As women are the main users of contraceptives<sup>2</sup>, both researchers and health service providers have focused almost exclusively on women (UNAIDS, 2015b). With modern developments, men became excluded from contraceptive decisions (Edwards, 1994), whereas male and receiver/female condoms are the only modern contraceptive method that provide protection against STIs, including HIV and unintended pregnancies simultaneously (UNAIDS, 2015b).

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<sup>2</sup> Currently, 16 of the 18 WHO approved modern methods of contraceptives rely on the female as the user. Male contraceptives are limited to male condom and vasectomy (WHO, 2017). It is important to note that in some instances it was not possible to obtain information on male contraceptive use, particularly on condom use, as this information was only available for women. For example, women were asked about male condom use.

In 2015, the most common modern methods of contraceptives in Europe was the Pill and intrauterine devices (IUDs) with 22% and 11% respectively (UN, 2015). Male condom use was reported to be at 17% of the total modern contraceptive among married or in-union women aged 15-49<sup>3</sup> (UN, 2015), while 30% used no contraceptive (Ibid). Condom use among men has increased in many countries but is still inconsistent and varies depending on the nature of the partner and length of relationship (Barker, 2003; Ku et al., 1994). Among stable partners, condoms are used mainly for pregnancy prevention and for casual partners condoms are primarily used for STI prevention, including HIV (WHO, 2000). The lack of communication between partners regarding contraceptive use was highlighted as a major issue to be addressed to promote contraceptive use (Barker, 2003; Brindis et al. 1998). Thus, condom use is reported to be higher when there is an open communication between partners and men support their partner's contraceptive use (Barker, 2003; Brindis et al. 1998; WHO, 2000). Many men stress the importance of communication around sex and reproduction but lack the skills to do so (Hardee et al., 2017; Hoga et al., 2014). Therefore, it is suggested that young men's involvement in contraceptive decision-making and supportive partner involvement can lead to higher contraceptive use, even if a female method is chosen (WHO, 2000; Brindis et al. 1998).

The wide range of research focused on contraceptive decision-making among male population distinguishes between external and internal barriers to contraceptive use. Some of the external barriers include availability and accessibility to condoms, cost and intermittent sexual activity (Brindis et al. 1998; Barker, 2003; Lindberg et al., 2006; WHO, 2000). Internal barriers include inconsistent and incorrect use of condoms, reported discomfort, lack of perceived risk and gender norms that inhibit communication and sexual scripts or norms about whose responsibility it is to propose condom use (Barker, 2003; MacPhail & Campbell, 2001).

Findings from a number of surveys conducted among young men, identified that there is a lack of health information and access to SRH services (Lindberg et al., 2006; Sonenstein, 2000), more precisely gender-specific health information and regular contact with health care professionals. The lack of information is further complicated by the disparity between male and female adolescents in terms of how effective sexuality education is in shaping long-term sexual behavior (Lindberg & Maddow-Zimet, 2012; Mueller et al., 2008). Therefore, the

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<sup>3</sup> The 'use of the male condom is likely underestimated given that where there is dual method use the more effective method used is recorded' (UN, 2015).



effectiveness of targeting SRH problems relies upon the ways of addressing the information asymmetry between two genders (Brindis et al. 1998; Barker, 2003; Promundo, 2010; UNFPA, 2017; WHO, 2000).

### 1.3 Contraceptive use among men in Sweden

A Swedish survey of Sexuality and Health among Young People– UngKAB15, showed the most prevalent contraceptive method used during last intercourse was an oral contraceptives (OCs) combined with a condom (Folkhälsomyndigheten, 2017; Tikkanen et al., 2011). Despite this, a number of studies have shown that OCs have a negative impact on STIs and unplanned pregnancies (Mohllajee et al., 2006; Peipert et al., 2007). The main reason is that the use of OCs can lead to a decrease in condom use, hence, increasing STI rates and unintended pregnancies (Fridlund, 2014; Mohllajee et al. 2006; Novak & Karlsson, 2005; Ott et al., 2002; Tikkanen et al., 2011).

Recent surveys in Sweden indicate a gap between genders with regards to reported condom use. In the study by Novak & Karlsson (2005), it was found that 21% of females and 30% of males aged 18, used a condom during previous intercourse. In a study conducted by Leval et al. (2011), 50% of women and 60% of men, aged 18-30 used condoms with a previous partner. In the latest Swedish National study UngKAB15, it was determined that among those aged 15-29, 50% of people used a hormone-based method and 25% used a condom with a previous sexual encounter (Folkhälsomyndigheten, 2017; Tikkanen et al., 2011). In the UngKAB study, young people were most likely to consider condoms for protection (88%) followed by contraceptive pills (47%). However, the most common contraceptive used during their most recent sexual encounter was the opposite, namely hormonal contraceptives (50%) followed by condoms throughout sexual intercourse (25%) (Folkhälsomyndigheten, 2017). Furthermore, the study pointed to the age decline in condom use among young male respondents, from nearly 40% for 16-19 age group down to 25% among the age group between 25 and 29 (Ibid).

In the same survey (Folkhälsomyndigheten, 2017), young people were asked about attitudes to condoms use, they found that 69% of respondents agreed with the following statement; ‘a sexual partner who suggests a condom is responsible and caring’. Conversely, equal proportions of women and men, 10%, felt that a partner who proposes condoms assumes that one of them has an STI (Folkhälsomyndigheten, 2017). The study on Swedish youth highlighted the discrepancy between intent to use, actual use and perceptions about condoms

that impact its overall consistent use of condoms by both men and women. The study did not however survey the prevalence of vasectomy or youth's attitudes towards vasectomies, which can be seen as a major shortfall to understand young men's overall contraceptive use and their perceptions.

#### 1.4 Rationale for the study: why focus on men?

According to our review there are few qualitative studies that have focused on perceptions of young men during their transition from adolescence to adulthood (Barker, 2003; Dariotis et al., 2008). Research and public health interventions have often relied on the studies aimed at women's use of contraceptives; however, it is important to consider men's attitudes and behaviours (UNFPA, 2017). More specifically, it is crucial to understand what are men's needs and what do they think when it comes to contraceptive use. In order to improve SRH outcome of young people, we need to know what are the reasons that lead to use or non-use of contraceptives. Based on research gaps discussed above, the study explores men's changing perceptions during the transition to adulthood. Furthermore, the study is rested upon the presumption of the critical role of shared responsibility for contraceptive use; thus, tailoring the study to capture this aspect. Finally, internal factors shaping contraceptive decision-making among men were identified, establishing the ground for transforming the study of attitudes into inclusive approach to SRH policy-making.

#### 1.5 Aim of study

The overarching aim of this study is to understand perceptions of modern contraceptive use among young men in Sweden. Objectives:

1. To understand what is the knowledge, attitudes and perceptions of contraceptives among young men
2. To explore how young men experience decision-making of male contraceptive methods

## 2. Methods

### 2.1 Study design

This study adopted a qualitative research design as it enables the participant to pave the way and gain a deeper understanding of a phenomenon embedded in their social context (Creswell & Poth, 2017; Dahlgren, Emmelin & Winkvisk, 2007). Qualitative methods allow the participants to be at the core of the research and bring forth the way in which experiences and perceptions are socially constructed to be explored in greater depth. Qualitative research is in harmony with the ontological and epistemological assumptions in this study, meaning that the basis of the methodological approach is subjective whilst acknowledging that there are multiple realities (Creswell & Poth, 2017). Further, it is important to note that knowledge is gained through the interaction between interviewer and participants in an inductive manner to discover something new that is embedded in social construction of reality (Kvale & Brinkmann, 2009; Kleinman, 2010). Moreover, as there is scarce research conducted on young men's perceptions of modern contraceptives it justifies using qualitative research design because of its exploratory nature (Creswell & Poth, 2017; Lincon & Guba, 1985).

Qualitative Content Analysis (QCA) was used in order to describe the participants' point of view in a legitimate way to find the underlying meaning of their thoughts (Kvale & Brinkmann, 2009; Graneheim & Lundman, 2004). This study strived to analyse the manifest and latent meaning of participants' interviews in a systematic way (Graneheim & Lundman, 2004), encapsulated in the participants' context. Therefore, QCA, as construed by Graneheim and Lundman (2004), was regarded as a suitable method for the analysis of this study.

Due to sensitive nature of questions relating to respondent's sexual experiences and practices, in-depth semi-structured interviews were chosen as the primary data collection method. In the course of interview's preparation and conduction, knowledge and understanding were established between the interviewer and interviewee about their social context and personal experiences (DiCicco - Bloom & Crabtree, 2006; Kvale & Brinkmann, 2009).

### 2.2 Study setting

The study was conducted in Lund, Skåne. Within Swedish health sector, there is a strong regional decentralization, thus, Region Skåne is a self-governing administrative body responsible for providing its' 1.25 million inhabitants the health care they need (Lunds

Kommun, 2017). Lund municipality houses just over 118,542 inhabitants (Statistiska Centralbyrån, 2016) and the region's largest university hospital, which facilities are located both in Lund and Malmö. Lund University has more than 40,000 students and 63% of the population aged 25-64 of Lund Municipality have higher education (Lunds Kommun, 2017).

In Sweden, young people get information about sexuality, sex and contraception in school and from public health services. In 1955, Sweden was one of the first countries in Europe to introduce comprehensive sexuality education in public schools, for students ranging from 7 years to 19 years (Sherlock, 2012; Sydsjö et al., 2006). Since then, the national curriculum has undergone several changes. In 2011, Sweden introduced a new Education Act for Knowledge, Choice and Security. The curriculum outlines that students by the 5th grade (ages 10-12), should know about reproduction, birth, puberty, aging and death (Ekstrand et al., 2011; Skolverket, 2017). By the end of 9th grade (ages 15-16) students should understand the biology of the reproductive system, contraception and STIs. Furthermore, they should also be able to discuss gender equality, relationships and responsibilities (Ekstrand et al., 2011; Sydsjö et al., 2006; Skolverket, 2017).

Access to sexuality education is equally important as public health services. Alongside primary health clinics, there are more specialized clinics to support different life-stages. From the age of 12 to 23, young people can go to a Ungdomsmottagning or Youth Clinic specialized in sex, sexuality and sexual health. The Youth Clinic provides services and counselling on contraceptives, pregnancies, relationships, alcohol, and drugs and STI testing - all free of charge (Ungdomsmottagningar, 2017). After the age of 23, there are several options with regards to STI-testing and access to free condoms. The university provides free chlamydia testing at the Student Health Center. Projekt Sex, for short P6, provides student sexual health through peer-education and free condoms. Outside university, there is Lund STI-clinic located in the University hospital and the SESAM clinic located in the city center.

Since 2001, emergency contraceptives pills have been available without prescription at pharmacies and free at Youth clinics (Ungdomsmottagningar). Contraceptives that need a prescription require a visit to a general practitioner or midwife. In Lund, there are 9 clinics specialized in midwifery, that provide STI-testing and advice on contraceptives, pregnancy, fertility, abortion and specific gynaecological services. None of the clinics provide specialized sexual health care for men, however, anyone can visit a midwife.

### 2.3 Sampling of participants

Purposive sampling was the strategy employed to identify participants to ensure that the richest source of information was collected (Creswell & Poth, 2017). Simultaneously, the study identified a gatekeeper that helped in finding participants suitable within the targeted study population. Additionally, informal channels of communication were used to recruit participants.

To fit the criteria for participation in this study, one had to identify as a man who was born in Sweden and lived the majority of one's life in Sweden. The men's age had to range from 20 to 30 years, to allow for a wider range of participants with varied backgrounds and experiences, despite the UN's definition of young people (15-24). The criteria were set for three reasons. Firstly, the study deemed it unethical to recruit minors for the study because it was more important to ensure autonomy of participants. Secondly, it was important to allow for sufficient range of ages to allow for diverse experiences whilst remembering and reflecting on past experiences (Dahlgren, Emmelin & Winkvisk, 2007). Thirdly, it was important to capture the transition from adolescence to adulthood.

The study intended to interview 7-8 participants, however, this yielded a small sample of six participants. One of the six interviews was conducted via Skype as this was a preferred method by this participant due to his busy work schedule. Four additional participants were invited to participate but were unable to make time as the interviews coincided with the beginning of the academic year. Therefore, from a pool of ten persons, six were interviewed due to time constraints. All participants were given a consent form prior to the interview so they had time to consider participation. Before the start of each interview participants had the opportunity to ask questions regarding the consent form. An excerpt of the consent form can be found in Appendix 2.

The study aspired to continue sampling more participants until theoretical saturation however the sample was too small to arrive at this goal (Dahlgren, Emmelin & Winkvisk, 2007; DiCicco-Bloom & Crabtree, 2006). Despite this, similar themes and patterns emerged by interview 4, which allowed developing more questions aimed at covering the issues identified based on previous interviews.

## 2.4 Data collection methods

The data was collected using in-depth interviews, which were transcribed verbatim from the audio recordings. Before the first interview was employed, a pilot interview was carried out in August with the gatekeeper. Together with the gatekeeper, the age group was discussed and the questions were adjusted to create a more natural flow. A semi-structured interview guide with open-ended questions was prepared to establish common ground for all interviews, yet allow new notions to come forth (Kvale & Brinkmann, 2009). In addition, the interview guide included introductory ice-breaking questions to build rapport with participants. The interview guide was structured around the core themes of questions and included probing questions to guide the participants if they deviated. The interview guide can be found in Appendix 1. The following themes were used:

- Background of the participant
- Men's definition of sexuality
- Sexuality education
- Negotiation of contraceptive use and non-use

For practical purposes, the interviews were conducted in English, and thus an interpreter was not offered. English proficiency was discussed with the gatekeeper because, although Sweden has a generally high level of English and all participants were comfortable with the language, certain expressions may be missed. In addition, requiring a high level of English meant that the majority of participants had attended or were attending tertiary education.

Interviews were conducted from late August 2017 until mid-September 2017 and their length varied from 40min to 1hr 30mins. Verbal consent was given to audio record at the start of each interview after having discussed the purpose of the study and giving opportunity to ask questions. The participants were free to choose a location for the interview whilst it was communicated that it was possible to book a room to provide a neutral location at university. This resulted in a mixture of locations ranging from a café after opening hours, living-room, kitchen, and university rooms, which allowed maximum freedom for the participants to choose a comfortable and private space to speak. After each interview, analytical notes were used to contemplate on the content of each interview as well as write down key words and themes that were repeatedly used. The analytical notes were then reviewed in subsequent interviews and revisited during the analysis process. An example of these analytical notes can be found in Appendix 3.

## 2.5 Data analysis

The analysis of the collected data was done in accordance with Graneheim and Lundman's (2004) approach to qualitative content analysis at both manifest and latent level. Adapted from nursing research and education, QCA can be applied to a variety of data and interpreted to varying degrees depending on the subjective interpretation (Ibid). In addition, QCA allows for a thick description of a phenomenon (Elo & Kyngäs, 2008).

The data analysis process followed the subsequent steps. Firstly, the transcribed material formed the basic unit of analysis being studied. Secondly, the transcripts were read several times to understand the material and exclude irrelevant information. Thirdly, the unit of analysis was organized into clusters encompassing related aspects and concepts to form meaning units. This was followed by a condensation of meaning units into shorter text whilst preserving the core essence of the message. As much as possible, the words of the participants were retained to ensure the study's consistency and legitimacy. This initial process was followed by creation of codes uniting various meaning units. The process from condensed meaning units to code was done with the assistance of a special Macro complement for Microsoft Word program that allowed to see the condensed meaning unit and code simultaneously. Thereafter, Excel was used to find the underlying denominator of the codes to form the manifest sub-categories and categories. Categories and sub-categories were revisited by re-reading the transcripts a number of times to ensure all relevant data was included and the categories mutually exclusive (Graneheim & Lundman, 2004). The data analysis process is illustrated in Table 3. Although the example of the analytical process presents itself as linear or straight forward it is important to bear in mind the cyclical nature of qualitative research (Ibid).

## 2.6 Ethical considerations

The main ethical concerns revolved around the study design and ensuring it was in accordance with the ethical principles of the International Ethical Guidelines for Health-related Research involving Humans set by the Council of International Organizations of Medical Sciences (CIOMS) (CIOMS, 2016), and the principles of autonomy, beneficence, non-malevolence and justice pertaining of qualitative research in the field of public health (Dahlgren, Emmelin & Winkvisk, 2007).

The consent forms were distributed to the participants explaining the purpose and the voluntary nature of the study. As such, verbal consent was deemed sufficient in this research. Participants were made aware that it was possible to withdraw from the study at any given point. The participants were reassured the interviews and transcribed material would be strictly confidential. Thus, any identifying information about the participants was omitted to ensure anonymity (Dahlgren, Emmelin & Winkvisk, 2007). Permission to audio-record was given by each participant, and it was made clear to each participant that they could request the audio-recorder to be turned off at any point in time during the interview. A copy of the informed consent form can be found in Appendix 2.

The study considers biological sex and gender as a factor in this research that must be taken into account. Whilst the age group of the participants may be similar to that of the researcher, the biological sex and gender is not and thus may affect the way in which the participants express themselves. For this reason, it was crucial to take into account two issues. Firstly, to formulate open-ended questions so the researcher could evaluate their attitudes and perceptions regarding contraceptive use. Secondly, to build rapport with participants by being friendly and relaxed before and after the interviews. Further, for maintaining anonymity the names were changed into numbers in this thesis.

Based on Kvale and Brinkman's (2009) seven stages of research design and implementation, a more comprehensive table of the ethical considerations that arose throughout the course of the research can be found in Table 1.

### 3. Findings

In total, six young men were interviewed that varied by age and educational background. All male participants were single at the time of interview and had achieved tertiary education. A summary of the sample's sociodemographic characteristics can be found in Table 2. All but one of the participants recollected past relationships where contraceptives were discussed. Participants recalled sexual encounters and discussions on contraceptives as recent as 2 weeks to several years prior to the interview. All participants lived in Skåne, Sweden, at the time of interviews. With regards to knowledge of contraceptives, all participants were able to mention some contraceptive methods for both men and women, even if they only knew the words in Swedish. Some participants were hesitant to talk more in depth about women's contraceptives, for example IUDs or implants, as they were not familiar with them. Some participants were uncertain of a vasectomy procedure and lacked vocabulary to explain vasectomies and its effect



on the body. Among the different contraception methods, participants were most familiar with condoms; thus, it was easier for them to discuss condoms openly.

The analysis of the six interviews conducted resulted in one underlying theme; which connects five main categories and 12 sub-categories. The overarching theme is: **contraceptives: a juggle between social norms, lack of knowledge and communication**, which reflects the young men's attitudes and perceptions of contraceptives, their experience of decision-making and their SRH needs. This also revealed the young men's decision-making process with regard to rationalizing between condom and vasectomies. The theme is the connective thread which binds the five categories together.

Category 1, 2 and 3 address research objective one, and category 4 and 5 explain research objective two. The first category **realizing sexuality education was not enough** deals with the varied experiences of sexuality education and the gaps. It reflects the ways men perceive their education as an agent to frame sexuality and contraceptives as well as discussing knowledge. Second category addresses, the **role of external pressures in shaping perceptions** which looks at the ways men perceive external pressures as they become older. **Contraceptive use: a shared responsibility in theory but not in practice** embraces the ways in which the participants perceived contraceptives as women's responsibility whilst idealizing the need for mutual responsibility and how this impacts their experience of decision-making. The fourth category, **feeling caught between a rock and hard place** sheds light on the way the young men seemed to feel stuck without a way out; by perceived risk of pregnancy and STIs based on their trust for the partner and lack of motivation to use condoms. The final category, explores the **feeling that my voice is unheard** due to the lack of opportunities to share and express emotions and realizing their health needs are unmet. The final analytical model is summarized in Table 4.

To answer the overarching aim of the research, the findings have been structured according the categories found. In the following section, each category name is shown as a heading (in bold and numbered). Under each of these headings, the sub-categories are introduced in bold text and direct quotes from the participants (in italics) are used to help the reader understand the analysis on the bedrock of participant's verbatim.

### 3.1 Realizing my sexuality education was not enough

All participants have had sexuality education as part of their formal education in Sweden, although had different experiences. Participants acknowledged that **the role of education in framing knowledge and attitudes**, that gave them the basic knowledge and foundation to understand the body and practice safer sex.

*They gave us basic knowledge, we talked about menstruation. I will never forget! It was confronting for a 16-year-old – Participant 3*

*...very basic, a few hours talked about heterosexuality and homosexuality, how to use a condom and STIs, not very much they could have done more...- Participant 5*

*Basic knowledge made me use a condom and get to know a person before becoming sexually active because of the dangers and risks- Participant 3*

Some participants elaborated on their basic education and spoke of other sources of information that were complementary to formal sexuality education. For some participants, external sources such as a youth clinic and pornography played a role in sexuality education.

*...they sent us a month after to a youth clinic and talked about how to masturbate into condoms. That was the 2nd time we had sex ed. We were 12-13, it was weird! Can't you do it without a condom, they called it luxurious masturbation I remember that...- Participant 6*

*In high school, we had information from the youth clinic they receive young adults for free and give [STI]tests, information and counselling. They educate you...- Participant 3*

*Porn is a big thing in society. Kids learn how to have sex from porn...young people from 10-12 that is their first time they are exposed to porn, even hard-core porn and that is how they see things! When they grow up they have expectations and they want to do what they see on tv. that's the way they see things – Participant 6*

There were mixed feelings about youth clinics, neither overtly positive or negative. Pornography, on the other hand, was seen as an element of sexuality education for young men that impacted sexuality in a negative manner. One of the participants above the age of 23 and no longer able to go to a youth clinic, discussed his life and sex within the context of a young university student. He visited a student driven organization called Projekt Sex, P6 for short, that provided him with information and free condoms;

*...in university, P6 and they talked about this is the clitoris and how it looks and of course talking about condoms and that we should use them! – Participant 3*

Although participants shared the feeling that basic sexuality education was covered in school, many felt it was not sufficient and **questioned the quality of sexuality education**. The participants felt that the quality of education was poor in educating them in social aspects, health and a greater understanding of the risks of pregnancy.

*The basics of reproduction, how to use a condom and STIs but is a big problem, its limited to natural science and not at all social science – Participant 2*

*...i feel that they missed out on something...the risks of making someone pregnant because as a young person...you realize how easy it is to make someone pregnant! – Participant 3*

When participants discussed their perception of the shortcomings of their sexuality education it was evident that each participant felt differently and some needs were not met. The young men wanted to learn more about SRH issues that affected them. One participant went as far as to say he had not received any education, although he had received formal education in school. He emphasized that friends were the main source of information and knowledge about sex and sexuality.

*None, actually! I think we had sex ed. in 6th grade for about a month. We didn't get taught anything. We watched porn with our teacher, that what we did at school! I don't think it helped at all. I didn't talk to my parents either, I just knew I guess, you mostly talk to friends and learn as you go... when it comes to education we need to sit down and actually talk about what we need as real education. Not only diseases and how easy it is to die from diseases or get pregnant. It's not enough – Participant 6*

The participants made the link between formal sexuality education received and how we perceive sex on a whole. Further, participants made the link between how we perceive men and women in society and the idea that sex and sexuality is something that is shaped by education. This was shared by participants in various ways;

*Education is the most important thing. How we understand and perceive sex in society that's how we work – Participant 6*

*...not the biological aspect of it, but rather the social aspects of sexuality and how that links with everything else we do in society and how stereotypes and gender roles are very much connected to socialized beliefs and ideas about sexuality – Participant 2*

### 3.2 The role of external pressures in shaping perceptions

Growing up and becoming a man, in some form or another, was discussed by every participant as an important aspect of sexuality and contraceptives. Experiences of growing up varied

between participants but all had the common notion that friends were strong influencers in a young man's life. Overall three sub-categories were identified as external influences that shaped their perceptions of contraceptives: **the social pressure of being a man, confirming one's thoughts with peers**, and **planning fatherhood shifts the focus of the relationship**.

Feeling **the social pressure of being a man** dealt with ideas of gender expectations of young men. Some, men more than others, discussed the social pressures they felt during their younger years.

*In the end you get a lot of men who feel the need to show that they are strong and they can take care of family...there is a lot of skewed ideals about what it is like to be a man...what women are supposed to be and young girls as well! – Participant 2*

*In society, men are supposed to be stronger and the person that take care of things! I think less now than before but...they cannot show weaknesses. I think it is changing but still like that in many cases but they have it very hard more than women...it is good to have a lot of women and you're having a big dick and that you can take care of things sexually...as a man you are pressed and you feel that pressure! – Participant 4*

The concept of social pressure of being a man was linked to gender norms and expectations of acting a certain way. Those who were able to reflect more on this emphasized that social pressure impacted them most during teenage years but was still present as they became older.

As part of transitioning into adulthood, **confirming one's thoughts with peers** is seen as a normal part of learning about one's self, and defining the self through peer validation. This notion was combined with the view that peers were also a source of comparison and pressure.

*...when I was 19-20 we talked a lot about who they had sex with, how was that, why was it like that and when it was, how often...and how big their genitals are, how big their boobs are and everything like that. There is a lot of comparison going on, like teenage years, you try to figure out what am I, how do I fit into this. – Participant 1*

*When I was a teenager I was curious about sex, you want to grow up! It's exciting to talk about it because you are confirming yourself in the other person. Now I don't have the need to share...but as a teenager we talk a lot about...you learn from your friends, share knowledge and it's about becoming your own person, taking care of yourself and becoming grown up. – Participant 3*

The third sub-category, **planning fatherhood shifts the focus of the relationship**, was shared by those who saw fatherhood as an important factor to adulthood and discussions around contraceptives in the context of planning for a family.

*...close friends start to have a family, get married and have children they plan way head. Their plans are focused on where to live their focus is a little different...the defining factor, having or not having children. Children shifts your focus...-*

Participant 1

*...interesting to talk to friends who have been with their partners for 3 or 4 years or so and that changes the balance, it changes the reality of the relationship or even the purpose of the relationship! When they start talking about getting married or having children...- Participant 2*

This sub-category was very important to include because it addresses the issue of fatherhood as an important factor for entering adulthood. Wanting children or not was a key element to discuss contraceptives and how the young men engaged with contraceptives. Furthermore, this impacted their perception of contraceptives as one that changed over time and depending on where they were in their life stages.

### 3.3 Contraceptive use: a shared responsibility in theory, but not in practice

This category embraces the contradiction in the participants perceptions of contraceptives. Participants upheld **the ideal of shared responsibility**, however, this was overshadowed by attitudes of men **perceiving contraception as a women's responsibility**.

**The ideal of shared responsibility** was something they regarded as compromise and mutual understanding between two persons, but not reality.

*even though she is the one who is gonna carry the child it's equal...question yourself and you say to yourself: well of course it is the responsibility of both partners! It's mutual - Participant 3*

*...to know what the other person wants! So then you can compromise...in the relationship of course it should be mutual...condoms are also good if you know the person... It's a mutual understand. – Participant 4*

Participants shared positive ideas towards shared responsibility of contraceptives. However, the participants thought condoms were a man's responsibility. Still this notion was outweighed by participants **perceiving contraception as a women's responsibility**.

*...condoms is the man's responsibility and he should have one on him! That's sort of the norm! Furthermore, it is just the women's responsibility – Participant 3*

*...contraception, in a relationship is a sort of unanimous decision where the girl has the veto right – Participant 1*

*That's how it is seen: the woman should, well the norms are like that! The women should do it and not the man! – Participant 3*

*There are a couple of new methods I've heard for men...I read an article about that actually when I studied social norms that you always see that it is a women's responsibility! – Participant 4*

*...you don't even think about it, so when she said I don't [take birth control pills], I said why?...I couldn't really understand I mean if you want to have sex shouldn't you! You don't want kids right? So why don't you take them!?! -Participant 6*

Furthermore, the notion of women's responsibility was emphasized by feelings of normalization around women taking contraceptives, that excluded men.

*I have met so many people, girls, who have taken pills! It is such a normal thing here! That you don't even think about it... it is such a normal thing it's like taking a paracetamol – Participant 6*

*It's always been women that had these problems, you know these sexual problems! We men don't have anything to do with it! We're just happy and we do our thing! That's the stereotype! Of course, it is just the same for me! – Participant 3*

*It comes back to gender stereotypes...because the acceptability for female hormonal drugs is accepted and used widely! But not proven to be great for your body!...I think it is ridiculous that we are super careful about the male alternative but women have been dealing with the effects of these hormones for 5 or 6 decades now! That's just been okay with everyone! – Participant 2*

On the other side of the spectrum, one of the participants felt that men taking contraceptives was not normal in the way he perceived men. He expanded by emphasizing that contraceptives were associated with femininity and feminized objects.

*The concept of a man taking these is not something that is normal in your perception of men and women or even perception of humans! It's such a female thing because females have been doing it! It's feminized, makes you seem more feminine! Like heels, also something very feminine. It's just a feminine thing so I associate it with women. It's not something you associate with men. – Participant 3*

Despite the slight differences in how contraceptives were perceived, the similarities point toward women having the main responsibility. The participants held up the norm that women were responsible for contraceptives, contrasting to the idea there should be equal responsibility among partners. Shared responsibility was not a common idea held by all and it was enveloped

by the notion that contraceptives were associated with femininity and women, emphasising the gendered-notion of contraceptives.

### 3.4 Feeling caught between a rock and hard place

The category **feeling caught between a rock and a hard place** addresses the young men's contraceptive decision-making towards male contraceptives. They felt undesirability of condoms due to lack of sensitivity. On the other hand, when discussing vasectomy men expressed undesirability and lack of knowledge surrounding this contraceptive method, leaving them stuck with little choices.

**The construct of risk based on trust**, is a sub-category that all participants had in common in one way or another, reflecting their experience of choosing whether to use contraceptives or not was based on trust. Participants assessed the risk of pregnancy and STIs based on trust with a sexual partner, and thereafter made a choice to use contraceptives or not. On the whole, participants perceived high risk in short-term sexual relationships due to lack of time to build trust and unknown STI status.

*In short-term relationships, there is no time to build trust and check for STIs. The conversation is 'are you clear?', yes, I am, want to top using condoms? I have had those conversations too. – Participant 1*

*...if i meet someone it is not something I think of as a big risk...it comes pretty natural to me and if you feel like you trust the person! I like to trust people. (laughs) Let's put it that way! – Participant 2.*

*...when it is a one night stand you don't know the other person...you just don't know if she or he has diseases or if she wants a baby or something and is just looking for someone to get her pregnant so you go into those thoughts. – Participant 4*

One participant expanded without prompting by expressing a friend failed to use condoms due to blind trust in others', whilst another participant expressed his thoughts of not knowing if the partner had a contraceptive method until after they had had sex and discussed contraceptives;

*...I know that a lot of my friends don't [use condoms]! Because they have too much faith I guess and too much trust in people, that's why a lot of women have kids today! That's kind of crazy...- Participant 6.*

*Some weeks ago, I had sex with a girl and I didn't know if she had something and I thought a lot about it...She told me, 'just so you know I'm on the spiral', we didn't talk about it before or directly after, it took 3 or 4 days after – Participant 5*

This sub-category shows that the construct of risk is not uniform among all participants. More importantly the construct of risk depends on the level of perceived trust with the partner. Furthermore, all participants noted that trust was gained through time and therefore short-term sexual partners were often perceived as a higher risk, particularly for STIs. On the other hand, some participants showed that they were often unaware of their partner's contraceptive method and did not use a condom. Furthermore, often discussing contraceptives came up in conversations after sexual intercourse.

Once the participants discussed trust they began to reinforce the idea that using condoms is safe but affects sensitivity was the most common held perception but not universal among participants, resulting in **undesirability of condoms due to lack of sensitivity**.

*...if anyone would come to me and ask questions which they probably won't but I would suggest condoms it is the safest. – Participant 1*

*Growing up in Sweden condoms are free in school and health centres...condoms are the most spread method, I think the most practical! – Participant 2*

*Condoms lower sensual experience so you think how to have sex without... – Participant 3*

Although all participants agreed that condoms were safe and practical, one thought the reduced sensitivity can sometimes be a positive aspect of condom use.

*I'm pro-condoms. Some claim they don't feel anything when they wear condoms, sure you get less sensation but it's not like you don't feel anything. Sometimes it can be a good thing!...I feel the condoms is adding to my stamina, I like it, it's not messy – Participant 1*

The majority of participants expressed feelings of undesirability and lack of knowledge when discussing vasectomies.

*Vasectomy hasn't really been present in my life, when growing up or even now it's not something I would consider and I don't think any of my friend would either! It's...better to promote to use condoms than spreading vasectomy as a contraceptive method. – Participant 2*

*...you could sterilize someone but that's not very desirable! A vasectomy! I would never do a vasectomy!...shouldn't make a woman sterile either! I don't think it's justified I don't think it is a viable option to do! Just protect yourself! - Participant 3*

*I don't know about vasectomies, are they permanent like spirals?- Participant 4*



It is hard to say whether vasectomies are undesirable due to lack of knowledge but it was evident that participants didn't see vasectomies as a viable option due to its irreversibility and long-term effects. In contrast, condoms were seen as a safer option but impacted sensitivity. Thus, from the two modern methods of contraceptives available for men, men were essentially left with one contraceptive choice; condoms. All participants were pro-condom despite stating lack of sensitivity as the main drawback. Furthermore, participants shared that many times condoms were a normal and natural part of sex.

*I usually just go for the condom! We don't really discuss it, sometimes it is so natural! I want to be safe too! My instinct is to go for a condom, many chances I just put on a condom and continue – Participant 1*

*...It could just be natural...I have a condom and I'm gonna use it! I don't care what you say – Participant 2*

### 3.5 Feeling that my voice is unheard

The feeling of being unheard was tied to the men expressing themselves towards their partners and male friends with regard to contraceptive decision-making. The young men shared a lack of emotional outlets which transpired onto other areas of life. The participants discussed the pressures of being a man and living up to daily expectations as common issues they wanted to talk about. This category is broken down into 3 sub-categories, where the participants felt that **I have a limited role in decision-making, expressing emotions is difficult for me and recognizing a need for men's care.**

Participants reflected on this by expressing **I have a limited role in decision-making**, focusing on the context of a relationship, couples should have equal share of responsibility for contraception yet the young men felt their role was limited. The participants realized their role was limited due to social norms and personal ideas about women's responsibilities. Some participants felt they had a limited role with regard to contraceptives and the decision-making. Feelings of wanting more responsibility was expressed within the context of relationships and mainly for pregnancy prevention.

*It is important that not only women should feel like they can do something about it so it is really important...that me as a man can have sex even if I don't want to use a condom I can have sex and not have to feel worried about making someone pregnant so I can have responsibility on me as well. So that women don't have to have all the responsibility – Participant 5*

*The spiral being developed all the time with lower doses...I think it is great that it is exists. It feels like when it doesn't exist the man or male partner gets in a position where he is not able to do anything except use a condom...it is really sad that there is nothing really to do about it!...it would be good for everyone if everyone can and has the possibility to do something about it! So that everyone can take more responsibility*  
– Participant 4

Although some felt they had limited role in contraceptives, one participant shared his experience of accompanying a partner to a health clinic to get an IUD. The participant recognized that supporting their partner in obtaining contraceptive was also part of his sexual health.

*I felt great that I was there for her because it wasn't a very nice procedure and she was scared and she wanted me there so it was okay to be there! It felt nice like my responsibility to be there because it is part of my sexual health as well! So I felt really good!* – Participant 5

One of the underlying reasons that **expressing emotions is difficult for me**, was because *women talk to women, and women talk to men but men don't talk to men* was very well summarised by Participant 2. He elaborated on this sentence by explaining that women talk to their female friends and their male partners but rarely do men talk to their male friends about problems or concerns of daily life, let alone discuss contraceptives. This was then further explained in the context of men's groups movements in Sweden. Men's groups, allow men to talk to other men in safe places.

*...men getting together to talk about gender-based violence for example and sexual harassment...there is all these generations that didn't get those conversation early on in life and need to do something about it because they are still sexually active.* - Participant 2

*A place that specializes in talking about it for men, because men don't tend to talk a lot about sex and sexuality so I think perhaps having that, just for men, it could get guys who don't talk about it to go perhaps try it and perhaps affect in a positive way overall!* – Participant 5

*It's not the same for a man to talk about their feelings on such a thing but it is for women ... women are more willing to talk about those things but I think the men need the same support at the end of the day were all humans.* – Participant 4

Within the context of men's groups, the young men **recognized a need for men's care** that tailor to their needs and can help them. Although their suggestions varied, they mainly focused on a place for advice, testing and screening for men of all ages. The need to gain more information and advice from a legitimate source was a common denominator.

*...too much on the internet, perhaps a clinic just for men would be nice to talk... I haven't heard about some kind of male clinics and if it would get guys to talk about it more...it would be good to have testing, getting advice and talking about sex in an open setting! Talking about different possibilities and scenarios, and being able to just talk to someone about sex! I think it is important to have that possibility. – Participant 5*

*...my soldiers are asking me for time off from work to go a check on their private doctor...It [military health clinic] could be used for more but its not used. I think they would be very busy! Because there would be a lot of young men and women who would be happy to exploit such an opportunity at their work place, where they already feel safe and where everything is okay to talk about...almost everything – Participant 1*

*For people who have problem to go and talk about it, maybe it would be easier like a whole clinic just for men would be a good idea! Well it would be about sex, if you have questions or a disease or something that you cannot or don't want to discuss with your friends and to have a specialist for that it would be nice so you don't have to worry about it!... you get a lot of answers from the internet as well but the problem with the internet is you search for something then it says you have cancer!...I think it would be accepted because there are places just for women, gynaecologists, so women go there - Participant 4*

#### 4. Discussion

In relation to the study objective one, the overall findings of this study show that their knowledge of women's contraceptive methods and vasectomy was limited. On the other hand, participants discussed condoms with confidence and a part of their lives, even in instances when the partner's contraceptive method was unknown or they failed to use condoms. The participants highlighted the importance of looking at contraceptive use from a life-course perspective, particularly within the context of relationships and fatherhood. This resulted in a situation where the young men felt that the transition into adulthood meant going through changes in their lives and that although they had received sexuality education they realized that it was not enough to prepare them for adulthood. Although the young men idealized equality among contraceptive use their perceptions were gender-biased and the responsibility remains predominantly on women, and their attitudes revealed it had little to do with them as one of the participants explained *it's not in our vocabulary* (Participant 3).

In relation to the research objective two, the study brought to light that the young men rarely discussed contraceptives with male peers but discussed it with their female partners. Even though, some young men are communicating with their female partners but this varied greatly between each young man and the nature of the relationship. In short-term relationships, contraceptives were sometimes discussed out of failure to use condoms or after sexual

intercourse where there was a lack of decision-making on both parts. On the other hand, in long-term relationships men's experiences of decision-making of contraceptives were in the context of family planning, and mainly as pregnancy prevention. Regardless of relationship status, the young men's experiences of deciding on condoms versus vasectomy it was evident that condoms were the only option, and an unattractive one at best. Their decision-making often rested upon the assumption of the female partner was taking hormonal contraceptives and thus they were not using a condom. In fact, the findings showed that since the contraceptives were women's responsibility, the young men renounced responsibility to some extent. Resulting in limited responsibility and limited role in decision-making when it came to contraceptives. Coupling the young men's limited role in decision-making with difficulties of expressing emotions, often only talking to a partner or best friend, in situations of health concerns, may explain the young men expressing the need for SRH care for men. Furthermore, the overall findings suggest that **contraceptives are a juggle between social norms, lack of knowledge and communication.**

#### 4.1 Understanding the pressures of being a man: a life-course perspective

The issue of transitioning into adulthood was raised by the participants as a concept to express the changes occurring in their 20s and 30s. The process of growing up meant being faced with social expectations and peer pressure. This study shows that men's attitudes towards contraceptives change over time and depending on relationship thus their needs throughout the life-course change. In addition, the study puts emphasis on the importance of understanding the underlying pressures connected to gender roles attributed to men in the context of which these men live in, as they transition in to adulthood.

The variation in the young men's perceptions of transitioning into adulthood in this study has been found in studies on different contexts. Some research suggest that the male peer group is the place where young men learn and rehearse gender roles (Cohen & Burger, 2000) and that peer validation determines acceptable behaviour (Barker, 2003). However, some men report dual pressures to act like 'real men' among friends and be a provider whereby income and job status equates with manhood(Ibid).

Within the context of peer groups, this study showed that friends can be a source of negative pressure but also a positive means to vent and discuss their feelings about issues that matter to them. Similar findings in other studies indicated that male peer groups can be a source of traditions, companionship and job-related contacts (Shephard, 1996). Studies show that the

lack of opportunities to discuss and modify their gender roles among peer groups continue to be limited and thus perhaps resulting in confusion about gender roles and behaviours (De Keijzer, 1998). This becomes even more important in SRH and young people's health where understanding their contexts and experiences of everyday life become essential to overcome obstacles for accessing health (WHO, 2000). In a field where it is important to know the factors that influence young men's perceptions and attitudes we need to discern social norms, and pressures, from individual behaviour (Barker, 2003).

In addition, the participants had concerns regarding what it means to be a man and the social pressures they undergo. Studies addressing fatherhood and adolescent parenthood, show that men face pressures of dropping out of education, supporting their partner financially and becoming more involved fathers which they may not be prepared for (Cohen & Burger, 2000; Heilman et al., 2017; WHO, 2000). More recent studies looking at the Swedish context suggest a lack of research on the linkages between changing male identity, fatherhood and how external pressures influence fathers' behaviour towards contraceptives and gender equality (Plantin, Mansson & Kearney, 2003).

#### 4.2 Increasing men's sense of responsibility

Despite the fact that in this study, men idealized contraceptive use as an equal responsibility the reality revealed the responsibility remained heavily on women. The underlying reason in this study was that contraceptives were seen as feminine and not associated with men and how the young men perceived gender-roles (Herrman, Moore, & Rahmer, 2016). This raises an important question about the relationship between gender dynamics, contraceptive decision-making and responsibility.

Hoga *et al* (2014) have previously noted similar discourses with regard to contraceptive use. Two recent studies conducted within the Swedish context by Fridlund (2014) and Folkhälsomyndigheten (2017) demonstrated the responsibility for communication and prevention of pregnancy and STIs often falls on women. This finding was also concluded in older studies such as Ekstrand et al. (2007), where women were mainly responsible for preventing pregnancy which resulted in young men placing 'blind trust' in young women's use of oral contraceptives.

Conversely, this study showed that the young men perceived condoms as a man's responsibility. Studies looking at the Swedish context, showed conflicting results, pointing

toward the use of a condom to be a man's responsibility (Ekstrand et al., 2007; MacPhail & Campbell, 2001) whilst another study showed that men expected females to be 'condom promoters' (Christianson et al., 2003). This study showed that to some extent the young men did not seem to feel a sense of responsibility for themselves, this was found in a similar study in the Swedish context (Fridlund, 2014). Hence, this finding is especially important for the field of SRH at large and more particularly for programs aiming to increase men's involvement in SRH.

In a larger study, it was found that men with more egalitarian views were more likely to think that men and women have shared responsibility for contraceptives (Grady et al., 1996). For the field of SRH, it is important to understand that individual perceptions shape sexual and contraceptive decisions. This study is an illustration of this; the young men's perceptions of contraceptives was linked to their decision-making where the men were mainly absent and had a limited role to play in contraceptive decision-making. Thus, it is essential to understand how men's behaviour is shaped by their perceptions and attitudes, as well as the nature of the relationship and how this links to the experience of contraceptive decision-making (Ibid).

#### 4.3 Addressing the multiple needs of young men

The issue of men's health needs was raised by the participants posing questions about the importance of addressing the multiple needs of young men. This was brought up in the context of young men finding it hard to express their emotions and recognizing the need for care and spaces for them to discuss their concerns. This section ties it into the second objective of the study, whereby men found it hard to decide to use condoms and many times the participants said there was almost no communication or decision-making on their part. Thus, the decision-making was an internal one that revolved around whether or not to use a condom, vasectomy was not an option.

For the most part, SRH services have become synonymous with women's reproductive health and men often assumed SRH services to be for women and couples (Donnelly, 2000; Pearson, 2003; Hardee et al., 2017; Hoga et al., 2014; Lindberg et al., 2006; Varga, 2001). This study shows the young men lacked a place to go for advice and information and thus reaffirming the literature stance on the current gaps with regard to men's SRH needs (Cohen & Burger, 2000; Donnelly, 2000; MenEngage, 2017; Pearson, 2003; Varga, 2001). General SRH services include family planning, prevention and treatment of STIs, and sexuality. Tailoring SRH

services to men's needs could include services to address prostate and testicular cancers, urological conditions, and develop contraceptive counselling for young men, some of which were brought up by the participants themselves (Frey et al., 2008).

This study showed that young men found it hard to express their emotions and lacked opportunities to do so. Studies have shown that going beyond traditional family planning programs and talking with young males is important to improve communication with their partner (Brindis et al., 1998; Hardee et al., 2017), as a means to overcome internal barriers to contraceptive use (Barker, 2003; MacPhail & Campbell, 2001). Techniques to improve communication, such as couple counselling and role-playing, may help young men communicate their intent to use contraceptives and take an active role in the decision-making, even when they do not know their partner (Ibid). This has been further elaborated by Lindberg et al. (2006) suggesting that it is also important for providers to focus on improving the quality of care in existing SRH clinics. More particularly in the areas of access (Donnelly, 2000; Pearson, 2003), confidentiality, and developing youth-friendly clinics focusing on male services (Bender & Fulbright, 2013; Lindberg et al., 2006; Thomas, Murray & Rogstad, 2006).

#### 4.4 Methodological considerations: Trustworthiness

The definitions describing trustworthiness of QCA may vary; in this study trustworthiness refers to credibility, dependability and transferability as discussed in Graneheim & Lundman (2004) and further expanded by Dahlgren et al., in relation to the concept of confirmability (2007).

Credibility in its essence deals with the researcher's ability to understand the subjective reality of the participants and answering the research question (Graneheim & Lundman, 2004). Several strategies were used. Firstly, recruitment was done via using a gate-keeper but also through informal social media channels to try to capture different age groups of men. Secondly, by prolonged engagement and member-checks to provide the participants with the opportunity to read their transcripts and make clarifications. Thirdly, to ensure there was a common thread between the data and the findings, it was important to illustrate the analysis process in appendices to guide the reader through the entire process (Elo & Kyngäs, 2008). An illustration of the analytical process can be found in Table 3.

According to Lincoln & Guba (1985), dependability involves with the researcher's capacity to account for changes in the way the study was conducted. To enhance the dependability, efforts

were made to describe in as much detail as possible so that the study may be re-applied in a different context. With this in mind, a table to illustrate and further delve into the details of ethical considerations of the entire study is illustrated in Table 1. Further, it is a prerequisite that the research describes and illustrates the methodological and analytical process so that others' may understand the study findings (Dahlgren, Emmelin & Winkvisk, 2007).

Transferability refers to the degree to which the process, procedures and findings of this study and the ability to apply them to another context or group (Creswell, 2013; Dahlgren, Emmelin & Winkvisk, 2007; Elo & Kyngäs, 2008). Although some authors contest this claim by saying that qualitative research can never be entirely transplanted on to other contexts (Dahlgren, Emmelin & Winkvisk, 2007) the researcher aims to present thick descriptions and describes the context so that other researchers may evaluate its' contextual relevance (Elo & Kyngäs, 2008; Geertz, 1973). In addition, young men are not a homogenous group and the sample size was relatively small thus the findings may have limited transferability to larger groups of young men in Sweden.

Confirmability addresses the neutrality of the data and biases in the study findings (Dahlgren, Emmelin & Winkvisk, 2007). Firstly, the author aimed to bracket previous assumptions and knowledge of the topic. Therefore, it was important to return to the transcribed material to ensure the interpretations that were made based on the data. Additionally, the use of tables and quotations to highlight and display how the researcher arrived at the conclusions so that other researchers could assess the interpretations.

#### 4.5 Strengths and limitations

An important limitation of this study is that coincidentally all participants were single at the time of the interview making a comparison with young people in a relationship problematic. Despite this, since some participants recently became single and were able to reflect on their experiences with their previous partners. Furthermore, all participants identified themselves as heterosexual and thus it is perhaps of limited relevance to men who do not identify as such. However, there could be a self-serving bias for men who may identify as bisexual or homosexual but are not comfortable revealing or discussing it with someone they are not familiar with. Without having further prolonged engagement it is hard to step outside heteronormativity.



On a positive note, early in the interviews some participants showed they had a broad knowledge of various contraceptives for men and women. Their knowledge made the conversation flow smoothly and it was possible to probe earlier than anticipated. Although for some they knew the types of contraceptives by name they lacked language on how they worked, especially for women's contraceptives.

Conducting studies on young people can be precarious as some are enrolled in academic education while others are in full-time employment. Thus, the recruitment process was lengthier than expected as some participants had gone on vacation or began the academic year hence, resulting in a limited number of participants. This also meant that the educational and socio-economic background did not vary greatly between participants and reduced the credibility of the study.

On the other hand, allowing young people to be categorized up to the age of 30 highlighted aspects of men's perceptions of contraceptives that may otherwise not be captured. As some participants belong to the older range, they were able to retrospectively think about their early 20s and teenage years as well as reflect on past short and long-term relationships. Again, this may present a bias as participants are likely to ascribe successes due to their abilities but attribute failures to external factors when they are recollecting past experiences about relationships or contraceptive use (Campbell & Sedikides, 1999).

#### 4.6 Conclusion

This study contributes to the literature on young men's SRH by highlighting the need for a gender-sensitive approach to men's SRH. Understanding men's perceptions can be instrumental for public health interventions that aim to increase men's involvement and encourage them to take responsibility for their SRH. Perceiving contraceptives as women's responsibility brings research closer to understanding contraceptive use by men. One possible reason for the gendered notion of responsibility is that women have been targeted heavily by public health interventions and the fact that there are far more options available for women. Further research is needed on the linkages between gender and health behaviour, more particularly how changing gender roles impacts contraceptive use.

Within the Swedish context where SRH clinics for youth are a common part of health services, existing clinics should focus on improving youth-friendly clinics targeting male audience. Thus, more is needed, particularly of a quantitative nature, to build the strategic foundation for

improving existing SRH services and effective outreach to patients. Further it is important to go beyond clinical services and consider men-groups and that tailors to men's needs but also allow men to use support groups to talk about fatherhood and sexuality that affect men of varying ages. In the field of public health, this has huge repercussions for interventions reaching out to men but also in the context of gender-transformative programs. Consequently, an important step forward in public health interventions would be to increase men's sense of responsibility and involve them in taking preventative measures. This is even more important in such a contested field as SRH whereby men's involvement can have far reaching benefits for women's SRH outcomes as well.

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## Tables

Table 1: Ethical considerations for a qualitative study

Seven Stages of Qualitative Interview Studies (Kvale, Brinkmann 2009)		
Stage	Concern	Comments
Conceptualizing: <i>WHY?</i> <i>WHAT?</i>	<ul style="list-style-type: none"> <li>Justification for the study</li> </ul>	Although some issues may be of sensitive nature to some, it is a low risk study. Study contributes to limited studies conducted on men and contraceptives. Focused on a group of men, often side-lined by public health interventions.
Designing: <i>HOW?</i>	<ul style="list-style-type: none"> <li>Gatekeeper</li> <li>Formal Channels</li> <li>Moral implications of the study</li> </ul>	Informal contact with gatekeeper has revealed far more than expected. Gatekeeper stated concern over language barrier and socio-economic determinants of participants. Gatekeeper asked to reconsider age. Acknowledgement of biological sex and gender is essential thus researcher aims to reduce power asymmetry by conducting study within similar age group as the researcher (Creswell & Poth, 2017). Gendered nature is inevitable as the researcher is of the opposite sex of participants, and the participants are all male.
Interview	<ul style="list-style-type: none"> <li>Position of researcher</li> <li>Confidentiality</li> <li>Researcher as instrument</li> </ul>	Informal contact with gatekeeper as this person is a friend and thus social distance is more challenging. On the other hand, very open to discuss the study and willingness to help. Rapport but not an expert, state this is for my Master Thesis. Previous assumptions and knowledge will be bracketed to its fullest capabilities however knowledge of the methods of contraception is needed to be able to discuss them if the participants are unaware they exist. Researcher is reflective in analytical notes ensuing each interview (Dahlgren, Emmelin & Winkvisk, 2007).
Transcription	<ul style="list-style-type: none"> <li>Accuracy</li> </ul>	Interviews recorded. Verbatim transcription done via OTranscribe software. Transcriptions were sent to participants for their approval and asked whether they had anything else they wanted to add (member checks)
Analysis	<ul style="list-style-type: none"> <li>What should be the level of interpretation?</li> </ul>	Manifest level poses little ethical concerns. Latent depth of analysis should reflect the context of each participant. Successive quotes provide the reader with the opportunity to reflect on the trustworthiness and reliability of the findings to the interview.

Verification	<ul style="list-style-type: none"> <li>• Credibility</li> <li>• Dependability</li> <li>• Transferability</li> </ul>	See section on Trustworthiness. Cred.: prolonged engagement, Dep was insured by sending the transcribed material to the participant as asking whether they wanted to include or clarify statements made in previous days. Trans: context, selection and characteristics of participants and data collection process described to facilitate this (Graneheim & Lundman, 2004).
Reporting	<ul style="list-style-type: none"> <li>• Report findings</li> <li>• Conflicts of interest</li> </ul>	A written Master Thesis at Lund University, whereby no ethical board approval needed. No conflicts of interest were recognized.

Table 2: Characteristics of interview participants

Participant	Sex	Age	Employment field	Highest education level obtained	Relationship status
P1	Male	30	Military	Tertiary	Single
P2	Male	24	Consultant	Tertiary	Single
P3	Male	23	Student	Tertiary	Single
P4	Male	27	Waiter	Tertiary	Single
P5	Male	23	Student	Tertiary	Single
P6	Male	26	Self-employed	Tertiary	Single

Table 3: Example of analysis process

Meaning unit	Condensed meaning unit	Code	Sub-category	Category	Theme
...contraception, in a relationship is a sort of unanimous decision where the girl has the veto right	In a relationship, contraception is a unanimous decision where the girl has the veto	contraception is a unanimous decision where the girl has the veto	Perceiving contraception as a woman's responsibility	Contraceptive use: a shared responsibility in theory, but not in practice	<b>Contraceptives: A jungle between social norms, lack of knowledge and communication</b>
I think i would prefer if a woman would take it but i understand that this should be an equal responsibility! But it's just strange!	I prefer a woman to take it but understand it should be equal responsibility, but it's strange	It should be equal responsibility, but it's strange	Sharing equal responsibility, but I have limited role		
People can say something and it doesn't necessarily have to be the truth. when i am not sure i	People can say something and not the truth. If it is someone I don't know and I'm not	It's about trusting the other person to tell the truth: that's a risk	Construction of risk based on trust		



would trust the person to say 'oh i've tested myself 2 weeks ago'...that could be just something you say! and that is obviously a risk and that also can go the other way around that it is just something i say, which the other person wouldn't know!	sure I would trust to say 'I've tested myself', that is obviously a risk. That can also be something I say, which the other person wouldn't know.			Feeling caught between a rock and a hard place
condoms are good because you can just get them in the store and when whenever you can get it you can have it! Well maybe it affects the sensitivity	Condoms are good because you get them at the store whenever but maybe affects sensitivity	condoms are convenient but affect sensitivity	Undesirability of condoms due to lack of sensitivity	

Table 4: Analytical model describing findings of a qualitative study in Sweden

Theme	Category	Sub-category
<b>Contraceptives: A juggle between social norms, lack of knowledge and communication</b>	<b>OBJ 1:</b> Realizing sexuality education was not enough	The role of education in framing knowledge and attitudes
		Questioning the quality of education
	<b>OBJ 1:</b> Role of external pressures in shaping perceptions	The social pressure of being a man
		Confirming one's thoughts with peers
		Planning fatherhood shifts the focus of the relationship
	<b>OBJ 1:</b> Contraceptives: a shared responsibility in theory but not in practice	The ideal of shared responsibility
		Perceiving contraception as a women's responsibility
	<b>OBJ 2:</b> Feeling caught between a rock and hard place	Construction of risk based on trust
		Undesirability of condoms due to lack of sensitivity
	<b>OBJ 2:</b> Feeling that my voice is unheard	I have a limited role in decision-making
		Expressing emotions is difficult for me
		Recognizing the need for men's care

## Appendices

### Appendix 1: Interview guide

#### ***Icebreaker questions***

##### **Concept on Sexuality**

What is sexuality to you?

What kind of sexuality education did you receive?

What according to you is good 'sexual health'?

##### **Relationship history**

Could you tell me about the types of relationships young boys around you have?

What kind of partners do they like?

What are your views on these partnerships?

What does serious relationship mean to you?)

##### **Contraception**

Could you tell me more about the types of contraception?

What do you think about male contraceptive methods?

What is your opinion on female contraceptive methods?

Do young boys these days use condoms? (why? Why not? In which circumstances would a guy be more likely to use a condom?)

PROBE DEEPER HERE

##### **Negotiation of contraceptive use**

I am interested in hearing about how you discuss the use of contraception in sexual relationships?

Could you give an example of a time you did not discuss contraception?

What were the reasons and situations when you did not use contraception?

PROBE DEEPER HERE

## Appendix 2: Informed consent form

### **Title: Swedish men's perceptions of modern contraceptive methods**

I am Adriana Pereira, a student at Lund University, currently doing research to understand Swedish men's reproductive health needs, as a part of my Master Thesis in Public Health. I would like to know your perceptions and experiences of modern contraceptive methods and would greatly appreciate your participation.

The aim of this study is to explore Swedish young men's perceptions and attitudes of modern contraceptive methods. The purpose of this study is to explore the way men perceive, use and talk about contraceptives. I would therefore like to invite you to participate in an interview that would last for about 1 hour.

This research study will maintain its anonymity and all the names used on the thesis will be pseudonyms. The interview will take place in a private room where no one will be allowed to walk in so that you can speak freely and openly. The participation in this study is voluntary. Therefore, if you are uncomfortable at any point of the study please feel free to withdraw.

If you agree to participate, the interview will be audio-recorded and will only be available to me and the supervisor. The recorded material will be secured on a hard drive.

You will receive a snack and drink after the interview. If you are interested in participating in this study please contact me by email or telephone, if you have any questions regarding the study.

Adriana Pereira, Student  
adriana.pereira.358@student.lu.se  
+45 267 078 39

### Appendix 3: Example of Analytical notes

**Location:** Skype. Quite surroundings and good internet connection. **Age:** 24, **Education:** tertiary.

**Notes:** Quite a more advanced and nuanced perspective than other participants. Works with gender and gender equality issues thus it has impacted how they think but also their exposure to topics relating to this study. The topic of the thesis was very natural for him to discuss however even with a high level of awareness it is still hard and awkward to discuss sexuality and contraception.

- **Sexuality is more than just babies**, biology forms the basis of education in Sweden but it needs to be more than that. Sex and sexuality needs to be part of a holistic approach to a healthy lifestyle and throughout the life-course. Spectrum of sexuality is missing and usually focused on women.
- **Respect for one's self** and others are 2 very important starting points to begin discussing sex and sexuality.
- **Concept of acceptability** (male condoms and other contraceptives) linked with stereotypes and expectations of men and women's roles in society. In Sweden, the easy accessibility of condoms was a huge step to normalize condoms but also part of everyday life.
- The **process of normalization** is an important part in accepting and utilizing condoms, just like women's contraceptives were normalized. Normalization is about breaking myths and actively pushing it into conversations, it is about breaking stigma and stereotypes for both men and women. **Emphasis on social expectations of men and women.** Normalizing condoms is about men getting together, men-men groups and having a role-model (strong influencer) to start talking.
- **Perception of risk depends on type of relationship** (casual versus long-term). Perception of risk is linked with trust and respect. Trust is the foundation of relationships. STI testing involves trust in the other person to tell the truth.

## Appendix 4: Popular science summary

### **The forgotten 50 percent**

Sexual and reproductive health (SRH) has been used interchangeably to talk about women's health for a long time. Even if public health projects are successful, men, are often not a priority. Men are assumed to not have any particular needs when it comes to SRH. When looking at contraceptives for example women are asked about condoms use, not men. In essence there are very few studies conducted on men and contraceptives, let alone other sexual and reproductive health issues.

Young people in this vulnerable age group are at a higher risk of to unwanted pregnancy, early parenthood and risks of sexually transmitted infection including HIV/AIDS. This study aimed to understand knowledge, attitude and perceptions of modern contraceptive methods among young Swedish men. This study focused on conducted in-depth interviews of young men between the age of 20-30. Analysing their interviews gave insight into how they each young man was unique but how they perceived contraceptives.

Our understanding of contraceptives depended a great deal on the type of relationship the young men had and it was different for the age range we investigated. During their adolescent years it was about sexually transmitted infections and not wanting to become a father. As they got older contraception became more about couples talking about starting a family. As they transitioned into adulthood they felt the social pressure to behave in a certain way which affected their sexual behaviour. Because of this, the young men saw contraception as a women's responsibility. Young men felt that they wanted more responsibility in terms of contraceptive use but lacked control apart from condom use.. It was evident during the interviews that their close friends and long-term partners were the only people they discussed contraceptives with. Men expressed difficulties in showing their emotions to others, particularly to other men. When reflecting on this, they discussed the unmet need for tailored SRH services.