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Sexual Risk Taking

– Perceptions of Contraceptive Use, Abortion, and Sexually Transmitted Infections Among Adolescents in Sweden

MARIA EKSTRAND

ACTA
UNIVERSITATIS
UPSALIENSIS
UPPSALA
2008

ISSN 1651-6206
ISBN 978-91-554-7144-6
urn:nbn:se:uu:diva-8598

Dissertation presented at Uppsala University to be publicly examined in X, Universitetshuset, Biskopsgatan 3, Uppsala, Friday, April 25, 2008 at 09:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish.

Abstract
Ekstrand, M. 2008. Sexual Risk Taking – Perceptions of Contraceptive Use, Abortion, and Sexually Transmitted Infections Among Adolescents in Sweden. (Sexuellt risktagande – svenska ungdomars inställning till, och erfarenhet av preventivmedel, abort och sexuellt överförbara infektioner). Acta Universitatis Upsaliensis. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 325. 81 pp. Uppsala.
ISBN 978-91-554-7144-6.

The overall aim of this thesis was to inestigate Swedish adolescents' perceptions and behaviours regarding sexual risk taking. Specific objectives were to explore teenagers' perceptions of contraceptive use, unintended pregnancy, and abortion; teenage girls' experiences of decision making process and support connected to abortion; and male adolescents' perceptions of sexual risk taking and barriers to practicing safe sex. Another objective was to evaluate the effect of advance provision of emergency contraceptive pills to teenage girls. The methodologies included focus group discussions, in-depth interviews, and a randomized controlled trial.

Among the adolescents in our studies, teenage parenthood was generally viewed as a "catastrophe", and the majority expressed supportive attitudes towards abortion (studies I-IV). Occasions of failure to use contraceptives were common, especially when sex was unplanned (studies I-V). Pregnancy prevention was perceived as the woman's responsibility. However, many girls were reluctant about using homonal contraceptives due to worries about negative side effects (I, III). Initiating condom use was difficult for girls, as well as for boys, for a number of reasons (I-IV): fear of ruining an intimate situation, associations with disease, distrust, pleasure reduction, and (for the boys) the fear of loosing one's erection. Males generally perceived personal and partner-related risks connected to unprotected intercourse as low. Few males were worried that an unintended pregnancy would be carried to term, and the majority would urge the girl towards abortion if she seemed ambivalent (II, IV). Girls viewed the abortion decision as a natural, yet difficult choice, strongly influenced by attitudes of partners, parents, peers and societal norms (III). Teenage girls provided with emergency contraceptive pills in advance used it more frequently and sooner after unprotected intercourse compared with controls, without jeopardising regular contraceptive use (V).

Keywords: Adolescents, attitudes, sexual risk taking, contraceptive use, unintended pregnancy, teenage abortion, communication, gender, decision making, STI, Chlamydia, condom use, Health Belief Model, emergency contraception, RCT

Maria Ekstrand, Department of Women's and Children's Health, Akademiska sjukhuset, Uppsala University, SE-75185 Uppsala, Sweden

ISSN 1651-6206
ISBN 978-91-554-7144-6
urn:nbn:se:uu:diva-8598 (http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-8598)

To my Family

Innocent – like a blank piece of paper
I would tell u that with me, you'd be safer
Than letting the world scribble all over u
But I'm a thief, and that's the sober truth

I'm stealing away all of your chances and possibilities
Robbing u of a future, and that makes me a thief
Thinking about u living and what you could have become
And the fact that I still have a choice is what's making me feel dumb

In only a few hours, I will forbid your little feet from ever touching ground
I could still change my mind and turn my whole life around
I'm the only one u know, the one person you're supposed to rely on
There are too many obstacles, although this could be my great triumph

I'm too scared to overcome them yet, I'm just not ready
I wish I could put u on hold for a few years, until my life goes steady
I'm sorry if it sounds like I'm making up excuses
You'd be too smart for not knowing what the truth is

I probably could if I tried real hard, we all know it
What u want from me is life, not a stupid poem
I'm sorry for doing what I know I'll regret for all eternity
I will keep u in my prayers – this wont be the last u heard from me

This poem was written by an 18-year-old informant, pregnant for the first time, on the night preceding her abortion. It was sent to me in 2007, shortly after our interview, and is published with her full permission.

LIST OF PAPERS

This thesis is based on the following papers, which will be referred to in the text by their roman numerals:

I. Ekstrand M, von Essen L, Larsson M, Tydén T. Swedish teenager perception of teenage pregnancy, abortion, sexual behavior, and contraceptive habits – a focus group study among 17-year-old female high-school students. *Acta Obsetricia et Gynecologica Scandinavica 2005 Oct;84(10):980-6.*

II. Ekstrand M, Tydén T, Darj E, Larsson M. Preventing pregnancy: a girls issue. Seventeen-year-old Swedish boys' perceptions on abortion, reproduction and use of contraception. *European Journal of Contraception and Reproductive Health Care 2007 Jun;12(2):111-8.*

III. Ekstrand M, Tydén T, Darj E, Larsson M. An illusion of power – The female teenager's dilemma of having contraceptive responsibility, but limited freedom of reproductive choice. *Perspectives on Sexual and Reproductive Health.* (Accepted with revision)

IV. Ekstrand M, Tydén T, Larsson M. Sexual risk taking for self and partner as perceived by young men in Sweden – a suggestion for a modified Health Belief Model. (In manuscript)

V. Ekstrand M, Larsson M, Darj E, Tydén T. Advance provision of Emergency contraceptive pills reduces treatment delay – a randomized controlled trial among Swedish teenage girls. *Acta Obstetricia et Gynecologica Scandinavica 2008;87(3):354-9.*

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Contents

Abbreviations

CT	*Chlamydia trachomatis*
ECP	Emergency contraceptive pill
FGD	Focus group discussion
HBM	Health Belief Model
IG/CG	Intervention group/Control group
RCT	Randomized controlled (clinical) trial
STI	Sexually transmitted infection

Definitions

Abortion – Termination of a pregnancy before the foetus has attained viability. The legal requirements for abortion vary between countries.[1]

Abortion in Sweden – Pregnancy termination prior to the 18th week of gestation on request of the woman, and after that time for very serious indications only.[1]

Abortion rate – The number of abortions per 1000 females in the relevant age group in each health authority.[1]

Adolescence – The transitional phase of growth and development between childhood and adulthood, encompassing biological, psychological, and social development as well as the strictly reproductive aspects of maturation. The period of this development varies across individuals, groups, countries, and cultures; there is no exact time limit for either its beginning or its end.[2, 3]

Adolescent sexual risk taking – Caused by social, individual, and biological factors and forms part of normal as well as abnormal development; it may lead to both negative and positive consequences.[4]

Attitude – A summary of evaluations regarding an object of thought; a settled way of thinking or feeling about someone or something, sometimes reflected in a person's behaviour. Attitude often means some degree of aversion or attraction that reflects the classification and evaluation of objects and events. While attitudes are logically hypothetical constructs (i.e. they are inferred but not objectively observable), they are manifested in conscious experience, verbal reports, overt behaviour, and physiological indicators.[2, 3]

Gender – A euphemism for the sex of a human being, often intended to emphasize the social and cultural, as opposed to the biological, distinctions between the sexes.[2, 3]

Hegemonic masculinity – The "ideal" form of masculinity to which men are supposed to aspire. It is not the most prevalent form of masculinity, but the most socially endorsed. Characteristics associated with the hegemonic

masculinity are aggressiveness, strength, drive, ambition, lack of emotion, self-reliance, and risk taking.[5]

Induced abortion – An artificially-induced termination of a pregnancy which does not comply with the definition of a birth and in which there is no indication of intrauterine foetal death prior to the termination.[1]

Number per 1000 women - The number per 1000 women is based on the mean population for each year.[1]

One-night stand – A single sexual encounter where at least one of the parties has no immediate intention or expectation of establishing a longer-term sexual or romantic relationship.[2, 3]

Sexual and reproductive health – A state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual and reproductive health implies the possibility of having a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. Sexual and reproductive health implies the right of men and women to be informed about and to have access to safe, effective, and affordable family planning methods.[6]

Sexually transmitted infection (STI) rate – The annual number of new (known) cases of sexually transmitted infections.[1]

Teenager – A person aged between 13 and 19 years.

Pregnancy rate – The number of live pregnancies and abortions per 1000 females in the relevant age group in each health authority. Miscarriages are excluded.[1]

Week of gestation – The number of completed weeks from the first day of the last menstrual period to the day of i.e. the abortion.[1]

Young women / young men – Used here as overall terms for teenagers and adolescents in their early twenties.

Introduction

From an international perspective, Sweden is in a favourable position in terms of sexual and reproductive health, with low teenage pregnancy and abortion rates, compulsory sex education in the schools, subsidized contraceptives, free contraceptive counselling, and prescription-free emergency contraceptive pills. Nevertheless, Sweden has the highest teenage abortion rates among the Nordic countries,[7] as well as an ongoing Chlamydia epidemic among teenagers and young adults[8] — both clear indicators of increased sexual risk taking.

The reasons behind this situation are likely to be multidimensional, with social, cultural, economic, and epidemiologic factors all having an effect. A number of issues have been discussed by researchers, including the question of whether attitudes towards abortion and sexual risk taking among young people have changed,[9-11] or whether increased alcohol use among teenagers has led to greater sexual risk taking[12] Other factors under debate are the impact on young girls' contraceptive habits of recurring "Pill scares" in the media[13-16] and the general deterioration of the quality of sex education in schools.[17-19]

To design efficient preventative strategies and provide high-quality contraceptive counseling, information about the consumer group is vital. The overall aim of this thesis was to explore and deepen our understanding of Swedish teenagers' perceptions of sexual risk taking, contraceptive use, unplanned parenthood, and abortion. The thesis also aimed to evaluate whether advance provision of emergency contraceptive pill (ECP) would lead to more timely treatment, and whether it would influence sexual risk taking behaviour among Swedish teenage girls.

Background

Principles of prevention regarding sexual and reproductive health — the Swedish context

The perception of adolescent sexuality in Sweden is characterized by an accepting and confident attitude towards the ability of young people to behave in a sexually responsible way. Public health efforts in Sweden regarding prevention of unintended pregnancies and abortions and sexually transmitted infections (STIs) involve health promoting work in a broad perspective, guided by certain core principles, for example individual rights, self determination, individual volition and integrity, personal responsibility, and easy access to treatment, care, and support.

Preventative strategies should be implemented at different levels and in varying contexts, usually by means of *primary*, *secondary*, and *tertiary* prevention as described below:

- Primary prevention is designated as public health-promoting work in a broad perspective; executed by, for example, youth clinics, schools, or voluntary organizations.
- Secondary prevention represents in this context the early identification of a disease, specifically *Chlamydia trachomatis* (CT) infection. It also refers to the offering of high quality care, efficient treatment, and efforts to prevent further spread of disease or new unintended pregnancies.
- Tertiary prevention entails care and treatment in order to prevent complications following abortions or STIs.

Since unwanted pregnancies and STIs are both undesired consequences of sexuality, a great deal of the preventative efforts in each area coincides with those in the other. Over the years, several suggestions for action plans and overall objectives have been proposed in order to reduce unwanted pregnancy and the incidence of STIs in Sweden. Some of these goals are summarized below.

First, all young people should be given equal opportunities to develop a healthy sexuality. In order to meet this goal, regular school-provided sex education should be offered and continuously evaluated, young people should have easy access to youth centres, and specific measures should be taken to target young people in particular need of care and support.

Second, the number of unwanted pregnancies should be reduced. The efforts towards this goal include increased use of contraceptives, specific targeting

of groups at high risk of unwanted pregnancy, and free of charge and readily available family planning services and abortion counselling for both women and men.

Third, the incidence of new cases of STI should be reduced. Strategies include increased promotion of condom use, targeting of high risk groups, and measures to facilitate early diagnosis of infection, effective treatment, and high quality care.[20-23]

At the national level, four organizations share the main responsibility for preventative efforts within sexual and reproductive health issues in Sweden: the National Board of Health and Welfare, the Swedish Institute for Infectious Disease Control, the Swedish National Institute of Public Health, and the National Agency for Education. At the regional level, the main responsibility for preventing unintended pregnancies and limiting the spread of STIs rests with county councils and municipalities. County councils have the overall responsibility for health care and medical services under the Health and Medical Services Act, while municipalities, either separately or jointly with the County councils, have broad responsibility for the youth centres. However, to date, Sweden has no national *operational* goals for battling unwanted pregnancies and CT infection in a concrete manner.

School-provided sex education

Sex education programs have been compulsory in Swedish schools since 1955. However, in the early 1990s the Swedish school system was drastically reformed, and sex education was changed from a core subject to an overarching topic, intended to be included in other subjects.[17] National evaluations have since shown a wide variety in the quality of sex education, and reached the conclusion that it must be improved.[18, 24]

Youth clinics

Since the 1970s, youth clinics have been rapidly expanded, and now cover almost the entire country with over 200 centres. More than 200 000 visits by adolescents aged between 12 and 23 are registered annually. Nearly 85% of these visits are made by girls and young women. The core activities are contraceptive counselling, family planning advice, and STI/HIV prevention including CT testing. County councils are responsible for approximately 42% of the youth clinics and municipalities for about 13%, while the remainder are operated under joint responsibility.[20]

The centres have a multi-professional structure and aim to take a holistic approach to supporting young people's psychological, physiological, and

sexual health. Skilful staff with youth-friendly attitudes, along with accessibility, confidentiality, and appropriate opening hours, have been identified as key factors in successful health care.[25]

The Swedish abortion law

Abortion is a highly controversial issue in many parts of the world. Sweden has one of the world's most liberal abortion laws. The current law was passed in 1975 and permits abortion on the request of the pregnant woman until the 18th week of gestation, after which permission must be obtained from the Social Board of Health and Welfare and is granted on severe social or medical indications only.[1]

After the new abortion law came into force in 1975, many feared a drastic increase in the number of abortions. To prevent the law from being misused, a national abortion prevention program was initiated by the government. The overall goal of the program was, and still is, to reduce the number of unwanted pregnancies. The main strategies were to supply young people with safe and easily available contraception, and to develop a well-organized abortion service. Midwives were trained in inserting intrauterine devices and were authorized to prescribe contraceptives. Youth clinics, where young people could receive contraceptive counselling free of charge, were established in almost every town.[1]

Abortion and pregnancy rates among Swedish teenagers – trends over time

Thanks to the extensive prevention program described above, the expected increase in teenage abortions after 1975 failed to come. Instead, in the ten years after the legislation came into force, abortion rates declined steadily. In the years following this period, the number of teenage abortions has fluctuated. An increase in the late 1980s indicated unsafe sex practices among young people, but also a general trend of choosing termination over parenthood.[20] The lowest abortion rate was achieved in 1995, with 17 abortions per 1000 teenage girls aged 15-19. During the seven-year period between 1995 and 2002, the abortion rate among teenagers increased by over 50%, to reach a level of 25 abortions per 1000 women aged 15-19. In 2003 and 2004, this trend began to level off; however, even though the total number of teenage abortions had slightly decreased, the abortion rates still varied widely by geographical region. The teenage abortion rate in 2006 was 25.4 per 1000 teenage girls aged 15-19 (Figure 1).[1]

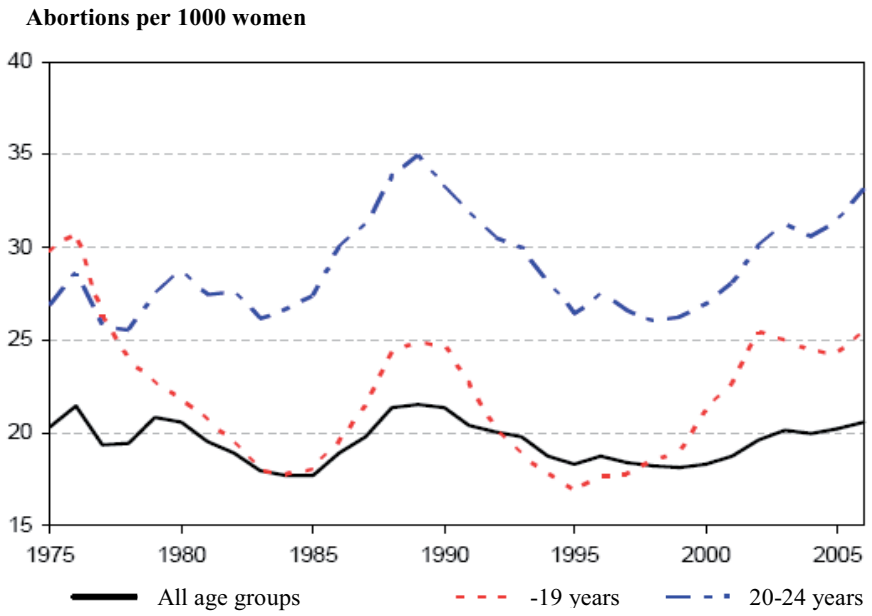

Figure 1. Number of induced abortions per 1000 women by age, 1975-2006. (Source: The National Board of Health and Welfare)

Most women who apply for abortion make the decision about pregnancy termination early in the pregnancy, and then wish to have the abortion performed promptly.[26] More than 70% of all induced abortions in Sweden are performed before the end of the 9th week of pregnancy. Most teenage abortions are requested before the 12th week of pregnancy. The numbers of first trimester pharmacological inductions (medical abortions) are constantly increasing; this type of abortion represented about 60% of all abortions in 2006.[1]

Abortion rates among the Nordic countries

In recent years, abortion rates have decreased among young women in Finland and Norway, but increased in Denmark and Sweden. In relation to the number of women of fertile age, Finland has the lowest and Sweden the highest number of induced abortions among the Nordic countries. In 2005-2006, there were 14.5 induced abortions per 1000 women aged 15 to 19 years in Finland and 24.4 in Sweden, a figure nearly double that for Finland (Figure 2).[1, 27]

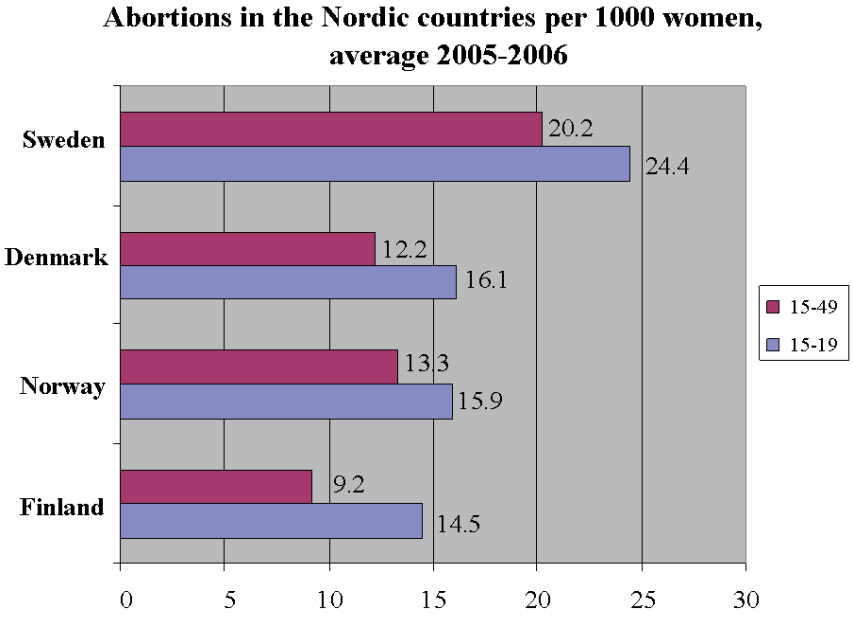

Figure 2. Abortions in the Nordic countries per 1000 women, average for 2005-2006. (Source: STAKES Official statistics in the Nordic countries)

Postponed childbearing

From an international perspective, the pregnancy rate among Swedish adolescents is low,[7, 28, 29] having been estimated at about 30 pregnancies per 1000 women aged 15-19 in 2006.[1] When contraception fails, pregnancy termination is the primary choice for the majority; about 70-95% of Swedish teenage pregnancies end in abortion, indicating an intense desire to avoid teenage childbearing.

The current trend in industrialized countries is to postpone childbearing, partly in order to finish education, ensure economic security, obtain work experience, and achieve personal fulfilment.[30-32] In 2006, the mean age in Sweden for birth of the first child was 28.7 years for women and 31.2 years for men.[33] The sexual debut usually takes place more than ten years earlier, at an average age of 16.5 years for women and 16.8 years for men.[34] This presents a challenge regarding young people's contraceptive use and society's ability to ensure safe and easily available contraceptive methods during a long period of high fertility.

According to a study which included teenage girls applying for induced abortion, the most common reasons for pregnancy termination were the young woman's age, financial concerns, and a desire to postpone childbearing in favour of education.[30] Most women undergoing abortion suffer no long-term emotional post-abortion consequences.[26, 35-37]

Chlamydia infections among Swedish youth

Genital CT infection, caused by the bacteria *Chlamydia trachomatis*, is the most frequently reported STI in Sweden. CT is often asymptomatic. If left untreated it may cause damage to the reproductive organs, for example salpingitis, persistent pain, ectopic pregnancy, epididymitis, and in severe cases infertility.[38-41]

Sweden was one of the first countries to establish a national reporting system for CT. Unlike most other EU countries, partner notification, contact tracing, testing, and free antibiotic treatment has been required by law since 1988. This law requires infected patients to abstain from sexual engagement until completion of treatment (generally with tetracyclines for just over a week).[8]

When CT was included in the communicable disease legislation, and diagnosis and contact tracing became routine, a considerable reduction of cases followed. Between 1988 and 1994 the incidence fell by 54% to reach a number of 13 625 cases. The rates thereafter started to increase rapidly. During the ten-year period between 1997 and 2007, there was a threefold increase in the number of CT infections; 13 905 cases were reported in 1997, compared to 44 026 in 2007.[8]

The highest prevalence was found among people aged 15-29 years, while the main increase was seen among teenagers aged 15-19 (Figure 3). This is unfortunate for several reasons; the reproductive health consequences of CT infection are most damaging to young people, and the risk of further spread is also greatest among the teenage population.

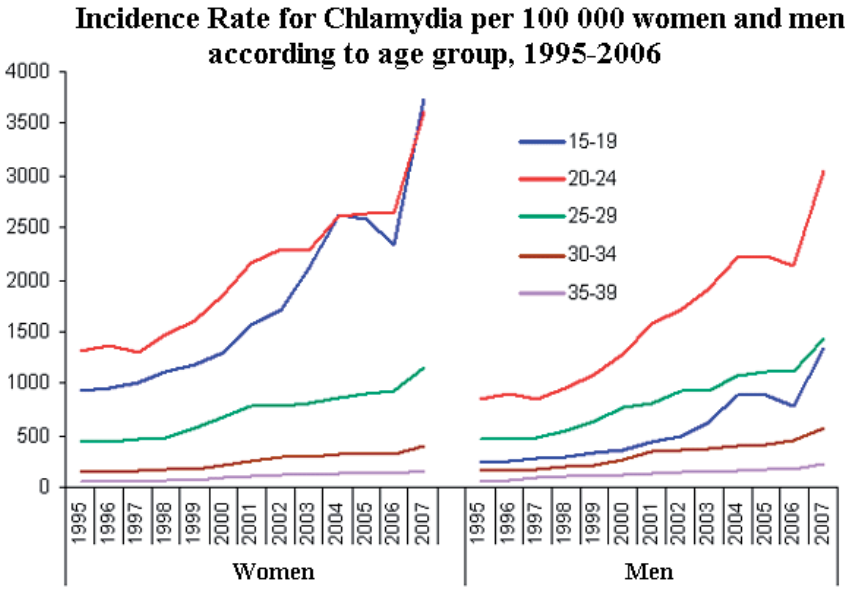

Figure 3. Incidence rate for Chlamydia per 100 000 women and men, by age group, 1995-2006. (Source: Swedish Institute for Infectious Disease Control)

One major problem is the consistently lower frequency of testing among males than among females.[8] This over-representation of diagnosed women is partly explained by the asymptomatic nature of the disease, the organization of care and testing possibilities, and by incomplete contact tracing.[21]

Adolescence, attitudes, and sexual risk taking

Adolescence

Adolescence means 'growing up'; it refers to the biological, psychological, and social development that takes place between childhood and adulthood. This time of transition varies across individuals, groups, countries, and cultures, and there is no exact time limit for the beginning and the end of this development. During this critical period, adolescents go through a rapid transition including both the physical process of puberty and intellectual development and autonomy. This process often involves different degrees of sensation-seeking, egocentrism, and sense of invulnerability. Sexuality is a central part of the adolescent transitional phase, and is closely linked to risk taking behaviour.[4, 42]

Sexual risk taking

Certain risk taking behaviour is part of normal development during the adolescent transitional period; stretching boundaries, experimenting, and collecting new experiences are all essential for the individual process of maturation.[4, 42, 43] In this thesis I use "sexual risk taking" synonymously with the risk of unintended or unwanted pregnancy and the risk of contracting STIs or passing them on to others. Sexual risk taking behaviour is often manifested in failure in contraceptive use, which in turn is associated with factors such as early age at coitarche, sex under the influence of alcohol, unplanned sex, casual sexual relations, a high lifetime number of sexual partners, and oral and anal sex.

With its combination of high fertility and limited experience of contraceptive use, the adolescent period involves a great risk of unintended pregnancies, abortions, and STIs. Even though an unintended or unwanted pregnancy may turn into a welcomed one, teenage pregnancy is often considered a public health problem because of its well known associations with socioeconomic difficulties and health-related problems for both mother and child.[44-47] As mentioned, STI is especially unfortunate in the young population, since the personal and epidemiological consequences may be particularly severe. The way young people approach and express their sexuality and their reproductive health choices may have a major impact on the direction of their future lives.

Explanations of adolescent sexual risk taking behaviour are much more complex than lack of knowledge. A review summarizing findings from 268 qualitative studies of young people's sexual behaviour between 1990 and 2004 revealed several key themes which help clarify why young people might have unsafe sex. Regardless of cultural background, potential sexual partners were regarded as either "clean" or "unclean"; condoms were found to be stigmatizing and associated with lack of trust; and gender stereotypes were shown to determine social expectations about how men and women should behave, which in turn determined behaviour and hindered communication about sex.[48]

A shift into more risky sexual practices appears to have taken place among young people in Sweden.[34, 49-53] Drug use, casual sex, multiple sexual partners, homosexual and bisexual experiences, and anal intercourse were reported more frequently by high-school students in a study carried out in 1999, compared to a similar investigation ten years earlier.[54] In 1989, 10% of Swedish girls aged 16-17 reported three or more sexual partners during the past 12 months. Almost twenty years later, this percentage had increased to 17%. The corresponding figures for women aged 18-19 in-

creased from 14% in 1989 to 26% in 2007 [52]. The trend is similar among males; in 1989, approximately 18% of Swedish males aged 18-19 reported three or more sexual partners during the past 12 months, compared to almost 30% in 2006.[55]

One-night stands

Swedish adolescents seem to be broadly accepting of one-night stands. The number of young people having sex "on the first date" has increased over the past twenty years. In 1989, 12% of girls aged 16-17 reported having had intercourse on the first date compared to 21% in 2003. The corresponding figures for boys of the same age were 16% in 1989 and 23% fourteen years later.[51] A study conducted in 2006 reported that more than 50% of Swedish males aged 18-19 had had intercourse "on the first date" during the past 12 months, without using a condom.[55]

Contraceptive use among Swedish adolescents

Although a shift into riskier sexual practices appears to have taken place among Swedish adolescents, mean age at coitarche have remained relatively stable over the past 20 years. There has also been an increase in contraceptive use at first intercourse. Forsberg gathered results from several Swedish studies conducted between 2000-2005, and showed that between 71% and 76.2% of Swedish adolescents used some kind of contraception at their sexual debut. This was an increase compared to earlier studies performed during the 1990s, which showed that 50-60% used some kind of contraception at their first intercourse.[11]

Contraceptive use at the most recent intercourse varied between 68% and 82% both in studies performed before 1989 and in studies carried out between 2000 and 2005.[11]

In general, Swedish adolescents seem to protect themselves more frequently against unwanted pregnancy than against STIs. According to a national Swedish survey, less than half of 16 to 17-year-olds had used a condom during the past month, and this figure was even lower among older teenagers and young adults.[51] A study of 187 adolescents visiting a youth clinic in 2001 found that seven out of ten had experienced unprotected sex with a new partner, and that calculation of the risk connected to unsafe sex was commonly based on the appearance and reputation of the partner.[56]

Although use of contraception at first intercourse has increased,[50] occasional contraceptive failure is common.[54, 56] Nearly half of the teenagers in a Swedish study of women requesting abortion reported that they had not used any kind of contraception at the time of conception. The main reasons for not

using protection were that the girls did not believe they could become pregnant at the time (34%); that they were willing to take the risk (27%); that the sex was unplanned (24.8%); or that they were under the influence of alcohol (11.3%).[30]

The emergency contraception pill

The ECP is an emergency contraceptive method aimed at preventing pregnancy after unprotected intercourse. The first ECP method using a progestogen-only preparation (750 µg levonorgestrel) was introduced to the Swedish market in 2001. The preparation had milder side-effects than its precursor, and could be administered as a single dose. A year later, the ECP was approved as an over-the-counter product, and can be purchased at pharmacies at a cost of approximately 160 SEK (March 2008). It can also be obtained free of charge at family planning clinics, hospitals, and youth clinics.

The main working mechanism of the ECP is not fully understood, but probably involves inhibition or delay of ovulation and thus prevention of fertilization. No teratogenic effects have been observed. The ECP can prevent pregnancy up to 120 hours after coitus[57-59] but is recommended to be taken as soon as possible after unprotected intercourse, since its effect is estimated to decline gradually from 95% to 58% during the first 72 hours.[60]

Although the ECP is a well-known product in Sweden, especially among young women, there are a number of misconceptions about the method, due to lack of knowledge regarding its mode of action and the timeframe for optimal use.[61-63] If used correctly, it is theoretically capable of preventing up to 95% of all unintended pregnancies.[64] Thus, difficulties in accessing the ECP on time have been reported as a great barrier to its use.[65, 66]

Male involvement in abortion and reproductive health issues

Concurrently with the passing of the new abortion law and the greatly improved accessibility of contraceptive methods during the 1970s, women gradually became objects for influence and change regarding sexual and reproductive matters. Men, on the other hand, were gradually released from these issues.[67]

Contraceptive counselling and pregnancy prevention efforts have since focused mainly on influencing young women towards well-planned and sexually responsible behaviour, whereas young men and boys are mostly targeted only in relation to STIs/HIV and condom use. As Kero (2002) points out, the man's position in relation to pregnancy is one of exclusion, reflected by the fact that there is not even a term for men involved in pregnancy and/or abor-

tion; *"either they can be defined as 'the impregnator', 'the father-to-be', or 'the man whose woman is pregnant, gives birth, or has an abortion"*.[35]

Although teenage boys and young men have long been a sparsely studied group with regard to abortion and reproductive health, researchers have begun to point out that men also require professional care and individual support when involved in unintended pregnancy and abortion.[68] A study reported that only 16% of Swedish youth clinics routinely offered individual support to males involved in abortion.[69] Conflicting feelings, ambivalence, anxiety, and shock were commonly expressed by men faced with an abortion situation.[69, 70]

Although a man has no legal right to affect his female partner's decision over abortion, his attitude towards the pregnancy is often of crucial importance for the outcome.[30, 37, 68, 69, 71] At the same time, studies have shown that men often rely on their partner for pregnancy prevention.[34, 72-74]

Theoretical framework

The Health Belief Model (HBM)

Human behaviour is grounded on both knowledge and attitudes, which are commonly established early in life and are often difficult to change. For this reason, young people are in many respects the strategically most important group to reach. However, despite good knowledge or favourable attitudes, the outcome of behaviour may change due to the influence of numerous surrounding factors.

The HBM is one of the most widely used theories of health behaviour; it offers a conceptual framework that identifies factors affecting human behaviour in relation to (personal) health (Figure 4). The HBM has been used in both behavioural and medical sciences. It was first developed in the 1950s in order to explain the widespread failure of people to participate in preventative screening programs for tuberculosis. According to the HBM, health-related behaviour is influenced either directly or indirectly by the following components: *perceived threat* (the perceived susceptibility to and severity of, for example, a disease), *perceived benefits and barriers* (positive and negative aspects of a particular health action), *cues to action* (action triggers such as symptoms, media campaigns, and existing knowledge), and *self-efficacy* (the conviction that one can successfully execute the required behaviour).[75]

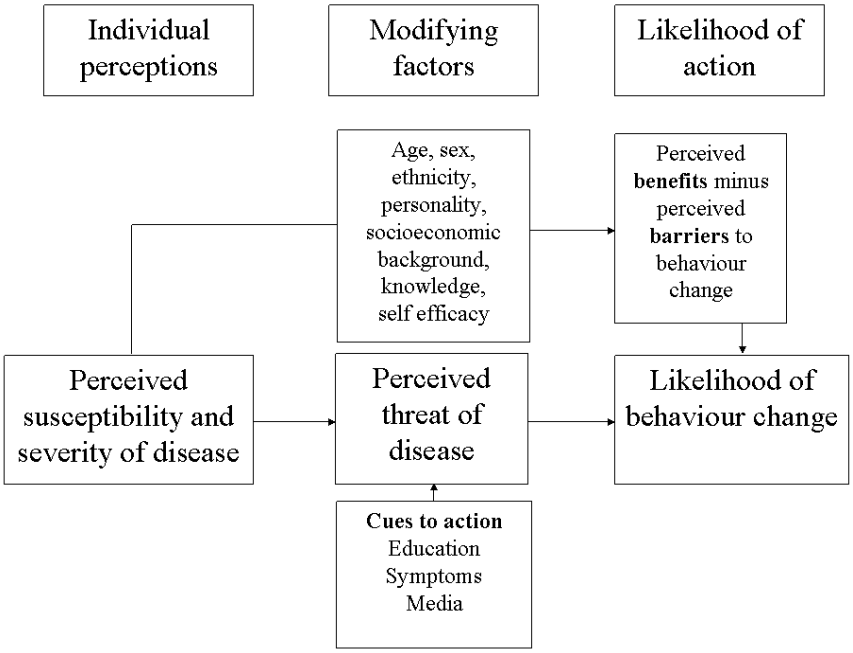

Figure 4. Health Belief Model – components and linkages.

Over the years, the HBM has been expanded, broken down, compared, and tested.

According to the HBM, protection of one's own health is central to all individuals; and people will take action to prevent, screen for, or control *ill-health* (primary and secondary prevention) if (i) they believe it would have potentially serious consequences, (ii) they believe that a course of action would be beneficial in reducing either susceptibility to or severity of the condition, and (iii) the anticipated barriers to (or costs of) taking the action are outweighed by its benefits.[75]

Common aspects studied with the HBM are for example the predictive qualities of individual's health beliefs, the components of the HBM, the relationship between the different HBM components, and how to use the HBM to understand and change behaviours within public health.[75]

A gender perspective

The words *gender* and *sex* both have the sense of 'the state of being male or female', but they are typically used in slightly different ways. Sex refers to the classification of people as male or female according to their chromosomal typing**,** biological differences, or reproductive functions.[3] Gender refers to the social and cultural construction of, or the perceived differences between, masculinities and femininities, according to normative ideas, attitudes, and activities that are 'suitable' for one's biological sex. Gender is found and reproduced as symbols, norms, and social structures.[76] In other words, gender describes male and female characteristics that are socially constructed.

As individuals are born female or male and grow into women and men, their behaviours and psychological and social characteristics help form their gender identity and determine their gender roles.

Used in this manner, the concept of gender does not reduce the potential importance of innate biological differences between men and women, but provides a broader and more informative frame of reference that includes consideration of social structure, power, and the social processes that construct masculinities and femininities in a society.[77]

Gender intervene in all levels of society; it creates identity and belonging on the individual level; it is seen in thinking patterns, metaphors, and categories on the cultural level; and it manifests in the principles used in work, laws, organizations, institutions on the social and economic level. It is also inherent in hierarchies characterized by male dominance and female subordination, which are established by keeping the different gender categories diverse and apart from each other.[76]

The hegemonic masculinity

Historically, research in the field of gender has mainly addressed issues about women. However, the focus has rapidly expanded and now includes a growing interest in men's and boys' identities, conduct, and problems. The concept of hegemonic masculinity, formulated in the early 1980s, has considerably influenced recent thinking about men, gender, and social hierarchy. The hegemonic masculinity refers to one of several masculinities, specifically, the "ideal" form of masculinity to which men are "supposed" to aspire. Characteristics associated with the hegemonic masculinity include aggressiveness, strength, drive, ambition, lack of emotion, self-reliance, and risk taking. Being the "ideal" model, the hegemonic masculinity requires all other men to position themselves in relation to it; this presumes and legitimizes the subordination of non-hegemonic men as well as women.

Hegemonic masculinity may not be the most common form of masculinity, but it is the most socially endorsed. Rather than relying on sheer numbers, hegemony works in part through the production of exemplars of masculinity (e.g., sports and movie stars), creating symbols that have authority despite the fact that most men and boys do not fully live up to them.

The concepts of multiple masculinities and hegemonic masculinity have been increasingly used to understand men's health practices, such as men's difficulties in responding to disability and injury. The concept of hegemonic masculinity has also proved to be important in understanding men's exposure to risk taking in general and sexual risk taking in particular.[5]

Gender perspective on sexual and reproductive health

Regarding sexual and reproductive health, certain outcomes and variations in the health status among women and men obviously reflect biological differences. Pregnancy inexorably leads to more severe bodily manifestations in women; and in addition women are generally more susceptible to STI transmission than men, and complications are generally more severe within the female population.[78, 79]

However, in other areas of sexual and reproductive health, explanations of biological influences remain incomplete without investigation of the nature of social systems and women's and men's structural place and roles within those systems. Examples of such areas include the decreased ability of women to suggest condom use;[80] the unfavourable health outcomes and increased risk for maternal mortality seen among teenage mothers:[45-47, 81, 82] lower STI testing rates among men;[8, 21, 83, 84] and the fact that considerably fewer appointments at Swedish youth clinics are made by boys and young men than by girls and young women.[85]

Gender is just one of many factors that influence couples and affect their reproductive decisions. Level of education; pressure from family, partner, and friends; social expectations; socioeconomic status; exposure to mass media; personal experience; expectations for the future; and religious beliefs may also help to shape such decisions. Gender analysis may help to address differences in gender dynamics that influence and determine decisions regarding both risk taking sexual behaviour and protective measures.

AIMS

Overall aim

The overall aim of the studies in this thesis was to explore and deepen our understanding of Swedish teenagers' perceptions of sexual risk taking, contraceptive use, unplanned parenthood, and abortion. This exploration included an evaluation of whether advance provision of ECP would lead to more timely treatment, and whether it would influence contraceptive use and sexual risk taking among Swedish teenage girls.

Specific aims

Paper I The aim of this study was to explore Swedish teenage girls' perceptions of teenage pregnancy, abortion, sexual behaviour, and contraceptive habits. The factors which female teenagers believe may explain the increasing numbers of teenage abortions were also investigated.

Paper II The aim of this study was to explore how teenage boys view abortion, adolescent fatherhood, sexual behaviour, and contraceptive habits.

Paper III The aim of this study was to deepen our understanding of issues related to teenage abortion. The main focus was placed on the circumstances behind the unwanted/unintended pregnancy, experiences of the decision-making process, and the perceived support from significant others and health care professionals in relation to the abortion.

Paper IV The aim of this study was to use the HBM to explain sexual risk taking behaviour among young men. The main focus was on perceptions of personal risk, perceptions of risk for the partner, and barriers to practicing safe sex.

Paper V The aim of this study was to evaluate the effect of advance provision of ECP to teenage girls, in terms of ECP use, time span from unprotected intercourse to ECP intake, contraceptive habits, and sexual risk taking.

METHODS

Studies I–IV took a qualitative approach, while study V took a quantitative approach.

Qualitative methods – an overview

A qualitative design is particularly appropriate when collecting data on previously unexplored areas or with regard to perceptions, feelings, attitudes, and beliefs.[86] The goal of qualitative research is to develop theories, descriptions, explanations, and understanding rather than to perform precise testing of hypotheses. Qualitative design is especially well suited to clinical health research, where multifaceted issues regarding human behaviour, beliefs, and actions are common areas of interest.

Qualitative interviewing is performed until saturation has been reached; that is, until no substantial further information is generated by further interviews. Preferably, each interview should be followed by a preliminary analysis in order to properly identify whether saturation has been reached.[87]

Focus group discussions

A focus group discussion (FGD) is commonly described as an in-depth, semi-structured group discussion moderated by a group leader, with the purpose of exploring a specific set of issues on a predefined and limited topic.[88] Focused discussions may provide insight into beliefs and perceptions and can produce rich data regarding new and unexpected areas. The interaction within the group may help participants to explore and clarify their views in ways that would be less likely to emerge in a one-to-one interview.[86, 89, 90] With proper guidance from a moderator, group members can describe rich details regarding attitudes, experiences, and the reasoning behind certain actions.

The optimal group size varies depending on context, but as a rule of thumb, an FGD should consist of no fewer than 4 and preferably not more than 15 participants. FGDs are led by two group leaders (one moderator and one observer) and are tape recorded in their entirety and subsequently tran-

scribed. An important task for the moderator is to monitor the group and adjust the guidance according to the present situation. Personal and social skills are essential in order for the moderator to be able to process the communication and encourage fruitful dialogues and vivid interactions between the group members. The observer may take a 'standing back' position from the group interactions, and instead concentrate on taking field notes and assisting with the logistics of recording and so on.[87]

Purposive sampling

Selection and recruitment of focus group members is usually a purposive sampling, based on their common experience of the research topic. Even though different opinions should be encouraged, too high a diversity among group members is usually not to be recommended.[86] If the group is too heterogeneous, members may feel insecure or hesitant to contribute fully. Conversely, similarities in for example social class, age, educational level, or family characteristics may create a discussion climate in which participants are willing to share their opinions and experiences with each other.

Methodological considerations

A special concern regarding FGDs is *confidentiality*. The group sessions may elicit more sensitive information than initially anticipated by the participants, and in reality it is impossible to ensure that information revealed during the discussions is not shared outside the interview context. One important role of the moderator is thus to protect group members from revealing "too much" about sensitive issues. Conditions of confidentiality should be described carefully prior to each interview session, and "ethical contracts" between the researcher and the group members could also be agreed in order to create an accepting atmosphere and a secure discussion climate.

As mentioned above, one great advantage of FGDs is that psychological factors may generate a creative group process in which members elicit each other's stories, leading to enhanced data richness.[90] However, the same factors can work in the opposite direction and potentially limit the quality of the findings.[91] A major pitfall in using FGDs is the impact of *censoring* and *conforming*, that is, a person adjusting his or her behaviour according to that of other group members.[88] Factors such as trust, deviancy, anonymity, self-esteem, and experience related to the topic may all influence censoring and conformity among participants, and this must be kept in mind during data analysis. Although the topics raised in FGDs are sometimes sensitive, focus group participants often feel empowered after a discussion session and many report their participation as enjoyable.

In-depth interviews

The main characteristics of qualitative individual interviews, or in-depth interviews, as they are referred to here, are that they entail a high level of informant participation; the question(s) asked are open-ended; and informants are encouraged to reveal personal experiences, thoughts, and perceptions while being gently guided by the interviewer who is listening and probing when necessary.[87] Although a topic guide may be used, the interviews are preferably viewed as jointly-shaped conversations. As in all qualitative interviewing, building of trust is important as well as for the researcher to be open-minded and flexible in regard to new or unexpected information that may be revealed during the interviews.

Qualitative content analysis

Content analysis covers a variety of techniques for analyzing textual data.[88] The method can be used with interview data, but also with other kinds of texts such as newspapers, songs, advertisements, diaries, and so on. It basically involves a systematic categorization of words and phrases.

Manifest and latent content analysis

Content analysis can focus on one of two aspects; manifest content (semantic content analysis) and latent content (inferred content analysis).[88] According to Graneheim & Lundman (2005),[92] manifest and latent content analysis both deal with interpretations, but differ in the depth and level of abstraction. Manifest content analysis is concerned with what *explicitly appears in the text*, or the visible and the surface content. By contrast, latent content analysis is concerned with the implied meanings that do *not actually appear* in the content; it is aimed at uncovering the underlying meaning of the message. The results of manifest content analysis are often expressed as categories and/or sub-categories, while latent content analysis involves a deeper understanding of the underlying meaning in the text, and the results are often expressed as one or more themes. Both manifest and latent analyses may be involved in a study.

Definitions of concepts

Qualitative research often holds a great variety of synonymous concepts, which can cause confusion and uncertainty for the researcher as well as for the reader. The definitions of Graneheim & Lundman (2004)[92] have served as the main guidance for the qualitative studies in this thesis. An overview of definitions of key concepts is given below.

The unit of analysis refers in this thesis to whole interviews/transcripts - large enough to constitute a whole, and small enough to allow the context to

be kept in mind during the analytical process. Parts of the text dealing with specific issues or addressing certain topics in, for example, a topic guide are called *content areas.* A *meaning unit* is understood as i.e. paragraphs or sentences that relate to each other through their content and context.

Condensation is the process of shortening and reducing the text while preserving the essential meaning. Condensation is followed by *abstraction*, that is, grouping meaning units together under higher order headings. The process involves the creation of *codes, categories, and themes.* A *code* is the label of a meaning unit, and should be understood in relation to the context. *A category* is a group of content that shares some commonality. Categories should be exhaustive and *mutually exclusive*, which means that no data related to the purpose should be excluded due to lack of a suitable category, but neither should any data fit into more than one category. A category often includes sub-categories at varying levels of abstraction. The sub-categories can be sorted and abstracted into a category, or a category can be divided into sub-categories.

The concept of *theme* has been described in varying ways in the literature. According to,[93] a theme can be viewed as a recurring regularity that is developed within the categories.

In studies I and II, the data was first sorted into mutually exclusive (preliminary) categories, and thereafter developed into themes and sub-themes on a slightly higher abstraction level.

A theme can also be defined as an expression of the latent content or the underlying meaning on an even deeper interpretative level. According to this view, themes are not necessarily mutually exclusive; and so condensed meaning units, codes, or categories can appear in more than one theme. In this thesis, we call this an *overarching theme*. In study III, mutually exclusive categories and sub-categories were formulated. Successively during the analytical process an underlying meaning emerged, resulting in one overarching theme that cut through the condensed meaning units, codes, and categories.

In study IV, a theoretical perspective was applied, and the content analysis was guided by the main concepts of the HBM. The analysis resulted in two main categories, several sub-categories, and an expanded and modified HBM.

Quantitative methods – an overview

Whereas qualitative research is holistic and uses semi-structured or unstructured methods with the main purpose being to describe and/or theorize, quantitative research is deterministic, its methods are structured and standardized, and the main purpose is to measure, assess, and/or evaluate.

Randomized controlled (clinical) trials (RCTs)

RCTs refer to true experiments that are conducted in the context of an intervention. RCTs allow the researcher to assign participants to different conditions (treatment and control) on a random basis, in order to control possible sources of bias within the experiment and thereby to draw generalizable inferences. In other words, RCTs provide the best evidence on the effectiveness of treatments and health care interventions, and are thus believed to form the gold standard of clinical research methodology.[94, 95]

Challenges and benefits in experimental design

What every true experiment aims for is to achieve perfect randomization, a large enough sample size (power), and maximum control over the independent variable (the manipulation of interest). In real life, the last factor may be the hardest to accomplish; phenomena have multiple, interactive causes and the relationships between variables can rarely be entirely isolated. Therefore, one of the biggest challenges for RCT studies in clinical settings is the controlling of confounding factors. Despite these limitations, the experimental design is the only one which seeks to establish cause and effect, and is thus the appropriate method to use when the aim is to demonstrate the impact of a particular variable of interest.[94, 95]

Introduction to studies I-V

Methods

An overview of the studies is presented in Table 1.

Table 1. Design, methods, and participants of the studies included in this thesis.

Study	Design	Data collection	Study group	Response rate
I and II	Qualitative study design analyzed by manifest content analysis	FGDs	Six focus groups, n=42 (girls) and six focus groups, n=40 (boys) recruited at high schools from theoretical and vocational study programs	
III	Qualitative interview study analyzed by latent content analysis	In-depth interviews three weeks post-abortion	25 young Swedish women aged 16-20 recruited at a hospital-based family planning clinic	
IV	Qualitative study design analyzed by latent content analysis	In-depth interviews one to two weeks after CT test	22 young Swedish males recruited via the local youth clinic (aged 16-20)	
V	RCT among Swedish teenage girls requesting ECP	Baseline questionnaire and structured follow-up interviews three and six months after enrolment	420 randomly selected teenage girls aged 15-19, recruited via the local youth clinic	Intervention group 80.4% Control group 76.2%

Settings

The FGDs in studies I and II were performed at the schools, during school hours. The in-depth interviews among young women approximately three

weeks after abortion (Study III) were partly conducted in secluded meeting rooms at the hospital and partly as pre-arranged telephone interviews. The individual in-depth interviews among young men (Study IV) were either carried out in specially designated meeting rooms at the youth clinic, or at the research office, according to the preference of each informant. Participants in study V were recruited during a daily drop-in service for young women requesting ECP at a local youth clinic, and participants were asked to individually fill out the baseline questionnaire in a secluded room while awaiting the consultation of the midwife. The structured follow-up telephone interviews were conducted by research assistants and the first author (M.E.), three and six months after recruitment. To maintain discretion, we made sure each informant could speak without being overheard during the interviews.

Ethical considerations

Research focusing on teenagers' reproductive and sexual behaviour may be sensitive. All potential participants received oral and written information about the studies. Before the studies began, we emphasized that participation was voluntary and could be discontinued any time with no negative consequences, and that the reporting of the data would be anonymous.

At the beginning of each FGD, ethical issues were addressed and an oral contract established emphasizing that what was said during the discussion would stay within the group. Prior to each in-depth interview in study III, the young women were notified that consultation with a professional counsellor would be arranged if unexpected thoughts or emotions occurred during or after the interview session. Boys in study IV who reported persistent symptoms were advised to contact the youth clinic. Participants in study V were given a wallet card including contact information for the research team in case of any questions or need for counselling.

Each informant in studies I-IV received two movie tickets as a reward for participation. All studies were approved by the Regional Medical Research Committee in Uppsala**.**

Participants and procedure

Studies I and II

A total of 12 FGDs were performed in 2003 in a medium sized town in Sweden. Six groups were comprised of girls (n=42) (Study I), and six of boys (n=40) (Study II). The groups were distributed between six schools, and each contained between four and ten participants. Students from theoretical and

vocational study programs were evenly included in order to ensure a wide variety in the participants' socio-economic backgrounds.

Senior nursing students, functioning as research assistants were trained in performing FGDs. The research assistants contacted the headmasters of the high schools and informed them about the study. After their approval, a total of 18 classes were selected for participation. The class teachers were given oral and written information about the study, and then the research assistants distributed written information to the students in the classrooms. The students were informed that participation was voluntary and that data would be treated confidentially. Students who agreed to participate wrote their name and telephone number on the application lists.

Participants were assigned to focus groups based on the order in which their names appeared on the lists. The first four to eight students on each list were contacted by the moderators. Of the 93 students contacted (48 girls and 45 boys), 82 attended the group discussions (42 girls in study I and 40 boys in study II).

The group discussions were held in the school buildings, and students were given permission to take part in the focus groups during their regular class time. The focus groups were conducted by two senior nursing students; one functioning as a moderator leading the discussion and the other as an assistant moderator taking notes. The sessions lasted between 25 and 60 minutes. Each interview session was audio-taped and transcribed verbatim by the first author.

Instrument

A semi-structured 11-item topic guide was used, covering questions about attitudes and knowledge concerning abortion, teenage pregnancy and parenthood, sexual behaviour, and contraception. Two groups with similar composition to the groups in the study were used in pilot studies performed in order to evaluate the topic guide, interview technique, and the technical equipment. No adjustments were needed.

Study III

We used purposeful and strategic sampling in order to select information-rich cases to illuminate the questions under study.[96] Swedish-speaking young women aged between 16 and 20, applying for induced abortion at two hospital family planning clinics in one large and one medium-sized city in Sweden, were invited to the study. Each potential participant was given verbal and written information about the study by a physician or a midwife at the pre-abortion examination. All were informed that participation was volun-

tary and that data would be treated confidentially. At the end of each session, the interviewer (usually the first author, M.E.) summarized the interview and asked the participant to contribute any additional comments or specific issues she wanted to highlight.

A few (n=3) pilot interviews were performed in September through November 2003 in order to test the topic guide and the procedure. No adjustments were made and these interviews were included in the study. The rest of the interviews were carried out during the summer and autumn of 2005 and the telephone interviews during three months in 2007.

A total of 36 young women signed a letter of consent including contact information and agreement to be contacted by the first author to arrange an interview approximately 2-3 weeks after the abortion. Three of these later declined participation without giving further reasons, five could not be reached despite several attempts, and three failed to attend the prearranged interview. The final sample thus represents in-depth interviews with 25 young women, approximately three weeks after medical (n=14), surgical (n=10), or second trimester (n=1) abortion.

Instrument

A topic guide with nine open-ended questions developed from previous findings[30, 97, 98] covered the circumstances of becoming pregnant and having an abortion, experiences of the decision-making process and received support, and perceptions regarding attitudes towards contraceptive use. Each interview lasted between 40 and 120 minutes.

Study IV

Between May and September 2007, young males aged 16-20 requesting a CT test at a local youth clinic were invited for in-depth interviews about 1-2 weeks after the visit. The nurse-midwife who performed the CT test informed each eligible participant about the study both verbally and in writing, and assured them that participation was voluntary and that data would be treated confidentially. The interviews were performed by the first author (M.E) in secluded “meeting rooms”, either at the local youth clinic or in the researcher’s office.

A total of 37 young men signed a letter of consent including contact information, and were contacted to arrange an interview shortly after the visit to the youth clinic. A reminder e-mail and a text message (SMS) were sent to each participant 1-2 days prior to the interview. Four could not be reached despite repeated attempts, four did not show up at the appointed time, and

seven declined participation because of second thoughts or lack of time. The final sample consisted of 22 young men.

Instrument

A topic guide was used covering the reasons for having a CT test, as well as the participants' perceptions of susceptibility and severity of STIs in general and CT and unintended pregnancy in particular, barriers to condom use, sexual risk taking for oneself and for one's partner, communication about safe sex, and responsibility for contraceptive use. Participants were also asked to express their beliefs about their friends' attitudes regarding condom use and risks in connection to unsafe sex.

Study V

Study V was designed as a RCT study with a sample size based on previous results from Gold et al. (2004) [99]. Assuming 15% and 8% ECP use (IG and CG, respectively) and a standard deviation of about 14 h from unprotected intercourse to ECP intake, 150 subjects per group would give approximately 80% power to detect a time difference of 11 h between groups at the 5% significance level. We assumed a drop-out rate of about 30%, and hence planned to recruit 210 subjects per group.

The study was conducted between July 2005 and November 2006. A total of 420 teenage girls aged between 15 and 19 who requested ECP at a local youth clinic in Sweden participated. The participants were consecutively asked to participate and thereafter randomly assigned to Intervention group (IG) or Control group (CG).

The CG obtained standard care which included ECP on request (1.5 mg levonorgestrel taken as a single dose), and a re-visit three weeks later for contraceptive counselling and a urine HCG pregnancy test. The IG received standard care and one extra dose of ECP. Each IG member was also provided with ten condoms and a specially-designed leaflet containing information and frequently asked questions and answers regarding ECP and condom use. Participants were followed up by structured telephone interviews three and six months after enrolment; some of these interviews were conducted by the first author (M.E), but most were performed by specially trained research assistants.

Instrument

The baseline questionnaire included socio-demographic data, sexual health history, contraceptive use, sexual risk taking, and ECP use. The follow-up interviews covered ECP use, time intervals for ECP intake, pregnancy history, contraceptive use, and sexual risk taking. To examine contraceptive use

and sexual risk taking, we asked respondents to recall for the past three months their number of new sexual partners, contraceptive use at first intercourse with most recent partner, non-condom use with new partners, occasions of unprotected intercourse, and acquisition of STI; additionally, we asked about contraceptive use at most recent intercourse.

Data analysis

Manifest content analysis (Studies I and II)

The focus group data were analyzed using manifest content analysis.[92] The first author initially read the transcripts in order to get a sense of the whole. Responses from each focus group were grouped into content areas according to interview question, using the cut-and-paste technique. Condensed meaning units were thereafter extracted and labelled with codes. Similar codes were compared and merged together, and then sorted into preliminary categories and sub-categories. This categorization process was aimed at extracting the manifest message in the texts and so frequency, extensiveness, and intensity of comments as well as verbal interactions within the groups were taken into consideration during the analytical process. All authors discussed and revised the content and boundaries of the preliminary categories, until consensus was achieved. The goal was to create mutually exclusive categories, which in their final stage were referred to as themes.

To avoid selective perception and achieve internal consistency the raw data were thoroughly reviewed by two authors, first separately and then together. A comparison of the categorizations of all recording units was made using the Kappa method,[100] resulting in a Kappa value of 0.92 in study I and 0.95 in study II.

Latent content analysis (Studies III and IV)

The in-depth interviews in studies III and IV were analyzed using latent content analysis. The analytical process in latent content analysis follows the same pattern as in manifest content analysis, but reflects more on the underlying message in the texts. The latent content emerged successively during the analytical process. In study III, mutually exclusive categories were formulated, including several sub-categories and one overarching theme. In study IV, the data was examined in light of the main HBM components, a process which resulted in two main categories, several sub-categories, and an expanded and modified HBM.

Investigator triangulation between all authors was used in studies I-IV in order to increase trustworthiness, and ongoing discussions were held during the categorization process until the final categories were settled.

Statistical analysis (Study V)

The Statistical Package for Social Sciences (SPSS) for Windows (14.0) was used to enter and analyze the data for study V. Differences between groups were tested at baseline and at follow-up using Student's t-test (mean time between unprotected intercourse and ECP intake) and Fischer's Exact Test/Pearson's $\chi 2$ test for two independent samples on nominal data (contraception/ECP use, sexual risk taking, pregnancy outcome, and STI).

RESULTS

Studies I and II

The manifest content analysis revealed six themes in study I and five in study II.

Study I themes: Negative attitudes toward teenage pregnancy; supportive attitudes toward abortion; risk-taking sexual behaviour; reproductive trends in society; responsibility regarding pregnancy and contraceptives – a girls' issue; and limited knowledge about abortion and contraception.

Study II themes: Ambivalent attitudes towards abortion; teenage parenthood – a catastrophe; a risk-taking lifestyle; preventing pregnancy – a shared responsibility in theory, but not in practice; and variations in school-provided sex education.

In general, male and female participants had similar views regarding teenage parenthood, sexual behaviour, and contraceptive habits. Attitudes towards abortion were positive. During the discussions, the boys seemed to focus more on the moral dilemma of abortion than did the girls. All groups, regardless of gender, put very strong emphasis on abortion's being a painful necessity and a right that should not be abused.

All male groups knew — and the majority agreed — that the unrestricted right to decide on abortion rests with the girl. However, some participants were frustrated by not having any legal right to influence the decision. It was stressed that men must be careful not to put pressure on the girl in her decision-making process. On the other hand, several boys stated that they would try to make a pregnant girlfriend have an abortion.

Both sexes considered teenage parenthood to be a catastrophe that would severely damage their lives and future prospects. Personal lack of maturity and insufficient economic means were considered to be hindrances to successfully bringing up a child.

All groups expressed liberal attitudes towards casual sex. Unconcerned attitudes towards sexual risk taking and its consequences were common. Failure

to use contraception mainly occurred under the influence of alcohol or in relation to unplanned sex; neither girls nor boys explained it as being due to lack of knowledge. Concerns regarding STI and unwanted pregnancy also seemed quite peripheral, especially among the boys.

Both boys and girls perceived girls as being mainly responsible for pregnancy prevention, and asking a new partner to use protection was often considered difficult – especially in unplanned situations. Overall, condoms were associated with embarrassment and discomfort. At the same time, several of the boys stated that they often put a silent trust in the girl's using hormonal contraceptives or taking emergency contraception after unprotected intercourse. The girls, on the other hand, were often apprehensive about the potential negative side-effects of hormonal contraceptives, and unreliable information sources regarding hormonal contraception were described as a considerable and confusing problem. Both girls and boys believed that ECP could be misused, or provide false security, which could ultimately lead to an increased risk of unwanted pregnancy.

The contemporary, sexualized media picture surfaced in the discussions of both the girls and the boys. Sexualized messages were believed to influence adolescents' sexual behaviour, mostly in a negative way. Several groups in both studies believed that people's sexual behaviour had taken a riskier direction over the past few years.

Gaps of knowledge regarding foetal development, abortion, and the risks connected to unprotected intercourse were obvious among both female and male participants, and experiences of school-provided sex education varied widely. The majority were dissatisfied with the quality and content of such education; nevertheless, several groups considered it to be an important counterweight to other sources of information about sex, such as pornography.

Study III

One overarching theme emerged from the content: "An illusion of power – the female teenager's dilemma of having contraceptive responsibility, but limited freedom of reproductive choice". The analysis also revealed six main categories, which are summarized below.

Underestimation of risk and inconsistent contraceptive use – reasons for unplanned pregnancy

The unplanned pregnancies were predominantly the result of very inconsistent contraceptive use. Several informants used no contraception, thinking they could not become pregnant at the time. Attempts at condom use were rare; general insecurity seemed to be the main barrier.

Lack of motivation to procure contraception and initiate safe sex was common, and often based on negative attitudes towards contraceptives. Several participants had previously experienced difficulties in compliance, or had experienced negative side-effects, especially regarding oral contraceptives. The young women were only vaguely attentive to their menstrual cycles. Several practised coitus interruptus but none of them had considered extra precautions during ovulation; most seemed to have heavily underestimated the risk of becoming pregnant.

Pregnancy prevention – the woman's responsibility

Contraceptive use was theoretically viewed as a mutual responsibility, but there was an underlying acceptance that the woman, and not her male partner, was "in charge" of pregnancy prevention in practice. The informants said their partners mostly relied on them to plan for, initiate, or provide contraception.

Paradoxical feelings accompanying the pregnancy and the abortion decision

The abortion decision was accompanied by mixed emotions and seen as a natural yet difficult choice. Social norms and negative attitudes of significant others strongly influenced the abortion decision. Partners and parents were regarded as the most important sources of support. Partners were commonly described as having made clear remarks in favour of termination, and the underlying message throughout the decision-making process was that the girls had freedom of choice – as long as they decided to terminate the pregnancy. Informants who were ambivalent, particularly, felt they were persuaded towards termination, and several stressed the need for more nuanced advice. For these young women, in particular, neutral attitudes from health care professionals were of great importance.

Social norms and significant others affecting the abortion decision

Social norms and negative attitudes of significant others were essential for the decision outcome. Parents, partners, or ex-partners were by far the most consulted and involved ones in the decision-making process.

Post-abortion reflections

Few participants had moral concerns regarding abortion. Instead practical, social, and economical reasons meant that most did not see continuation of the pregnancy as a realistic alternative. Immediately after the abortion, combined feelings of sadness, relief, regret, and emptiness were the most dominant. Generally, the abortion was regarded much more painful than expected. Nevertheless, three weeks post abortion, most of the girls — but not all — were convinced they had made the right decision.

Governed counselling and varying compliance regarding contraceptive use after abortion

Despite governed contraceptive counselling, motivation towards contraceptive use after abortion varied widely. Previous difficulties in finding a suitable contraceptive method meant that few of the contraceptive methods offered were seen as appealing.

Study IV

The analysis of young males' perceptions of risks for self and partner in connection to unprotected intercourse resulted in two main categories (presented below) and an expanded and modified HBM.

The first category was "Low perceived threat regarding sexual risk taking behaviour — personal consequences in focus". This category reflected the fact that threats connected with unprotected intercourse (e.g. CT infection or unintended pregnancy) could be *immediate*, for example subjective symptoms like itching and pain, or *distant*, for example future infertility. Generally however, the threat level was perceived as low. CT infection was the most commonly mentioned infection, but also considered the least severe; no one wanted to become a teenage father, but most of the young men were confident that any resulting pregnancy would not be carried to term. This led to decreased motivation for sharing pregnancy-preventing practices with their partner. The young men were also more concerned about personal con-

sequences regarding sexual risk taking than about the eventual consequences for their partner – especially if the partner was a temporary one.

The second category was "Perceived barriers to practicing safe sex". As already mentioned, fear of STIs or unwanted pregnancy was mostly of peripheral concern to the young men in our study, and so they had very little motivation to use condoms.

Other main barriers to condom use were interference with spontaneity, pleasure reduction, loss of erection, and embarrassment or distrust. Further obstacles were the girl's use of hormonal contraception, and difficulties in communicating about safe sex. Many of the young men generally preferred coitus interruptus to condom use.

Results in relation to the HBM

We found that the explanations for why young men may or may not use protection when having sex with a new partner were far too complex to be clarified by the original HBM. A modified HBM may help to increase understanding of young men's perceptions of sexual risk taking; our suggestion is presented in Figure 5.

For example, threats connected to sexual risk taking could be *immediate* or *distant*. In order to handle these threats, varying preventative strategies could be implemented (such as condom use, coitus interruptus, CT testing). However, before being implemented, these strategies were first evaluated according to their benefits (e.g. protection against disease and unintended pregnancy) and costs (e.g. pleasure reduction, fear of erection loss). Benefits and costs were, in turn, influenced by factors such as environmental context, partners' attitudes, significant others, self-efficacy/self-esteem, and gendered expectations.

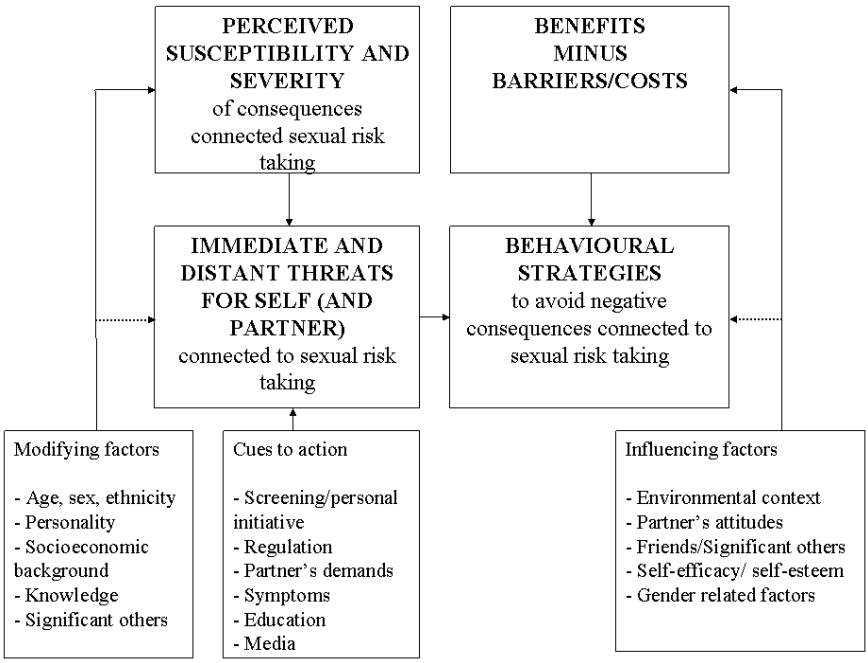

Figure 5. Modified version of the Health Belief Model — components and linkages.

This evaluation is illustrated by the following example. Using or not using a condom when having sex was generally determined by the perceived likelihood of STI transmission and/or the perceived severity of STI. Among our participants, CT was the most commonly mentioned infection, but also the least threatening one. The benefits and costs of using a condom were evaluated in each situation. If the sexual act took place somewhere that interruption was likely, for example in a public restroom or somewhere outdoors (environmental context), putting on a condom was usually not prioritized. The likelihood of using a condom was also diminished if the partner seemed hesitant towards condom use (partner's attitudes), if the peer group's overall attitude towards condom use was negative (significant others) or self-confidence regarding condom use was lacking (self-esteem/self-efficacy/gender roles).

However, preventative strategies were not solely determined by perception of threat or evaluation of benefits against costs. Protective measures were also connected to different trigger mechanisms, or *"cues to action"*. The main triggers for CT testing, for instance, were personal *initiative* (tests were sought due to worries about transmission, or as a matter of course after occasions of unprotected intercourse with new partners), *regulations* (related to

partner tracing), *demand from the partner* to take a test, and/or any *symptoms* that were experienced.

Study V

A total of 667 girls requested ECP during the study period; 52 did not meet the inclusion criteria regarding age and/or language barriers, 108 declined to participate, and 31 were not invited due to lack of staff time. During the recruitment period, 56 girls requested ECP on two or more occasions, but were only invited once. In total, 420 girls were finally enrolled and randomized to the study. Girls who declined participation were nearly five times more likely than participants to have a non-Nordic background (38% vs. 8%, p=<0.01) (Figure 6).

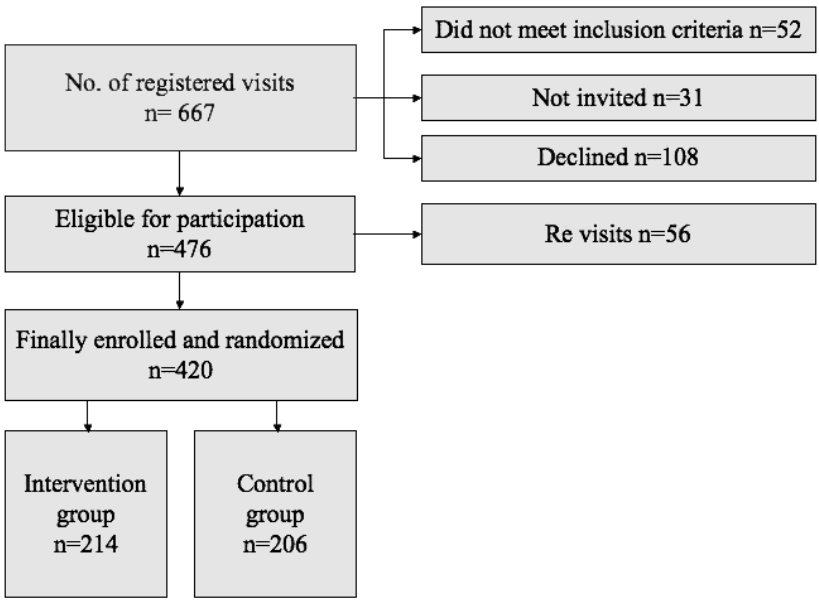

Figure 6. Trial profile, study V.

The main results of this study were that girls in the IG were almost twice as likely as those in the CG to have used ECP at the three-month follow-up (IG: 24.0%, CG: 13%, p=0.02), and they also used it sooner after unprotected intercourse (mean time IG: 13.61 h, CG: 25.47 h, p=0.007). The differences between the groups remained significant after six months (ECP use IG: 31%, CG: 19%, p=0.01; and mean time IG: 15.59 h, CG: 26.38 h, p=0.006).

Another major finding was that there were no significant differences in the use of regular hormonal contraceptives or condoms at either follow-up. About 40% (n=128) of the girls in both groups had risked pregnancy by having had unprotected intercourse at least once during the follow-up period, and only half of these (49%, n=63) had used ECP afterwards. However, more girls in the IG had used ECP, compared to controls (IG: 58%, CG: 37%, p=0.02).

Only half (55%, n=35) of the girls in the IG who reported unprotected intercourse during the study period had used their advance supply of ECP, whereas 39% (n=25) still had the package at home. Four of the girls had given their ECP supply away.

Change of partner during the study period was fairly common; more than one in three participants (37%, n=121) had changed partner at least once during the study period. At the three-month follow-up, girls in the CG reported partner change more often and with more partners than girls in the IG (partner change: CG 33%, IG: 21.5%, p=0.03; and mean no. of partners CG: 1.59, IG: 1.19, p=0.014), but these differences were no longer apparent at the second follow-up.

Among those reporting intercourse with a new partner at the three-month follow-up, 16 of 31 IG members (52%) and 17 of 46 controls (37%) recalled at least one occasion when condoms had not been used (p=0.198); the corresponding figures at the six-month follow-up were 62% in both groups.

Six months post-recruitment, seven girls had acquired an STI (five IG members and two controls). Seven had become pregnant (four IG members and three controls), one of them twice. Three pregnancies were terminated, three ended in early miscarriage, and two were continued.

DISCUSSION

Methodological considerations

Focus group interviews were used to collect qualitative data on attitudes and knowledge concerning teenage pregnancy, abortion, sexual behaviour, and contraceptive habits. The findings illuminate the participants' opinions and concerns on these matters. Our decision to carry out the interviews in the school buildings during school hours enabled students to participate easily and may have had a positive effect on the participation rate; altogether only five girls and six boys did not show up at the time of their assigned group discussion.

We decided to conduct the interviews for study III a relatively short time after the abortion, since we wanted the girls' experiences to be rather close to the actual period of the decision making process. Also the interviews in study IV were conducted soon after the invitation to participate.

Of the 36 young women in study III, who had agreed to be contacted for arrangement of an interview, 11 declined, could not be reached, or failed to attend the prearranged interview. The corresponding number for young men in study IV was 15 out of 37. Potential participants who were invited but declined immediately were not registered, and therefore we have no exact data on the external attrition rates in any of these two studies. The impression among the authors in charge of inviting participants to study III was that women with a non-Swedish background were more reluctant to participate than were native Swedes. Thus, the external and internal attrition may be explained by the sensitive matter of the subject and by possible second thoughts concerning participation.

Collecting and sharing sensitive data

In all forms of interview situations - FGDs, in-depth or structured interviews - sharing information on sensitive topics involves the risk that informants may say only what they find socially appropriate or think that the researcher wants to hear. For example, everybody "knows" that one should use protection in order to avoid unwanted pregnancy and STI. In the heat of the moment, however, this rule may not always be easy to apply.

Key concepts to reduce this risk are anonymity (to the degree possible), discretion of setting (e.g. secluded talking rooms), and trust between the interviewer and the informant. We tried to consider all of these in our five studies. In studies I and II, we chose young female and male moderators with a non-authoritarian approach to perform the interviews, which we believe had a positive effect on the credibility of the data. Conditions of confidentiality were carefully described in the focus groups, and "ethical contracts" were established prior to each session. Confidentiality was ensured also for participants in studies III, IV, and V. Secluded meeting rooms were used for all interviews, the questionnaire was filled out in private, and before the telephone interviews we made sure each informant could speak without being overheard.

Trustworthiness and interrater reliability

In qualitative research, trustworthiness is concerned with establishing arguments for the most probable interpretations. It can be assessed and obtained in a number of ways. In studies I and II, trustworthiness or "interrater reliability" was assessed using Kappa statistics.

The Kappa statistic determines the extent of agreement between two or more authors exceeding that which would be expected purely by chance. In other words, Kappa statistics indicate whether two or more investigators classify categories in a similar way. With 100% agreement, the Kappa value is 1.0.[100] A comparison of the categorizations of all recording units resulted in a Kappa value of 0.92 in study I and 0.95 in study II.

Triangulation is another excellent way to strengthen trustworthiness in qualitative data. Triangulation methods include, for example, the use of multiple methods, measures, researchers, and perspectives.[96] In studies III and IV we applied author triangulation – that is, in our case, having two or three authors independently analyze the same qualitative data and compare the findings. We did this in order to avoid single-analyst bias and thus strengthen the trustworthiness of our results.

Interpretation

Studies I-IV had qualitative design, with purposively selected informants, and so the results are not suitable for generalization. The advantages of qualitative research lie in the depth and complexity of the results and the variety of data gathered. We believe that our results illustrate Swedish adolescents' perceptions of contraceptive habits, unwanted pregnancy, teenage parenthood, and abortion, in an illuminating way.

Validity and reliability

In order to find out how many participants were needed to answer the questions posed in study V, we made a power calculation based on previous results from a similar study.[99] Since the participants were to be followed during six months after the initial visit, there was a great risk of high attrition. We therefore estimated a drop-out rate of approximately 30%, which was included in the power calculation.

In order to reduce the attrition rate as much as possible, different strategies were applied. An e-mail was sent to notify the girls a few days prior to the planned follow up interview, calls were attempted at different times and days of the week, and voice messages were left on the participants' mobile phones letting them know we would try to reach them again. After such attempts, most of the participants could be reached. However, some had changed their phone numbers over the study period; others were studying abroad or simply could not be reached. Some responded to the notifying e-mail message, either letting us know their new numbers and times when we could call, or declining further participation. In the end, some 78% of all participants were followed up at least once.

As in study III, difficulties in recruiting participants with immigrant background were also seen in study V. Both external and internal drop out rates were considerably higher among girls with non-Nordic background compared to girls of Nordic origin. The high attrition rate among immigrant girls might have affected the representativeness of our sample. Immigrant girls constitute a particularly vulnerable group concerning reproductive health issues,[101] and the intervention may therefore not have reached those who perhaps needed it the most. We cannot rule out that, for some, refusal to participate may have been due to concern over family members finding out about the study.

Recruitment, data collection, and follow up-interviews in study V were performed by seven different midwives and three research assistants. In order for the intervention procedure to be conducted in the same way for all participants, a manual was distributed to the midwives and research assistants prior to the start of the investigation. The participants were consecutively invited and thereafter randomly assigned to either IG or CG. Baseline characteristics between the groups turned out to be almost identical, and no systematic differences should therefore have occurred during the recruitment and randomization process. Hence, we assume that our results can be generalized to Swedish teenage girls requesting ECP also outside the context of the previous study.

Our questionnaire in study V was non-standardised, study-specific, and constructed by the authors. The questions were partially based on previous studies.[50, 99] Since the data were based on self-reported measures up to six months after the initial visit to the youth clinic, recall may have been biased, possibly regarding questions about time frames for ECP intake in particular. However, at both follow up interviews, most questions covered sexual events only for the past three months. Furthermore, any difficulties in remembering such events would have affected both groups similarly according to the randomization. When IG-participants were asked about the specific ECP pack that was distributed to the IG in advance, only a very small number of participants had difficulties in remembering whether they had taken it or not. Regarding the time frames of ECP intake after unprotected intercourse, our results are very much in accordance with results found in previous studies (Gold), and we therefore consider them to be reliable.

As in all research concerning human behaviour, there are great risks that confounding factors will ”disturb” the measured outcome. Participants may, for instance, be influenced in various ways by media, friends, partner, and parents, which in turn could have an effect on their behaviour. Some factors could have weakened our intervention and may have caused some diffusion of the results; for instance, some participants purchased new ECP at the pharmacies, some returned to the youth clinic for additional ECP, and some gave their advance provision away. Nevertheless, even with a limited intervention, our results regarding ECP use and time between unprotected intercourse and ECP intake were significant at both follow ups.

In our statistical analyses, we considered the limits of the Chi square test and have not presented values if more than 20% of the cells had an expected count of <5 or if any of the cells had an expected count of <1.

Ethical concerns

Any exploration of perceptions of sexual risk taking and contraceptive use can be a sensitive and complex undertaking, and approaching adolescents who are in what may be perceived as vulnerable positions may raise issues of concern. However, all informants were thoroughly informed that participation was voluntary.

In the interview studies, participants talked openly and extensively about general attitudes and/or personal experiences. Many appreciated the possibilities to reveal their needs, thoughts, and stories to an attentive outsider. A couple of girls in study III were advised to see a professional counsellor after the interview session.

According to the Swedish secrecy act,[102] information on all individuals' health is protected, and therefore parental consent was not needed when extending invitations or distributing ECP to the young participants in study V. No participants used the contact information on the distributed wallet cards. However, two wallet cards were found by the participants' mothers, both of whom contacted the first author (M.E) for further information about the study. Some of the girls in study V took advantage of the follow-up telephone interviews in order to ask questions about contraceptive use.

We were hesitant to distribute ECP in advance to young teenage girls without giving them additional information and protection against both unwanted pregnancy and STI. Therefore, in addition to the advance supply of ECP, girls in the intervention group also received ten condoms and a specially-designed leaflet containing information regarding ECP and condom use.

Reflections on results (Studies I-V)

When this research project was initiated, sexual health among Swedish teenagers seemed to be moving in an unfavourable direction, with increasing numbers of abortions and CT infections. The core question was, of course, *what are the causes of this development?* As noted earlier, the explanations are most likely to be multidimensional, with social, cultural, economic, and epidemiologic factors all having an effect. Prior to commencement of the present work, a number of issues had been discussed by researchers, including the question of whether attitudes towards abortion had become more liberal and whether young peoples' sexual behaviour had turned into riskier practices.[9, 30]

Considering that relatively few qualitative studies in Sweden had been conducted within this area, some specific questions were formulated. First, what attitudes do Swedish teenagers have towards contraceptive use and sexual risk taking, and how is teenage pregnancy and abortion perceived? (Studies I and II). Second, in a time with easily available contraceptive methods, what are the circumstances behind unwanted pregnancy and what determines young women's decisions about pregnancy termination? (Study III). Third, given the results of the first three studies, young men with personal experiences of sexual risk taking were asked how they perceived the risks connected to unprotected sex and what made them not use (or use) a condom when having sex with a new partner (Study IV). The findings of these four studies comprise the qualitative part of this thesis.

Study V was undertaken in parallel with studies III and IV. This RCT study differed from studies I-IV in method, but was broadly concerned with the

same core topic, namely sexual risk taking. Having considered the fact that many teenage girls were in need of a "plan B" after unprotected intercourse but often turned to the youth clinics *after* the weekends in order to obtain ECP free of charge, we wanted to investigate the effect that advance provision of ECP would have on ECP use. We also wanted to evaluate whether advance provision of ECP would affect sexual risk taking. No such study had previously been conducted in any of the Nordic countries.

I will now provide a brief summary of the results, and then discuss the findings in relation to previous research findings. Finally, I will propose some practical implications for future research.

Brief summary

Attitudes towards abortion were positive; most participants emphasized abortion as an asset that should not be abused. Low motivation to obtain and use contraceptives and unprotected intercourse under the influence of alcohol were suggested as the main reasons behind the increasing numbers of abortions among Swedish teenagers (Studies I and II).

Attitudes toward casual sex were liberal, and occasions of partner change combined with contraceptive failure seemed to happen rather frequently (Studies I-IV). Suggesting or initiating condom use was found to be difficult for girls as well as boys (Studies I-IV) for a number of reasons; fear of ruining an intimate situation, associations with disease, distrust, pleasure reduction, and (for the boys) the fear of losing one's erection. Many of the female participants revealed worries about negative side effects of hormonal contraception; these worries were also demonstrated in their reluctance to use such contraception (Studies I and III). Nevertheless, there was a widespread attitude among both females and males that placed the overall contraceptive responsibility on the woman (Studies I-IV). Men generally perceived risks in connection to unprotected intercourse as low, but at the same time expressed greater concerns for themselves than for their partners regarding the consequences of unsafe sex (Study IV).

Teenage parenthood was viewed as a "catastrophe" by both males and females (Studies I-IV). However, few of the men were seriously worried that an unintended pregnancy would actually be carried to term. Moreover, the majority of the males would urge the girl towards termination if she seemed ambivalent. In turn, some women felt persuaded towards abortion not only by their partners, but also by parents, peers, and the strong societal norm which favours abortion over teenage childbearing. Advance provision of ECP increased its use and shortened the time interval from unprotected intercourse to pill intake without increasing sexual risk taking (Study V).

Discussion of findings

Following the increased abortion rates among teenagers, voices have been heard suggesting a moral shift in young people's attitudes towards pregnancy termination. Even though the majority of the interviewed adolescents in our studies were positive towards abortion, we found no evidence for this hypothesis.

Liberal attitudes towards casual sex and frequent change of partners, combined with low motivation and/or lacking strategies for using protection is an ill-fated combination. Even though sexual experimentation and crossing boundaries are normal parts of adolescents' sexual development,[4, 42, 43] teenagers engaged in careless sexual behaviour are at risk of unwanted pregnancy, STIs, or both.

Equal responsibility among boys and girls regarding sexual and reproductive issues is a goal which seems far from being accomplished. From a gendered perspective, this reveals a worrying dilemma since both female and male participants viewed teenage parenthood as a "catastrophe". In addition, we have seen young women being reluctant to use hormonal contraception, while many of the young men were unwilling to use condoms. This is especially unfortunate considering that whether unprotected sex results in an unwanted/unintended pregnancy or an STI, the possible physical, social, and emotional consequences generally hit women harder than men.[45, 46, 78, 80, 103-107]

Motives and strategies for contraceptive use are complex. Despite thorough contraceptive counselling (Study III), the enthusiastic attempts of the health care professionals to successfully ensure contraceptive compliance were not unproblematic. Motives for contraceptive use post-abortion varied widely. Some of the young women experienced the counselling as being too persuasive while still failing to solve previous contraceptive problems such as compliance difficulties and persistent fears of negative side-effects.

Even so, women have been natural targets for pregnancy prevention for decades, and the organizational structure of preventative strategies and the health care system have meant that women have come to face greater expectations than men in contraceptive compliance.[67] Leaving the contraceptive responsibility in the hands of women has been reported as a recurring tactic among men in previous studies.[72, 97, 98, 108, 109] Since all available contraceptive methods except the male condom are applicable to women only, a general attitude may have arisen of women's being the "natural" contraceptive users.

The young men in study IV expressed greater concerns for themselves than for their partners regarding the consequences of unprotected sex. Similar attitudes have been recognized in a couple of other Swedish studies,[109, 110] and may reflect an *egocentric view* of sexual relations.[11] Consequently, this self-indulgent image of sexuality augments the already problematic power imbalance between young women and men, where men may continue to escape responsibility for sexual and reproductive health.

Helping young men gain confidence in their ability to use condoms, including increased emphasis on correct use, may be an important public health strategy. It is also important to challenge the contemporary western hegemonic picture of masculinity[111] in order to reduce performance anxiety and low self-esteem.

Although it is described as the "ideal" or normative form of masculinity, the hegemonic masculinity is not assumed to be normal in the statistical sense; it may in fact be enacted by only a minority of men. However, it embodies the way of being a man that is currently most valued in western societies.[5, 112, 113] We found that some of the main barriers for condom use were associated with such gendered expectations. The most obvious evidence for this was failure in sexual performance due to erection loss. According to previous research, gendered expectations and structures help to sustain and reproduce men's exposure to sexual risks.[111, 114]

Besides the abovementioned theory, our modified HBM may help to increase understanding of the complex factors determining sexual risk taking behaviours among Swedish adolescents.

Although the vast majority of young men in our studies saw teenage fatherhood as a catastrophe, few were seriously worried that an unintended pregnancy would actually be carried to term. Moreover, the majority said that they would urge the girl towards termination if she seemed ambivalent. This perception among the young males of being vulnerable while at the same time being set apart from reproductive responsibility is a matter of concern.

The male partner's attitude towards an unwanted or unplanned pregnancy is often crucial to the woman's decision.[30, 37] However, male partners (and others) may not always recognize the strength of their influential powers. The abortion decision among interviewees in study III was strongly influenced by partners in particular, but also by parents, peers, current norms, and societal expectations.

Negative attitudes towards teenage pregnancy are widespread in Swedish society and the norm strongly favours abortion over teenage childbearing.

We found that the societal expectations following this norm were closely intertwined with the interviewees' own attitudes - most of the young women in our study shared the view of abortion as being the one and only correct solution.

This norm of Planned Parenthood raises several questions. Why is teenage pregnancy perceived as such a big problem and whose problem is it?[115, 116] Could scientific messages about the negative outcome of teenage childbearing make us believe that *no* young woman – or man — is capable of taking care of a child? And could negative messages about teenage childbearing spread to also include older teenagers and even women in their early twenties? There may be wide differences in maturity between a 16-year-old girl and a 19- or 20-year-old woman. Nevertheless, the women in our study seemed to experience the same normative restraints and holdbacks in terms of childbearing at a young age.

Some of our interviewees had strong doubts regarding the abortion but the negative attitudes towards the pregnancy expressed by people close to them made them feel powerless during the decision-making process. An abortion decision often involves conflicting and contradictory emotions.[26, 117, 118] These are usually temporary, and most women who undergo abortion suffer no long-term regrets or negative effects.[26, 119] However, even if abortion under legal circumstances is regarded as a harmless procedure, persistent feelings of ambivalence and in some cases severe emotional distress do occur and should not be neglected.[26, 103, 104]

Previous studies have found that the strongest predictors of emotional distress and post-abortion depression in women who had experienced abortion were pressure from the male partner, and ambivalence prior to the abortion.[103, 104] Thus, ambivalence towards abortion combined with direct or indirect persuasion from others puts undecided teenage girls and young women in a vulnerable situation. The formal right to decide whether or not to terminate a pregnancy may therefore - in reality - not be a rule applicable to *all* women. This may, in turn, undermine teenage girls' and young women's freedom of reproductive choice.[120]

ECP is a valuable complement when regular contraceptives fail. It gives women – and men – a second chance to prevent an unwanted pregnancy. But should teenage girls have this available when the need has arisen at home or in their hand-bags? There are two mistaken but prevalent beliefs about teenagers: that their contraceptive use, including ECP, will promote promiscuity and that teenagers behave irresponsibly when it comes to sexual relations.[121] For the vast majority of young people this is not true and on the other hand adults may not behave any better as reflected in termination rates. We

showed that accessibility was an important factor for both increased use and reduced treatment delay: thus having ECP at hand meant that it was more likely to have worked – without increased risk taking.

Since many young women delay treatment until after the weekend, thus potentially reducing the efficacy of the treatment, advance ECP provision on a routine basis may be a good strategy. Providing teenage girls with ECP in advance did not jeopardize regular contraceptive use, nor did it increase sexual risk taking behaviour in general. Our findings are in agreement with previous international studies, and conclude that the possible health risks of providing increased ECP access to teenagers should be considered minimal.[122-125]

Even when provided with ECP in advance, about 40% of the girls had risked pregnancy during the study period and only half had used ECP afterwards. Again, this highlights the complex nature of contraceptive use in general and ECP use in particular. In reality ECP is still largely under-utilized, even when it is readily available.[126-128] Underestimation of the risk of pregnancy and lack of knowledge about the menstrual cycle or the distinction between high-risk and low-risk coital acts were seen in studies I-III and may serve as an explanation for this phenomenon.

The summary above highlights a few important issues. First, civil society, researchers, and counsellors, cannot rely solely on women as compliant contraceptive users. In order to prevent unwanted pregnancy and STIs, the man and the woman need to share contraceptive responsibility, and should both be empowered to better communicate safe sexual practices, especially with casual partners in unplanned sexual situations.

Second, the lack of motivation to use contraception and the fear of negative side-effects need to be taken into serious consideration. It is important to take advantage of the valuable counselling session in order to create a sound dialogue with young women about the best suitable contraceptive method, with the highest chance for individual compliance.

Third, the limited knowledge about menstruation cycles and the underestimation of the pregnancy risk combined with overestimation of the risks of hormonal contraception are matters of concern. Both male and female teenagers also seemed to have limited knowledge regarding abortion and foetal development. Our findings are in concordance with those of a recent study where the time of ovulation was known by 21.4% of male students aged 13-25 and 63.4% of their female counterparts. The majority lacked general knowledge of the way oral contraceptives work, and 57.5% stated that they had not received enough information on reproductive issues. The authors

concluded that the students had not achieved the level of knowledge concerning sexual and reproductive matters that, according to the national curriculum, they should have attained by the end of the 9th grade.[19]

Despite thorough plans and national guidelines for sexual education that exists,[129] students receive different standards of education.[18, 24] However, even though the quality and the quantity of sex education received in school seemed to vary widely among the participants in our studies, the results indicate that the students had high expectations of such education and considered it to be an important counterweight to other common sources of information on sex such as, for example, pornography.

Basic knowledge about fertility and the menstrual cycle is of fundamental importance for women's sexual and reproductive health and rights. In order for young women to be able to make informed choice about whether and how to avoid pregnancy, we believe it is important to give these issues higher priority not only during contraceptive counselling but first and foremost within school-provided sexual education.

Over the years, several suggestions for action plans and overall grand goals and objectives have been proposed in order to reduce unwanted pregnancy and the incidence of STIs in Sweden. Unfortunately, broad-based and concrete implementation, and follow-ups and evaluations of these goals and strategies, are lacking. There are currently no operational goals aimed at battling these issues in a concrete manner. Considering the drastic increase in the number of abortions and the generalized CT epidemic among Swedish youth during recent years, there is an urgent need to actually put the preventative plans into action.

Implications and suggestions for future research

Our results suggest a number of implications. Some of them have been proposed previously by others, but nevertheless deserve to be repeated.

1. Enhanced primary prevention strategies, such as increased quality of the school-provided sex education, are definitely needed. Skill training and discussion groups should be developed and recurrently used among male and female students, with a focus on concrete strategies for practicing safe sex (such as communication, negotiation, and empowerment).
2. Further research is needed to better understand reproductive responsibilities from a gender perspective; that is, the factors which

determine young men's and women's motives and prevention strategies for reducing the risk of STI and unintended pregnancy.

3. Gender-based aspects of sexual and reproductive health should be incorporated within counselling and teaching.
4. There is a need for strategies which empower boys and young men to play a greater part in sexual and reproductive responsibilities. My specific suggestions are: enhanced efforts to make youth clinics more "male friendly", broad based media campaigns with male role models as condom promoters, and serious enlightening of the issues and barriers which deter adolescent males from using condoms.
5. Considering the new challenges facing health professionals during contraceptive counselling (e.g. widespread fear of hormonal contraceptives), ongoing development is needed. Counsellors should continue to strive to provide balanced information along with open dialogue, with the aim of identifying those contraceptive methods which have the highest compliance probability for the individual person.
6. A neutral approach by health care professionals when meeting with the abortion applicant and during counselling seemed to be of immense importance, and should be further encouraged.
7. Better access to ECP was an important factor for increased use and reduced treatment delay. Extended opening hours and drop in services on week ends are therefore suggested.
8. Our modified HBM may serve as a complement to the original version and is suggested to be used for teaching, design of questionnaires and interventions, and in development of primary prevention strategies. Whether our modified HBM can explain sexual risk taking behaviour in settings and contexts outside those of our study would be an interesting topic for further research.

SUMMARY AND CONCLUSION

Studies I and II

Male and female participants were mostly unanimous in their views of sexual behaviour, contraceptive habits, and teenage parenthood. Girls seemed to bear the main responsibility for pregnancy prevention and contraceptive compliance, while at the same time many of them feared negative side-effects from hormonal contraception. Experiences of sex education varied widely, and were considered unsatisfactory by the vast majority. Both males and females showed insufficient knowledge of basic reproductive health issues.

Schools generally need to improve the quality of sex education, and give priority to covering abortion. Equal responsibility among boys and girls regarding reproductive issues still remains a challenge, but is nevertheless an important key in preventing unwanted pregnancies.

Study III

The basic right of Swedish women to decide on abortion may be limited by the societal norm and disapproval of teenage childbearing. The perception of women as being mainly responsible for pregnancy prevention implies that sexual responsibility needs to be considered as a gender issue, and that efforts are needed to include males in prevention practices to a greater extent.

Study IV

A modified HBM may help to increase understanding of young men's perceptions of sexual risk taking. Helping young men gain confidence in their abilities to share contraceptive responsibility with their partners, and challenging the contemporary picture of western masculinity, may constitute important public health strategies for protecting young people's sexual and reproductive health.

Study V

Even though no study has yet been able to show reduced pregnancy rates at a population level, the positive effects of easy ECP access for individual women should not be ignored. Teenage girls in need of emergency contraception are known to be at risk for unintended pregnancies. Since we have demonstrated that advance distribution of ECP shortened the time interval from unprotected intercourse to pill intake without jeopardizing contraceptive use and without increasing sexual risk taking, ECP distributed on a routine basis could be beneficial. However, unless additional strategies are also employed, it may not result in increased ECP use after unprotected intercourse.

ACKNOWLEDGEMENTS

The studies were supported by financial grants from: The Swedish Research Council, Uppsala County Council, The Swedish National Institute of Public health, Organon AB (part of Schering-Plough), The Family Planning Fund in Uppsala, and Föreningen Uppsala sjuksköterskehem.

I would like to thank *all the participants* for your generosity and willingness to share your intimate thoughts and feelings with me. I feel very privileged.

Professor Tanja Tydén, my supervisor. Who would have known, when at the age of 13 I and my classmates helped distribute the condom promotion posters for the fourth study in your PhD project, that I would be writing these words today… You invited me to this research project, encouraged me to carry it through, and gave me the best possible support throughout my years as a PhD student. With fine tuned ability and remarkable balance you have always seemed to know when to govern and when to let go. Your enthusiasm, genuine commitment, wisdom, and presence have always been inspiring for me. Thank you for introducing me to the academic world.

Associate Professor Margareta Larsson, my supervisor. Thank you for your excellent coaching, and for always giving me such sharp and intelligent feedback on my work. Your analytical skills are impressive, covering a broad field of knowledge – in several different disciplines. You are a true role model.

Associate Professor Elisabeth Darj, my supervisor. Thank you for your valuable scientific guidance and skillful contribution to my work, for your help in recruiting study participants, and for endless encouragement throughout the research process.

Professor Ove Axelsson, Head of the Department of Women's and Children's Health. Thank you for welcoming me as a PhD student.

My managers at Kvinno- och barndivisionen, Akademiska sjukhuset, Uppsala, for giving me the working conditions which enabled me to work wholeheartedly on this research project.

Professor Louise von Essen, co-author. Thank you for your valuable contribution to the first paper.

Markus Thuresson and Stefan Sörensen, for valuable statistical guidance.

Eva Grönlund, Madeleine Langfos-Jonsson, Ulrike Aldegarmann, Margareta Johansson, Margareta Lhådö, Nanna Bjarman-Bing, and Anna-Nora Morén. Thank you for your outstanding dedication and help in recruiting the study participants. This would not have been possible without your support and efforts!

Maria Fagerström, Annika & Åsa Martén. Your dedication and thoroughness during data collection has been invaluable.

All nurse students, some of whom I wish to thank for helping with the data collection, others for interesting collaboration during essay writing, and also for providing me with interesting reading matter. I appreciate it!

Suzanne Bielik, for thorough and rapid help with transcription of the extensive interview material.

Kake Pugh at Proper English AB, for professional, fast, and always very perceptive review of my English.

All wonderful colleagues in the network for researching midwives, for valuable and constructive criticism and for help in preparing the defense of my thesis.

Karin Törnblom, administrator. I cannot cherish the excellent support of yours high enough. It has reached way beyond administrative and economic matters. The project would not have runt so smoothly or been as much fun without you at the office!

Kristine Eklund, computer coordinator. Thank you for always helping me out when I needed it. I admire your never-ending patience with my computer.

Barni Nor, colleague and friend. I will miss your unique generosity and all our intense discussions. I could not have had a better room mate than you. I also truly appreciate all the times you have reviewed my texts – always very thorough, always very honest. Thank you!

Staff and colleagues at the Institution of Women's and Children's Health. Thank you for providing a friendly and stimulating working atmosphere, not to mention all the interesting conversations in the lunch room!

My colleagues in clinical practice, for your interest and encouragement throughout the entire research process.

Maria Nöremark, for being such an excellent proof-reader, friend, and neighbour.

Tobias Berving, for creating the cover of this book.

*To **all** my other friends*, all over the world, that I have been blessed to meet in life. In good times and in bad times I can always count on you. Do know that you are very dear to me.

Johan – with endless love and genuine support you always stand by my side. Now it is payback time and you have certainly earned it!

My mother, father, brother, and Johan – There are no words that can do you justice. You are my beloved family, and I want you to know that of all things in the world, you mean the most to me.

SAMMANFATTNING PÅ SVENSKA

Trots subventionerade och lättillgängliga preventivmedel, kostnadsfri preventivmedels-rådgivning på ungdomsmottagningar och obligatorisk sexualundervisning i skolan, skedde från mitten av 1990-talet och framåt en kraftig ökning av antalet tonårsaborter och klamydiainfektioner bland ungdomar i Sverige. Sannolikt berodde denna utveckling på flera samverkande faktorer men mycket talade för en ökning av sexuellt risktagande bland unga.

Studier som jämfört ungdomars sexualmönster och beteende över tid, har bland annat visat att unga i början av 2000-talet har en mer tillåtande syn på tillfälliga sexuella kontakter, fler antal sexualpartners och oftare sex ”första kvällen” jämfört med ungdomar för 20 år sedan. Porngrafi har blivit alltmer lättillgängligt. Såväl flickor som pojkar ”konsumerar” pornografi - något som också speglas i en mer avanserad sexuell repertoar, där exempelvis oral-anal- och gruppsex tycks ha blivit vanligare.

Kondomanvändningen har dock inte följt trenden av ökat risktagande. Trots att många tonårsflickor och unga kvinnor använder hormonella preventivmedel har bland annat återkommande larmrapporter i media om risker i samband med p-pilleranvändning, medfört en ökad misstro mot hormonell antikonception med minskat användande som följd. Majoriteten unga känner till akut-p-piller, men få använder det varje gång de utsatt sig för risk att bli oönskat gravida. Gravida tonårflickor väljer i högre utsträckning att göra abort idag jämfört med för 10-20 år sedan.

Utgångspunkter

Jag ville fördjupa kunskaperna om sexuellt risktagande bland svenska ungdomar. Mot bakgrund av den kunskap som fanns om förändrat sexualbeteende bland unga, identifierades ett antal områden där ytterligare forskning behövdes. Några av dessa presenteras nedan.

Aktuell kunskap saknades om vad ungdomar själva trodde att ökningen av antalet tonårsaborter berodde på, men framför allt vilka attityder unga tjejer

och killar hade till sexuellt risktagande, preventivmedelsanvändning, oönskad graviditet och abort.

Flera studier fanns om svenska kvinnors upplevelse av, samt motiv till abort. Få studier har däremot haft huvudfokus på beslutsprocessen i samband med abort och hur denna är relaterad till stöd och bemötande från betydelsefula personer i flickornas omgivning samt rådande normer i samhället.

Det fanns heller inga (enligt vår kännedom) aktuella studier som utifrån en vedertagen teori försökt förklara hur svenska *tonårspojkar* ser på risker i samband med oskyddat sex för sin egen del, eller för sin partner samt vilka barriärer som kan utgöra hinder för preventivmedelsanvändning i olika sexuella situationer.

Akut-p-piller (750 µg levonorgestrel) är en metod som kan användas som nödlösning för att förhindra oönskad graviditet efter oskyddat samlag. För bäst effekt rekommenderas kvinnor att ta akut-p-piller inom 72 timmar efter oskyddat samlag. Såväl vetenskapliga studier som kliniska erfarenheter har visat att behov av akut-p-piller ofta uppstår under helgen då apoteken har begränsade öppettider och ungdomsmottagningar vanligtvis har stängt. Då akut-p-piller blev receptfritt i Sverige år 2002 var det många som trodde att antalet tonårsaborter skulle minska. Besvikelsen var stor när detta inte infriades och en av anledningarna ansågs bero underanvändning av preparatet efter oskyddade samlag. Internationella studier hade bland annat visat att utdelning av akut-p-piller i förebyggande syfte ledde till ökad användning och dessutom snabbare intag efter oskyddade samlag. Någon studie i skandinavisk kontext hade däremot dittills aldrig utförts.

Syftet med avhandlingen var att i fem delstudier undersöka ungdomars inställning till och erfarenhet av preventivmedelsanvändning, oönskad graviditet och abort **(studie I, II, III)**. Vidare att utifrån en teoretisk förklaringsmodell undersöka hur unga män såg på sexuellt risktagande för egen och partners del samt barriärer för preventivmedelsanvändning **(studie IV)**. Syftet var även att undersöka om en intervention bestående av förebyggande utdelning av akut-p-piller till tonårsflickor kunde leda till ökad användning och snabbare behandling **(studie V)**.

Både kvalitativa och kvantitativa metoder har använts. Metoden för de två första delstudierna var fokusgruppintervjuer, den tredje och fjärde var djupintervjustudier och den femte en randomiserad kontrollerad interventionsstudie. Materialet omfattar studier bland svenska ungdomar mellan 15-20 år.

Vad har dessa studier tillfört?

Nedan följer en sammanfattning av avhandlingens delarbeten. Av stilmässiga skäl kommer jag framför allt att använda mig av uttrycken tonårsflickor/pojkar, trots att några deltagare hade hunnit fylla 20 år.

Övergripande resultat delstudie I-IV

Trots att det i abortdebatten framförts farhågor att tonårsflickor idag tar alltför lättvindigt på oönskad graviditet och abort, fann vi inga belägg för detta i våra studier. Däremot visar våra resultat att även om intentionen att använda preventivmedel fanns i teorin, så fullföljdes den inte alltid i praktiken. Många av ungdomarna i våra studier tycktes dessutom under-skatta risken för oönskad graviditet. Liksom tidigare forskning visat fann vi att såväl flickor som pojkar hade begränsade kunskaper i centrala frågor beträffande sexuell och reproduktiv hälsa (till exempel menstruationscykel, abort, fosterutveckling).

Våra studier stärker också tidigare resultat beträffande liberala attityder till tillfälliga oskyddade sexuella kontakter (I, II) samtidigt som många av ungdomarna uttryckte negativa attityder till preventivmedelsanvändning i allmänhet och kondomanvändning i synnerhet (I, II, III, IV). Många flickor oroade sig för eller hade negativa erfarenheter av biverkningar i samband med hormonell antikonception (I, IV). Bristande kommunikation mellan parterna ledde ofta till outtalade förväntningar vilket bidrog till en ojämn ansvarsfördelning gällande preventivmedelsanvändning, där såväl flickor som pojkar tillskrev flickorna huvdansvaret för preventivmedel i praktiken (I, II, III, IV).

Omedelbara risker (såsom erektionssvikt, osäkerhet inför partnern eller tidsbrist) hindrade tonårspojkar från att använda kondom. Dessa risker ansågs generellt sett utgöra större hot än eventuella framtida hälso-konsekvenser (IV). Personliga risker i samband med oskyddat sex vägde dessutom ofta tyngre för dessa pojkar än eventuella risker för partnern, i synnerhet en tillfällig sådan. Risk för oönskad graviditet blev i realiteten ett hot först om den skulle fullföljas – ett alternativ som dock få av de intervjuade tonårspojkarna ansåg som troligt.

Majoriteten av ungdomarna ansåg att en tonårsgraviditet skulle påverka livet i en mycket negativ riktning. De flesta flickor med erfarenhet av abort såg det som ett svårt men samtidigt självklart val, vilket i stor utsträckning påverkades av samhällets normer och omgivningens – synnerhet partnerns, negativa inställning till tonårsgraviditet. Många av tonårsflickorna som gjort abort vittnade om att de fått genomgående bra stöd från vårpersonalen där ett

vänligt, förstående men framför allt neutralt förhållningssätt tycktes särskilt uppskattat.

Paradoxalt nog uttryckte både flickor och pojkar maktlöshet inför beslut om abort; flickor å ena sidan genom de påtryckningar som ofta utövades av omgivningen (dvs. partner, föräldrar, vänner) och pojkar å andra sidan inför avsaknaden av formell medbestämmanderätt (II, IV). Trots att flera av pojkarna hävdade vikten av flickors ensamrätt till beslutet, trodde de flesta att de ändå kulle försöka övertala en gravid partner att göra abort.

Alla tonårsflickor som hade genomgått abort hade fått efterföljande preventivmedelsrådgivning. Många beskrev att de var avsevärt mer motiverade att använda preventivmedel efter aborten än före, men flera hade trots detta återfallit i osäkra metoder som till exempel avbrutet samlag. Andra hade redan innan aborten haft problem att finna passande preventiv-medel och tyckte inte att de fick ordenligt gehör från barnmorskan eller läkaren, till exempel beträffande oro för biverkningar.

Förklaring av delstudie IV utifrån en teoretisk angreppspunkt

Våra analyser gällande bakomliggande faktorer till tonårspojkars sexuella risktagande (IV) utgick från ”The HBM” som är en i sammanhanget vedertagen teoretisk angreppspunkt vilken går ut på att identifiera faktorer som utifrån ett hälsoperspektiv kan förklara individers agerande. Modellen innefattar i korta drag följande huvudbegrepp (fri översättning); *upplevt hot* (hur pass sannolikt eller allvarligt det skulle vara att t.ex bli smittad av klamydia/göra en partner gravid), *kostnad* gentemot *vinst* (positiva och negativa aspekter på t.ex preventivt handlande), *triggerfaktorer* (t.ex sjukdomssymptom, media kampanjer) och *tilltro till sin egen förmåga* (att t.ex använda kondom).

I likhet med tidigare framförd kritik fann vi att denna modell inte till fullo kunde förklara det komplicerade samspelet mellan individens sexuella risktagande och preventiva handlande. Vi modifierade modellen på flera plan bland annat genom att inkludera *sociala, individuella, kontextuella* och *genusrelaterade faktorer* för att på ett bättre sätt kunna tolka det komplexa fenomen som sexuellt risktagande innebär. Den modifierade modellen tar även större hänsyn till att risker i samband med sexuellt risktagande kan ha olika dignitet och upplevas som *omedelbara* eller *avlägsna*. Kombinerat med hur pass *allvarligt* och hur pass *troligt* man upplever att det är att till exempel smittas av en könssjukdom eller göra en partner gravid har dessa faktorer avgörande betydelse för huruvida man väljer att använda preventiv-medel eller inte.

För att hantera avlägsna eller omedelbara risker använde sig deltagarna i vår studie av olika strategier (till exempel att avbryta samlaget innan utlösning, använda kondom under hela eller delar av samlaget, eller att låta klamydiatesta sig efter perioder av oskyddat sex). Att vidta preventiva åtgärder som till exempel att använda kondom, skedde oftast under kontinuerligt utvärdering av *kostnad* (enligt tonårspojkarna kunde detta till exempel handla om miskad känsla, irriterande avbrott och i värsta fall förlorad erektion) gentemot *vinst* (till exempel minskad risk för smitta och/eller oönskad graviditet).

Utfallet i beteende påverkades i sin tur av olika faktorer som till exempel *fysisk miljö*, *partners och kompisars inställning till kondom, tilltro till sin egen förmåga* att använda densamma, samt *genusrelaterade förväntningar* i samband med sex. Till exempel; om samlaget genomfördes utomhus där risken för att bli påkommen var överhängande var kondomanvändning högst osannolikt. Vidare, om partnern verkade ogilla användandet av kondom om det generellt sett fanns en utbredd skepsis gentemot kondomanvändning bland ens nära vänner eller om man inte litade till sin egen förmåga att använda kondom så minskade sannolikheten att använda kondom ytterligare.

Förutom hur pass allvarliga eller troliga man upplevde risker/hot i samband med oskyddat sex, eller huruvida kostnad vägde tyngre än vinst, fanns även olika *trigger faktorer* som också påverkade ungdomarnas beteende. Dessa grundades dels på *personligt initiativ* (att låta klamydiatesta sig på grund av oro för smitta och/ eller rutinmässigt efter oskyddat sex), *rådande lagstiftning* (exempelvis partnerspårning), önskemål från *parnter* (i synnerhet vid nyetablerade förhållanden) samt *individuella sjukdoms-symptom.*

Övergripande resultat delstudie V

Farhågor om att utökad tillgång till akut-p-piller skulle leda till ökat sexuellt risktagande framförs ofta i internationella sammanhang. I samklang med liknande studier som genomförts internationellt kunde vi för första gången visa att flickor som fått akut-p-piller i förebyggande syfte i Sverige använde preparatet i högre utsträckning och dessutom snabbare efter oskyddat samlag, jämfört med kontrollgruppen, utan att detta ledde till ökat sexuellt risktagande (V).

Reflektion

Resultaten visar att det fortfarande finns en utbredd inställning där båda könen tillskriver flickor/kvinnor huvudansvaret för preventivmedel och där pojkar/unga män fjärmar sig från delaktighet och engagemang när det gäller sexuellt och reproduktivt ansvar. Detta är olyckligt av flera anledningar; visserligen upplevde båda könen att en oönskad graviditet skulle vara lika med en ”katastrof”. Den känslomässiga påfrestningen för flickorna i samband med abort var emellertid påtaglig medan en oönskad graviditet i realiteten inte innebar särskilt stora konsekvenser för tonårspojkarna – förutsatt att den inte fullföljdes. Attityder till tillfälliga sexuella konakter var positiva medan attityder till kondom och hormonella preventivmedel inte var det. Både flickor och pojkar uttryckte dessutom svårigheter att prata om preventivmedel med varandra. Om man vidare betänker att sexuellt över-förbara infektioner generellt sett får allvarligare medicinska konsekvenser för kvinnor, inser man att sexuell och reproduktiv hälsa i högsta grad är en jämställdhetsfråga.

Sverige har en ambitiös målsättning och goda intentioner beträffande prevention av oönskade graviditeter, abort och sexuellt överförbara infektioner. Mycket gott arbete utförs. Dessvärre saknas ännu grundlig implementering, uppföljning och utvärdering av dessa mål, med risken att handlingplanerna allför ofta stannar som välformulerade skrivbordprodukter.

Sammanfattningsvis kan sägas att sexuellt risktagande bland unga är ett komplext fenomen som svårligen låter sig förklaras utan att samtidigt ta sociala, individuella, kontextuella och genusrelaterade faktorer i beaktande. Flickors formella rätt att självständigt fatta beslut om abort riskerar att i realiteten undermineras av det informella maktutövande som ofta före-kommer bland betydelsefulla personer i flickornas omgivning. Den ojämna ansvarsfördelningen gällande preventivmedelsanvändning och det faktum att tonårspojkar tog mindre hänsyn till eventuella risker i samband med oskyddat sex för sin partners del, speglar attityder som förstärker traditio-nella könsroller men speglar också en osäkerhet bland unga i sexuella situationer. Delat ansvar för preventivmedelsanvändning tycks ännu vara långt ifrån ett faktum och däför ett fortsatt viktigt mål i arbetet med att främja sexuell och reproduktiv hälsa bland ungdomar.

Konklusion

- Såväl flickor som pojkar tillskrev flickorna huvdansvaret för preventivmedel i praktiken, men båda könen tyckte att det var svårt att kommunicera om preventivmedel innan sex.
- Negativa attityder till preventivmedelsanvändning var vanliga.
- Tonårspojkar tog lätt på risker i samband med sex med ny partner.
- Hinder för kondomanvändning baserades på låg motivation, oro för negativt bemötande från partnern, att det ansågs mindre skönt, och/eller rädsla för erektionssvikt.
- Abort sågs som ett svårt men samtidigt självklart val, vilket i stor utsträckning påverkades av normer och attityder från omgivningen.
- Trots pojkars utslagsgivande påverkan genom informellt maktutövande, upplevde både pojkar och flickor begränsat inflytande i beslut om abort.
- Utdelning av akut-p-piller i förebyggande syfte ledde till ökad användning och snabbare behandling utan ökat sexuellt risk-tagande.

Förslag på åtgärder och framtida forskning

Mot bakgrund av resultaten föreslår jag följande åtgärder i arbetet med att förebygga oönskad graviditet, abort och sexuellt överförbara infektioner;

1. Primärpreventiva insatser måste förstärkas. Med detta menar jag i synnerhet att kvaliteten på sex- och samlevnadsundervisning i skolan måste höjas och elevernas kunskapsnivå i frågor som rör sexuell och reproduktiv hälsa bör förbättras. Samtalsgrupper bland både pojkar och flickor inriktade på konkreta handlingsstrategier för säker sex bör ingå i undervisningen.
2. I undervisningen bör även diskussion och problematisering ingå om vilken betydelse genus/kön har för de villkor som styr ungdomars preventivmedelsanvändning.
3. Ytterligare forskning behövs för att vidare studera och förstå preventivmedelsanvändning ur ett genusperspektiv, dvs vilka villkor som styr unga kvinnor och mäns val och strategier för att undvika STI och/eller oönskad graviditet.
4. Strategier på bred front krävs för att stärka pojkars delaktighet i preventivmedelsanvändning. Ett led i detta är mediakampanjer med adekvat kondomreklam (t.ex manliga förebilder som förespråkar kondomanvändning vid nya sexuella kontakter) samt att göra ungdomsmottagningar attraktiva även för pojkar och unga

män. Fokus bör också ligga på att hjälpa pojkar och unga män att hantera rädslor och hinder för att använda kondom.

5. Fortsatt strävan efter balanserad information med öppen dialog vid preventivmedelsförskrivning är av stor vikt för att på bästa sätt bemöta unga p-pilleranvändares oro för biverkningar.
6. Neutralt bemötande från vårdpersonalens sida är viktigt i samband med abort.
7. Ökad tillgänglighet och flexibla öppettider på landets ungdomsmottagningar, således utökat öppethållande, förslagsvis med dropinmottagning även på helger.
8. Praktisk applicering och implementering av vår modifierade HBM-modell i undervisningssammanhang, alternativt i design av frågeformulär, interventioner och/eller primärpreventiva insatser. Det vore också intressant att undersöka om vår modifierade HBM-model är hållbar även utanför de sammanhang som jag har presenterat.

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