“I think it’s safer, then you don’t have to worry about getting a disease or anything”

A QUALITATIVE STUDY EXPLORING THE PERCEPTION OF SWEDISH YOUTH ON THE USE OF CONDOMS IN PREVENTING SEXUALLY TRANSMITTED INFECTIONS

Oluwadamilare E. Oladimeji
Supervisors: Prof Beth Maina-Alberg, Dr Jill Trenholm
International maternal and child health (IMCH)
Department of women’s and Children’s Health
Uppsala University

Degree project in International health
30 credits, spring 2016
ABSTRACT

Introduction: Youth (15-24) have the highest prevalence of sexual transmitted infections (STI) among all the age groups and this has been attributed to high sexual risk behaviour and low condom use in this group. The use of condoms by youth is negotiated through a complex array of personal and social factors.

Aim: The aim of this study was to explore the perceptions of Swedish youth on the factors that affect their use of condoms to protect against STI.

Methodology: The data collection was done over a period of 3 months using semi-structured interviews and focus group discussions (FGD) and the collected data was analysed with thematic analysis.

Findings: Participants perceived that different factors across intimate social circle, community and access to condoms influence the use of condoms by youth in Sweden. The lack of information from the media, embarrassment as a barrier to obtaining condoms and the influence of parents on condom use were prominent findings.

Conclusion: Efforts to improve condom use by youth will benefit from exploring the different factors that inform youth’s perceptions on condom use. Opportunities for improvement identified in this study include the installation of condom vending machines, promoting condom use through the mass media and parents discussing condoms with their children.
Contents

ABSTRACT ........................................................................................................................................... 1
ABBREVIATIONS .............................................................................................................................. 4
GLOSSARY .......................................................................................................................................... 4
INTRODUCTION ..................................................................................................................................... 5
  Sexually transmitted infections ........................................................................................................... 5
  The Swedish context .......................................................................................................................... 6
  Condom as a double agent ............................................................................................................... 8
  Rationale ........................................................................................................................................... 10
  Aim .................................................................................................................................................... 10
    Objectives ...................................................................................................................................... 10
    Research question ......................................................................................................................... 11
    Theoretical framework .................................................................................................................. 11
METHODOLOGY .................................................................................................................................. 12
  Study design ..................................................................................................................................... 12
  Study settings ................................................................................................................................... 12
  Participants and sampling ................................................................................................................ 13
  Data collection methods ................................................................................................................... 14
  Data analysis ..................................................................................................................................... 16
  Ethical consideration ......................................................................................................................... 17
  Reflexivity ......................................................................................................................................... 18
RESULT .................................................................................................................................................. 20
CONDOM USE HAS MULTIFACTORIAL INFLUENCES ....................................................................... 21
  Condom minimizes risk and anxiety ................................................................................................. 21
  Condom use negatively affected by several factors .......................................................................... 22
  Factors that promote condom use .................................................................................................... 24
CLOSE SOCIAL CONTACTS AFFECT YOUTH’S CONDOM USE .............................................................. 25
  Parents have a role to play ................................................................................................................ 25
  Youth, their peers and condom use ................................................................................................... 26
  Condom use influenced by partners ................................................................................................. 27
THE SOCIETY AND ITS INFLUENCE ON CONDOM USE ..................................................................... 28
  Community norms may influence condom use .............................................................................. 28
  School as a source of information .................................................................................................... 28
  The media shapes norms and perceptions ....................................................................................... 29
ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome
FGD – Focus Group Discussion
GDP – Gross Domestic Product
HIV – Human Immunodeficiency Virus
IMF – International Monetary Fund
PHAS – Public Health Agency of Sweden (Folkhälsomyndigheten)
RFSL – Riksförbundet för homosexuella, bisexuella, transpersoners och queeras rättigheter (The Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights)
RFSU – Riksförbundet för sexuellupplysning (Swedish Association for Sexuality Education)
SCB – Statistiska Centralbyrån (Statistics Sweden)
STI – Sexually Transmitted Infection
TA – Thematic Analysis
TPB – Theory of Planned Behaviour
TRA – Theory of Reasoned Action
WHO – World Health Organization
YHC – Youth Health Centre

GLOSSARY

Notifiable disease

A disease that, by statutory requirements, must be reported to the public health authority in the pertinent jurisdiction when a diagnosis is made. A disease deemed of sufficient importance to public health to require that its occurrence be reported to health authorities (1).

Withdrawal method

The withdrawal method of contraception, also known as coitus interruptus, is the practice of withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation to prevent pregnancy. The goal of the withdrawal method is to prevent sperm from entering the vagina (2).
INTRODUCTION

The definition of a youth varies from country to country but the United Nations defines youth as individuals between the age of 15 and 24 (3). This age range includes most teenagers (13 - 19), adolescents (10 - 19) and young adults (18-35) and there are about 1.8 billion people in the world today between the age of 10 and 24 (4). This is the period of transition from childhood to adulthood and is characterized by pronounced physical, mental, biological and sexual changes. These changes expose a youth to unique sexual and reproductive health and right challenges such as unwanted marriages, unwanted pregnancies and sexually transmitted infections (5).

Sexually transmitted infections

Sexually transmitted infections (STIs) are infections that are spread primarily through person to person sexual contacts (6). Most infections are transmitted through vaginal, anal, and oral sex. However, some infections can also be transmitted via blood or blood products and from mother to child. More than 30 sexually transmissible infective agents have been identified including bacteria, viruses and parasites. The most common infections are gonorrhoea, chlamydia, syphilis, trichomoniasis, human immunodeficiency virus (HIV), hepatitis B, genital herpes and Human papilloma virus (7).

The common symptoms of STIs include vaginal discharge, urethral discharge, painful urination and genital ulcers. Systemic symptoms such as losing weight and generalized weakness may be noticed in people with HIV. However, a person infected with an STI may not have any symptom (7).

There are more than one million STIs acquired worldwide everyday according to a WHO estimate. Each year an estimated 357 million new infections with chlamydia (131 million), trichomoniasis (143 million) gonorrhoea (78 million) and syphilis (5.6 million) is reported (7). HIV/AIDS has been a major public health problem having claimed about 34 million lives since it was first identified. At the end of 2014, there were approximately 36.9 million people living with HIV and 2.0 million people becoming newly infected in the same year (8) . The highest prevalence of STI is among 20 -24 year olds, followed by 15-19 year olds (9).

The bacterial infections (gonorrhoea, chlamydia, syphilis) and trichomoniasis, a parasitic infection, are generally curable with antibiotics. However there has been increasing concern about antibiotic resistance especially with gonorrhoea infection. The viral infections such as
HIV and genital herpes are not curable but available antiviral drugs can control the viruses and improve the wellbeing of infected people (7).

Efforts to prevent transmission of STI include comprehensive sexual education, STI testing and counselling, programs targeted at reducing risky sexual behaviour and promoting condom use (7).

**The Swedish context**

Sweden is located in northern Europe and is bordered by Finland in the East, Norway to the west and is connected to Denmark in the southwest by a bridge-tunnel across the Öresund. Sweden is one of the Nordic countries and with a total land area of 450,295 square kilometres is the third largest country in the European Union (10). According to Statistics Sweden (SCB), as of February 2016, Sweden has a population of almost 10 million, and this corresponds to an increase of 1.09% from the same month in the previous year. The population of people between the age of 15 and 24 years is 1,178,920 and this constitutes approximately 12% of the total population (11).

Sweden is classified as a High income country by the World bank (12) and an estimate by the International monetary fund (IMF) indicates Sweden’s gross domestic product (GDP) to be $484 billion and GDP per capital to be $58,538 (13). The unemployment rate was 7.4% in 2015, a decrease of over 1% from 2008 (8.5%) (14). In Sweden it is compulsory to have primary or elementary education. Approximately 41% of the population between the age 25 and 64 have tertiary education (a substantial increase from only 11% in 1990) and 26% study for 3 year or more after high school. More females than males are enrolling for higher education (15).

![Map showing Sweden and some European countries](image)
HIV, chlamydia, and gonorrhoea belong to the notifiable STIs in Sweden, and are registered by the Public Health Agency of Sweden (PHAS) (16). Chlamydia is the most prevalent bacterial STI reported in Sweden and according to a yearly report on sexually transmitted disease by PHAS, there was a surge in the reported cases of chlamydia in year 2007 due to a new variant of chlamydia (17). Since then, there has been a progressive reduction in the reported cases of chlamydia infection till 2014 when 36,125 (370 cases per 100,000) cases were reported, a decline from 47,099 in 2007. In Sweden, the largest burden of chlamydia is among the age group 15-29 which is about 84% and more than half of the cases of chlamydia are reported among females (57%) (17). HIV/AIDS is a rather uncommon infection in Sweden with a prevalence rate of 0.07%. The total number of people living with HIV is about 6,800 in year 2014 (69 cases per 100,000 people) and new infections reported to be 473 cases in the same year (18). In 2014, 1,336 cases of gonorrhoea were reported which is a 20% increase from cases reported in 2013 (1,114 cases) and the highest proportion of males infected through heterosexual contact was found in the 20–24 age group (19).

Improving overall sexual health of youth, minimizing sexual risk behaviour and improving condom use in this group has been a public health focus in Sweden (20). PHAS is responsible for the STI/HIV prevention on a national level (21). The agency is involved in the planning, coordinating, evaluating and monitoring of the preventive efforts against STI/HIV (16). At the local level, the counties and municipalities have the responsibilities for prevention of STI/HIV and work closely with PHAS. Among other things, they manage and supervise the Youth Health Centres (YHCs) (22).

The first YHC was established in 1970 and currently there are over 200 YHCs in Sweden. They were established with the aim to promote the physical, mental and sexual health of young people and these centres are opened to people between the ages of 13 and 25. A youth can visit the YHCs during drop-in hours or book an appointment. The centres also have websites where youth can access valuable information relating to sex and sexuality. The staff working at these centres include nurses, social worker, doctors and psychologist among others. Services such as counselling, psychological support, STI testing and provision of condoms and other contraceptives are offered at YHCs (23).

Compulsory sex education in Sweden has been a part of school curriculum since 1955. Over the years the content of sexual education in Sweden has expanded to include sexual health and gender roles among others. It has also been integrated into some subject curricula in schools.
such as science, biology, sport and health and history. This means that the responsibility for including sex education falls on several teachers and that it will be brought up within the scope of multiple courses and subjects (24). In addition to sexual education, it is required by law that schools provide sexual health services. The services include a visit to the school nurse during which issues relating to sexuality, contraceptives and safer sex are discussed (21).

Several organizations have been working with and to support the government in Sweden both at the national and local levels to address issues of sexual health among youth. RFSU (Swedish Association for Sexuality Education) is one of such organisations. As a non-profit organization, RFSU has been involved in promoting sexual health and other related issues since 1933 (25). They organize educational events for youth, offer sexual counselling, and provide free condoms among other things. Other organizations include RFSL (the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights) (26), RFSL ungdom (27) and Kondoma Mera (28).

**Condom as a double agent**

The use of condom as a protective device dates back to the ancient Egyptians and is the oldest form of barrier contraception used by men (29). Over the years the materials from which condoms have been manufactured include animal membrane, rubber and more recently latex and polyurethane. Latex condoms are both thinner and stronger, with lesser offensive smell and have a longer shelf life (five years vs. three months) than their rubber predecessors (30). There are both female and male condoms, however the male condoms are generally more accepted and in common use (31).

Condoms serve the double function of preventing pregnancy and protecting against STI. Furthermore, it is the only device available for men and women to prevent the transmission of STI/HIV(30). Male condoms have been reported to be highly effective in preventing pregnancy with an estimated perfect-use failure rate of 3% for the first year of use and the typical-use failure rate is estimated to be 14% (32). A Cochrane review (33) reported that condoms are highly effective for preventing the transmission of HIV/AIDS, if it is used consistently and correctly. Condoms were also shown to be effective against other STI in a review by Holmes et al (34).
Given the effectiveness of condoms against STIs, it is expected that condom use by youth would be high, but an opposite trend has been reported in studies (35). An analysis of a Swedish population based survey regarding condom use in 2004, reported an overall condom use in the study population (18-74) to be 12%, while it is 15% in the age group 18-49 (36). This shows a slight reduction from 15% among the general population (18-74) in national survey conducted in 1996 (37).

The low reported use of condoms have been associated with many factors. Previous research has shown that these factors include individual, relationship and social factors. Feeling embarrassed to buy condoms has been commonly cited by studies as a reason why youth fail to obtain condoms (38,39). Embarrassment may be due to the presence of familiar persons or the awkwardness of obtaining condoms when other people are around (40). Excessive consumption of alcohol has been associated with poor decision making in relation to condom use (41,42). In their study, Coleman and Suzanne explained the risky sexual behaviour associated with excessive alcohol consumption using the following 5 stages: “(1) alcohol affecting young people’s assessment of a person’s sexual attractiveness; (2) alcohol used as an “excuse” for socially unacceptable behaviour; (3) increased confidence and lowering of inhibitions; (4) impaired judgment in accurately recognizing and controlling a potentially risky situation; and (5) complete loss of control, memory loss, and black-out” (43). The reduction of sexual pleasure due to the use of condoms has been reported in studies as a common reason for low level of condom use (44,45). Furthermore, the cost of condoms have also been reported to negatively influence the use of condoms (35,46,47).

Fridlund et al reported that the expectation to use condoms and the actual use differ based on the type of relationship (48). The study identified types of relationships to include casual unknown, casual known, regular sexual partner and main partner. The expectation to use condoms and the actual use was lowest with main partners (45,48) due to trust, duration of relationship and familiarity (49,50). The study also showed that largest discrepancy between the expectation to use condoms and the actual use was for vaginal and anal sex with a casual partner (48). Fortenberry et al reported that it takes approximately 21 days for the condom use in new relationship to approach the level of condom use in established relationships (similar to main partners mentioned before) and this early abandonment of condoms has it associated risk (51). Bauman et al showed that while there was expectation of monogamy in some types of romantic relationships (hubby-wifey according to the classification in this study), it is not
uncommon for partners to cheat on each other (50). If this happens in a context where condom is not used, it will expose the “unaware” partner to the risk of STI (52). Other factors that have also being reported to affect the use of condoms negatively include low perceived vulnerability to STIs (44,53), and use of other contraceptives (54).

However factors that encourage the use of condoms have also been identified in some studies and these include self-efficacy (44), less perceived invulnerability to STIs (44,53) and parent support (55,56). Self-efficacy in negotiating condom use during sex or the confidence to use condom correctly has been shown to correlate positively to consistent condom use (44,57). In a study by Baele et al that investigated self-efficacy in relation to technical skills, image confidence and emotional control among other things, it was shown that intended and actual condom use by adolescents is positively affected by self-efficacy (58). Individuals who perceived that they are vulnerable to being infected with STIs have been reported to likely use condoms more consistently with new or casual partners than those with less perceived vulnerability (44,53). Hadley et al reported that adolescents who have discussed condoms with their parents are more likely to report condom use at last sexual intercourse compared to those who have not (55).

**Rationale**

Notwithstanding the effort of the Swedish government to improve the use of condoms by youth, the overall condom use in this population is low (36). Concurrently the prevalence of STIs, especially chlamydia is highest in this age group (17). It has been shown by some studies that people’s perceptions on condom use and STIs influence the consistency of condom use (59,60). Understanding the perceptions shared by youth on condom use can help to target relevant and effective means to improve condom use by this group.

**Aim**

This aim of this study was to explore the perception of Swedish youth about the factors that affect their use of condoms to protect against STI

**Objectives**

- To explore the factors that influence condom use by youth in Sweden.
- To explore their perceptions about the effect of gender on the use of condoms.
- To explore suggestions on improving condom use by youth in Sweden.
**Research question**
What are the perceptions of Swedish youth on the use of condoms?

**Theoretical framework**

Theory of planned behaviour (TPB) is an extension of the theory of reasoned action (TRA) (61) and TPB was developed to address the deficiency of TRA. Ajzen et al incorporated perceived behavioural control in TRA to develop TPB (62). TPB aims to predict the accomplishment of a behaviour through the intention to perform the behaviour. The components of TPB (intention, behavioural attitude, subjective norm and perceived behavioural control) will be defined to give a better understanding of this theory.

According to Ajzen “**Intentions** are assumed to capture the motivational factors that influence a behaviour; they are indications of how hard people are willing to try, of how much of an effort they are planning to exert, in order to perform the behaviour” (62). The **attitude** towards the behaviour refers to the positive or negative evaluation a person attributes to the completion of a behaviour. **Subjective norm** refers to the perceived social pressure to perform or not to perform the behaviour. **Perceived behavioural control** is an adaptation of Bandura’s concept of perceived self-efficacy and “is concerned with the judgment of how well one can execute courses of action to deal with prospective situations” (63). The central factor in TPB is the behavioural intention, which can be predicted using the behavioural attitude, subjective norm and perceived behavioural control.

![Diagram of theory of planned behaviour](image)

**Figure 2**: theory of planned behaviour. Icek Ajzen 1988
Antecedent to each of behavioural attitude, subjective norm and perceived behavioural controls are beliefs. These beliefs are behavioural beliefs (behavioural attitude), normative beliefs (subjective norm) and control beliefs (perceived behavioural control) (62).

METHODOLOGY

Study design

This study uses two qualitative methods for the data collection; semi-structured interviews and focus group discussions (FGD). Semi-structured interviews are useful for the exploration of thoughts, attitudes, beliefs and knowledge pertaining to a given phenomenon (64) and FGD employs interaction between study participant to elicit norms, meanings and opinions (65). The process of using two or more methods for data collections is termed Triangulation (66). Michael Patton explained triangulation as the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (67). Triangulation allows for generating complementary views of the same phenomenon and the combination of different data collection methods contributes to a more nuanced understanding of the phenomenon being studied (64). Furthermore, “the use of different methods in concert compensates for their individual limitations and exploits their respective benefits” (66).

Study settings

Uppsala is located in the southern part of Sweden, about 70km from the capital Stockholm. Uppsala town is the seat of the Uppsala municipality. 2015 statistics shows that the municipality has a total population of 354,164 out of which 210,126 are living in Uppsala town with 106,545 females and 103,581 males. Individuals between the age 15 and 24 living in Uppsala town are 30,550 in number (9). Uppsala is the 4\textsuperscript{th} largest town in Sweden and has two universities. These university have a combined student population of around 48,000 (68,69).

In 2015 there was a total of 1445 cases (414 cases/100,000) of chlamydia in Uppsala, a slight increase from 1226 (351 cases/100, 00) in 2013. As of January 2016 there has been 112 reported cases of chlamydia (17). Several organizations are working in Uppsala to promote condom use for example RFSU (23) and komdom Mera (28) among others.
Participants and sampling

Participants for this study were selected using purposive sampling method with the following inclusion criteria: Swedish, between the age of 18 and 24 and English speaking. The lower age limit was set to 18 due to the difficulty of getting parental consent for individuals younger than 18 years. Individuals were contacted through Facebook or approached in person to participate in the study. Information about the study was posted on Facebook groups and five people volunteered to participate. The main researcher also walked up to people in different university building and reading halls or rooms to talk to them about the study. The people that were approached in person were given a brief verbal overview of the study and the inclusion criteria. If they were interested in participating, their email and other contact information were taken. 11 people approached in person volunteered to participate. An email containing the study information sheet was sent to everyone who showed interest in participating. After a few days, they were asked to confirm if they were still interested in participating after reading the information sheet. For those who maintained interest, dates and venues were scheduled for interview or FGD. The interviews were conducted first, so individuals who indicated interest earlier were interviewed. Interviews were conducted in venues comfortable for participants and group discussion were done in the researcher’s faculty which is centrally located and has comfortable rooms. Six individuals were recruited for the interviews and 10 people for two FGDs, a table containing participants’ information is shown in table 1 below.

<table>
<thead>
<tr>
<th>PARTICIPANTS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Sexual orientation</th>
<th>Age</th>
<th>Level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>22</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>23</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>23</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>21</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>19</td>
<td>Gymnasium</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>21</td>
<td>Undergraduate</td>
</tr>
<tr>
<td><strong>MALE-ONLY FGD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>23</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>19</td>
<td>Gymnasium</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>20</td>
<td>Gymnasium</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>18</td>
<td>Gymnasium</td>
</tr>
<tr>
<td><strong>MIXED FGD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>24</td>
<td>Masters</td>
</tr>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>23</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Female</td>
<td>Heterosexual</td>
<td>20</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>21</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>20</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>Male</td>
<td>Heterosexual</td>
<td>20</td>
<td>Undergraduate</td>
</tr>
</tbody>
</table>

Table 1: study participants’ information

A few people declined to participate because they were having exams and one because she was not interested in participating. A third FGD, which was planned to be a female-only FGD, could not be coordinated because some participants said they were no longer interested in participating after the FGD had already being scheduled. This occurred twice and due to time constraint, the third FGD was cancelled.

**Data collection methods**

Data collection was done over a period of 3 months between January and March 2016 using semi-structured interviews and FGDs. Six semi-structured interviews were conducted with three male and three female participants. Due to the sensitivity of discussing about condom use, the male participants were interviewed by the main researcher and the female participants by a female colleague. The female interviewer has a master’s degree in international health and has some experience with conducting semi-structured interviews. The male researcher and the female interviewer had a meeting where the study was discussed in details and the female interviewer was also given a copy of the information sheet to read. She was only involved with interviewing the female participants. To ensure consistency across the interviews, a common interview guide (annex 1) was used by both interviewers. The interview guide was developed to explore participants’ perceptions of the following areas; access to condoms in Sweden;
factors that affect the use of condoms; influence of significant social contacts on condom use; how societal factors influence the use of condoms.

All the interviews except one were conducted in the researcher’s department which is centrally located. The department has comfortable rooms where privacy can be ensured for participants and is accessible any time of the day. The interview with one participant was conducted in his apartment. The interview were conducted in English and the durations were between 25 and 35 minutes.

Two FGDs were conducted with four participants in the first one and six participants in the second one. The first FGD was a male only discussion group while the second was a mixed group. The mixed group consisted of 3 males and 3 females to balance the gender dynamics in the group. The FGDs were conducted in the researcher’s department and were coordinated by the researcher. A vignette was used to introduce the participants to the discussion and is shown in the figure below:

![Figure 3: Vignette for FGD](image)

In Sweden there are systems in place to provide education on condom use through schools and different organizations. There are also outlets to get condoms either free or purchased. However there is high level of sexually transmitted diseases among the youth e.g. chlamydia. We will be discussing around condom use by youth in Sweden with the following three Swedish youth in mind. Person 1 uses condoms all the time he is having sex, person 2 uses it sometimes and person 3 rarely uses condoms. This is irrespective of who they are having sex with.

In the male only FGD, male Swedish names were used instead of person 1 or 2 to create a sense of familiarity with the characters in the vignette but in the mixed group they were left as person 1 or 2 to avoid any form of gender bias in the vignette. After the vignette had been read to participants, an opening question about their general perceptions on condom use was asked by the researcher. The rest of the discussion after the opening question was guided by topics written on note cards for the participants to discuss around. The note cards had been shown to each participants before the discussion started and had been told what purpose the note cards would serve. Participants were also informed that the discussion was not limited to the note cards, which were just to serve as guide for the FGD. The note cards were placed in the centre of the table were everyone could see them. Using the note cards ensured that the researcher
only had to talk a few times during the discussions. The topics written on the note cards included: parents, negative factors, positive factors, peer, media and school. The length of the first FGD was 62 minutes and the second was 58 minutes.

The interviews and FGD were audio recorded using a laptop and a mobile phone as a backup. The quality of the recording from the laptop and telephone were checked and observed to be good before they were used to record the interviews and FGDs. The recorded data were later transcribed by the researcher.

**Data analysis**

The transcribed data were analysed using thematic analysis (TA) as inspired by Braun and Clarke (70). TA is a flexible analytical method suitable for researcher with limited experience in qualitative researcher, and it, in addition, minimally organises and describes data set in rich details (70).

Braun and Clarke described six step for conducting TA; 1) getting familiar with the data by reading them multiple times and noting down initial ideas, 2) generating initial codes in a systemic fashion across the entire data set and collating the data relevant to each code, 3) searching for themes by collating codes into potential themes and gathering all data relevant to each theme, 4) reviewing the themes in relation to the code extract (level 1) and across the entire data set (level 2), 5) generating clear definition and names for each theme, 6) producing the report of the analysis through the selection of vivid, compelling extracts that are related to the research question (70).

The process of data analysis started during the interviews and FGDs by listening to and observing what participants emphasised. Self-transcription of the recorded data by the researcher helped to further strengthen familiarity with the data set. Once the data were fully transcribed, the identification of codes in the data set was done by reading and re-reading the transcripts. The identified codes were collated into potential themes and the themes were reviewed by constantly moving between the developing analytical extract and raw data set. Once a level of “satisfactory” analysis has been attained, a description of the themes with supporting quotes from the data set was produced.
A theme represents some level of patterned response within the data set and captures something important in the data in relation to the research question (70). An example of the process of analysis is given in the table below:

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Code</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The media could do that better because, I don’t, the media doesn’t do anything right, like do you see stuff in the media about condoms?</em></td>
<td><em>Lack of information from the media</em></td>
<td><em>The media shapes norms and perceptions</em></td>
<td><em>The society and its influence on condom use</em></td>
</tr>
</tbody>
</table>

Table 2: the process of analysis

**Ethical consideration**

After thorough consideration of the ethical implications of this study, approval for the study was given by supervising lecturers in the IMCH department, Uppsala University.

The preparation of the study ethics and the involvement of participants in the research were implemented with consideration to the Helsinki declaration (71). All the participants were informed about the purpose of the study and how their participation will help to achieve this purpose. An information sheet (Annex 2) detailing the study procedure was given to each participant and they signed a consent form (Annex 3) prior to participating. They were also informed about the right to refuse to participate in the study and furthermore the right to withdraw from the study at any point without having to give an explanation. In addition, they were told that they can refuse to answer any question they do not feel comfortable with and that there is no right or wrong answer.

The interviews and the FGDs were recorded, after consent had been taken from the participants. The recorded data was saved securely on a password-protected computer which was only accessible to the researcher. Measures that were taken to preserve the confidentiality of each individual participating in the study were explained to the participants. Their names were replaced with codes in the transcripts, the result section and the table containing participants’ information. In the FGDs the participants were told to keep what was discussed in the group confidential.
Discussion around sex, condoms and related subjects are sensitive and can possibly evoke emotional distress. The participants in the study were considered protected from such harm because they only talked about their perceptions and not what they practise themselves.

No compensation in any form was offered to the participants during the recruitment. This ensured that participation was voluntary and not motivated by any incentive. However for those who took buses to the venue of the interview or FGD, an offer was made to pay for their transport fees after participation.

Participants were informed about how the result of the study is going to be distributed and utilized. Furthermore, they were notified that they might not get a direct benefit from participating in the study, but that the study result will potentially contribute to improving the sexual health of youth in Sweden.

**Reflexivity**

“To be reflexive means we are fully conscious of the lenses through which we see the world” (72).

In qualitative research the researcher is the main tool, therefore researchers need to increasingly focus on self-knowledge and sensitivity; better understand the role of the self in the creation of knowledge; carefully self-monitor the impact of their biases, beliefs, and personal experiences on their research; and maintain the balance between the personal and the universal (72). To critically discuss my positionality in relation to this study, it is imperative to share information about myself as the main researcher. This will highlight how I may have influenced and had been influenced by the whole research process and the research outcome. I am currently studying a programme in international health with a focus on reproductive and sexual health and rights. Prior to this, I had my first degree in medicine and worked with obstetrics and gynaecology. As a young adult growing up in a West African country where there is relatively high prevalence of HIV, I have always been interested in the prevention of HIV, especially among youth. My undergraduate thesis was on knowledge and attitude to condom use in relation to HIV. Therefore the decision to study the perception of Swedish youth about condom use was not a difficult one, coupled with high level of STI, especially chlamydia in this age group.

Having a female colleague conduct the interviews with the female participants because of the sensitivity of the study subject, can be seen as a way of maximizing participants’ comfortability
and improving the quality of data given by the participants. Since the quality of the data collected is also affected by the interviewer, she was chosen because she has been trained to conduct qualitative study and has some experience. Furthermore, since the researcher is the main tool of a qualitative study (in this case the interviewer), it is important to point out the individual differences between myself and my female colleague, such as country of origin (female colleague is Swedish) that play a role during the interviews. However, listening to and transcribing the whole data set, showed there are no appreciable differences in the interviews conducted by her and myself, such that could have affected the quality of the interviews.

Sweden’s statistics in terms of STIs definitely paints a different picture when compared to my country of origin. However the use of condom is a common denominator in the prevention of HIV/AIDS and STIs in both countries. In both countries, with adequate information and adoption of healthy sexual habits, the transmission of STIs may be effectively reduced among the youth.

The relation between the researcher and the researched is an important one because power difference between them may affect the data quality. As a young adult within the age bracket as all my participants I think any power difference was at the minimum. Couple with me being a university student as most of the participants, I think they found it largely comfortable discussing with me and the same applied for my female colleague.

Coming from a country where there is no sex education in schools and talking about sex is just short of being a taboo, I was slightly surprised by the ease at which participants discussed in the mixed sex focus group discussion. The group consisted of 6 participants (3 males and 3 females) and everyone was comfortable with the discussion. This might have been encouraged by the fact that participants were discussing about their perceptions and not their personal practice. Nevertheless the liberal attitude of the participants towards condom use is different from what obtains in my country.

With Swedes generally taking pride in the liberal attitude towards sex and sexuality, I am not entirely sure if being an international student from Africa influenced the information given by some participant. This could have happened due to several reasons; participants could have been inclined to emphasise the positive aspects of condoms use in Sweden and minimize shortcomings, participant could have felt maybe I may not really understand the liberal culture
in Sweden and only chose to say what they think I will understand, they could have also tried to enlighten me about the sexual norms in Sweden especially among the youth.

The question of how the researcher influences the study process and outcome resurface during the analysis and the interpretation of the result. Although I made effort to be objective in the analysis, interpretation and discussion, the personal filter through which I passed the data is undeniable. Repeatedly I have questioned myself about my relation to the data, how I have influenced what is reported and how the data has influence what I chose to report. The journey through data reporting, interpretation and discussion has been conducted by simultaneously distancing myself from the data while also familiarizing with it.

RESULT

Thematic analysis of the data set yielded four themes, which are Condom use has multifactorial influences, Close social contacts affect youth’s condom use, The society and its influence on condom use and Gender construction influences condom use. The themes and subthemes are shown in the table below.

<table>
<thead>
<tr>
<th>THEMES</th>
<th>Condom use has multifactorial influences</th>
<th>Close social contacts affect youth’s condom use</th>
<th>The society and its influence on condom use</th>
<th>Gender construction influences condom use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subthemes</td>
<td>Condoms minimize risks and anxiety</td>
<td>Parents have a role to play</td>
<td>Community norms may influence condom use</td>
<td></td>
</tr>
<tr>
<td>Condom use negatively affected by several factors</td>
<td>Youth, their peers and condom use</td>
<td>School as a source of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factors that promote condom use</td>
<td>Condom use is also influenced by partners</td>
<td>The media shapes norms and perceptions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Themes and subthemes.
The perceptions expressed by participants about obtaining condoms in Sweden and factors that influence the use of condoms are presented under the theme *Condom use has multifactorial influences*. Here participants discussed how much importance they place on the use of condoms and how accessible condoms are in Sweden. In addition, participants mentioned the negative and positive factors that influence the use of condoms by the youth in Sweden.

The theme *close social contacts affect youth’s condom use* comprises the perceptions that participants conveyed about how important individual within a youth’s social sphere can influence their condom use behaviour. Mentions were made of the role of parents, peer norms and partner choice or pressure and they were perceived to influence youth’s condom use through varying dynamics.

Participants’ perceptions on how the society that youth live in affects their condom use behaviour are presented under the theme *the society and its influence on condom use*. Sexual education received in school, the media and the prevalent attitude towards condom use in the community were discussed as affecting condom use behaviour.

Under theme *gender construction influences condom use*, the perceptions that participants have about how being male or female affects the use of condoms are presented. The reluctance of males to use condoms because of reduction in pleasure and females being more conscious of using condoms because of the fear of pregnancy were mentioned among other things.

**CONDOM USE HAS MULTIFACTORIAL INFLUENCES**

Participants talked about obtaining condoms, the different beliefs and factors that determine the use of condoms by youth. This theme is divided into four subthemes which consist of general opinion on condoms, obtaining condoms, negative and positive factors affecting condom use.

**Condom minimizes risk and anxiety**

The general opinion expressed by participants was that condom use is important for individuals who are involved in casual sex or who are not in a stable relationship. The correct and consistent use of condoms prevents an individual from worrying about STIs or pregnancy after a sexual encounter as indicated below:

“I think it’s safer, then you don’t have to worry about getting disease or anything.” M, 23, Male only FGD
Participants further buttressed their perception that condoms eliminates after-sex anxieties with their expressed beliefs that condoms are very effective against STIs. Discussing about condom’s effectiveness in preventing STIs, one participant said:

“If you use the condom right, it’s very effective.” F, 23, Interview

For condoms to be effective, there should be no breakage or slip off. Although participants agreed that using condom is important, they also mentioned that youth do not use it all the time.

**Condom use negatively affected by several factors**

As expressed by participants, condoms are readily accessible to youth in Sweden. Condoms can be bought in supermarkets, pharmacies, gas stations, etc. They are also available for free in YHCs, schools and sometimes handed out for free on the streets by organizations concerned with sexual health. These multiple avenues for obtaining condoms make it easy for youth in Sweden to get them.

Despite the easy access, participants identified cost and embarrassment as possible factors that may prevent youth from obtaining condoms. Some participants considered condoms sold in the pharmacy or supermarkets to be quite expensive and thus may discourage youth from buying them. Being embarrassed is a factor that comes into play either with obtaining free condoms or buying them especially at a younger age.

“...I think also it’s a very big age different between when you are like young and starting to have sex, it is more shame, hmm it’s harder to go and buy. But when you are like over a certain age, you like don’t care. Of course you can buy and you don’t care.” M, 19, Male only FGD

Few participants however believed that cost should not really be a barrier since condoms are available for free in many places and youth are encouraged to pick them up whenever they want. And to deal with embarrassment, one participant suggested going with a friend.

Participants further gave a few suggestions that may improve access to condoms and minimize the embarrassment some youth face when they have to get condoms. These suggestions included the installation of vending machines on the streets and pubs where you just put in some coins to buy condoms, and delivery of condoms by mail post. Further diversifying the outlets through which youth can obtain condoms may mitigate the challenges they face to get them.
Reduced sensation during sex was cited by participants as one of the main reasons people do not want to use condoms. Sex is perceived to be more pleasurable when sexual partners do not use condoms. This is often the rationale behind stable couples opting not to use condoms, especially if the female is using other contraceptives.

“I think that’s a big issue, sensation of using condom being not as good as not using it.” M, 21, Mixed FGD

Few participants, while acknowledging that condoms might reduce sensation, said they would not risk contracting an STI because of that. In addition to reduced sensation, the interruption of sexual rhythm was also mentioned. Transition from foreplay to penetrative sex is interfered with in the process of taking and wearing the condoms.

Non-availability of condoms during sexual encounter was discussed as another reason people do not use condoms. This may occur if the sexual partners do not know in advance that they are going to have sex or if they forgot to bring one even though they had prior knowledge that sex is a possibility. Participants perceived that many youth will still go ahead and have sex if they do not have condoms available.

“….and eh of course having condoms readily available with you. I think that’s almost the biggest part. If you, I mean if you don’t have one and you are in the situation then it might be like eh well we do it anyway.” F, 22, Interview

One participant stated that in a situation where condom is not available, she will suggest that they do something non-sexual.

Being intoxicated was said to be another common reason youth do not use condoms. They have the propensity to make risky sexual decisions when they are drunk and sometimes end up not using condoms. Most participants however shared the perception that pre-intoxication attitude towards condom use might influence the decision to use one, especially when you are not “too drunk”. This coupled with having condoms available can improve condom use when intoxicated.

“I guess it could have, cos maybe you are not aware, or maybe you don’t take good decisions when you are intoxicated. But I think often if you take a decision before hand, before getting drunk, maybe I have condoms or I will definitely use condoms. You take a conscious decision before drinking, it think that helps. But if you didn’t really think about it before hand and then it happens, it
think there is a risk that you end doing something stupid or not using contraception.” F, 22, Interview

Participants emphasized that a prior good condom behaviour will increase the likelihood of using condoms even when youth are under the influence of alcohol.

The belief that one cannot be infected or that the risk of one getting infected is low can contribute to non-use of condoms. In addition to this, the assumption that the person they are going to have sex with is not infected is also a common reason for not using condoms according to participants:

“I don’t think they take it so serious, that’s the problem, they don’t think they will get it maybe.” M, 19, Interview

Other factors discussed by participants as preventing the use of condoms includes being caught in the moment, laziness and the use of other contraceptives.

Factors that promote condom use
Discussing the factors that make it more likely for youth to use condoms during sexual encounters, participants perceived that having condoms readily available, knowing how to negotiate condom use and being STI conscious are important.

Being condom prepared, which means having condoms available when there is a possibility of sexual encounter was considered by participants to facilitate condom use. Participants stated that non-availability of condoms is a reason youth do not use condoms and to address that it is vital to ensure the availability of condoms when sex is likely to happen.

“I don’t know but I feel like it, there is always a chance, even if it’s unlikely, that you met with that one person that has something. So I feel like you should always be on your guard cos that could be anyone, you don’t know. Even if its 5% that has an STI, you could still, you don’t know if the person you are with is one of them. Part of that 5%.” F, 22, Interview

There is a higher probability to use condoms when they are available than when there is none around. Participants perceived that when condoms are available but there is a disagreement on whether to use it or not, being able to negotiate condom use is important.
All participants said they will decline having sex in a situation where the person they are going to have sex with says no to using condoms. They will rather suggest having sex some other time or doing something else that does not involve sex at that particular point in time.

“I did say no and maybe suggest we do something else that does not include such sexual activities or just walk away.” F, 22, Interview

Participants believed the ability to negotiate condom use will enable youth to ensure their partners uses condom or at least prevent them from engaging in unprotected sex.

Furthermore, participants stressed that being conscious of STI, enables youth to protect themselves during sexual intercourse. Youth will be more STI conscious, according to participants, if they know someone who has had an STI or if they themselves had a previous infection. This takes away the cloak of invincibility and makes them realize getting an STI is a possibility. Awareness about STIs may also be improved on if youth have information about how many people are being infected, either from schools or the media.

**CLOSE SOCIAL CONTACTS AFFECT YOUTH’S CONDOM USE**

The significant people in a youth’s social sphere such as the parents, peers and partners are believed to have some influence on their condom use behaviour. They were perceived to affect youth’s decision to use condoms in different ways and to different extent.

**Parents have a role to play**

Most participants had the perceptions that parents may be influential in developing a healthy condom behaviour especially among younger youth who are just starting to have sex. Few participants from one of the FGDs however expressed contrary thoughts and stated that parents have limited or no influence on a youth’s decision to use condom. These few participants remarked that youth make their decision on condom use irrespective of what their parents say and that friends have more influence than parents. Those who believed that parents can influence the use of condoms by youth mentioned that parents’ disposition towards condom use affects youth’s condom use behaviour. Parents can also compliment and reinforce the information a youth receive from other sources.

“Because they are your original role models and if they are open about it and positive towards contraception you are more likely to enter that world with a
Talking further about the role of parents, some participants (including those who thought that parents do not have a role) said that most parents do not talk about condoms with their teenagers. The few parents that do talk to their children focus on pregnancy, which may leave the youth with the impression that with the use of other contraceptives, there is no need for condoms.

“Maybe they often I don’t think so often that people, parents talk about it so much in the home. Maybe they do, and it is very good, but often I don’t think. Where you get to learn all these things is from school.” M, 19, Interview

Participants thought awkwardness is the main reason most parents do not talk to their children about condoms. They stressed that it is awkward for parents to bring up the topic and that teenagers often do not feel comfortable discussing with their parents.

“I think the most common reason will be like it feels embarrassing talking about it, so that’s they get discouraged. I think that is the most common reason why they don’t talk about it.” M, 21, Interview

However according to a participant during her interview, awkwardness is a small price to pay to ensure that youth develop a positive condom use behaviour. Parents may also think talking about condoms can sound like they are encouraging their children to engage in sex at an early age. Participants mentioned that in addition to discussing about condoms, parents should also provide condoms for their children. Participants remarked that parents making condoms available for the youth may increase condom use by the youth.

**Youth, their peers and condom use**

The prevalent discussions about condoms among friends were considered by most participants to influence the use of condoms by youth. The participants indicated that youth can develop a positive or negative opinion about condoms based on what their friends say and experiences their peers share about condoms.

“Well, that depends on the group of people and how they view condoms. I remember for example in school back in the day, I remember that if, when we talked about sex and condoms, they were like well you should not use a condom cos it’s
much better without it and stuffs like that. And then you get like that unhealthy view of it and it kind of sticks to you for a long time. And then they might think like shit am not cool if I wear one. Stuff’s like that. I think that’s something that especially younger people would maybe think in those ways.” M, 21, Interview

Beyond discussion about condoms, it was pointed out that friends can pressure a youth into having sex when they do not have condoms available, and hence be exposed to the risk of contracting STIs.

On the contrary a few participants perceived that friends have limited influence on a person’s final decision to use condoms. Since condom use is personal, the decision is up the person to make and individuals can choose what they disclose to their friends about their condom use behaviour.

**Condom use influenced by partners**

Participants shared the view that partner type influences the use of condom by a youth. Sexual encounter with new person will likely involve the use of condom compared to having sex with a steady partner. Trust and familiarity makes it less likely for steady partners to use condoms especially if the female is using other form of contraceptives. On occasions that steady partners use condoms, it is more to prevent pregnancy than to protect against STIs. According to participants, you cannot trust a person you are not familiar with, so you have to use condoms. One participant pointed out that familiarity can also be a risk factor:

“I like to think you are more likely to use condom if it’s the first time with someone, cos then that’s the first thought in your mind that this person has an STI. But I think that could also be a problem cos if you have sex with somebody several times then you kind of think they are fine cos you get to know them. Then you get this illusion in your head that he doesn’t have, he can’t have any or she can’t have any STIs. I think that’s important to know even if it’s somebody that will become your partner, you still have to use protection until you have been tested and then use other means of contraception.” F, 22, Interview

Having unprotected sex with someone familiar but who is not a steady partner (i.e. having sex with other people) may expose a youth to the risk of STIs. Few participants mentioned that the problem of infidelity may occur in a relationship that is considered to be a steady type. If the unfaithful partner does not use condoms, it may expose both of them to the risk of STIs.
Partner choice or pressure was also mentioned by participants to affect the decision to use condoms. Irrespective of it being a steady or casual partner, there may be pressure from one partner to have sex without condoms. Succumbing to this pressure may increase the risk of contracting STIs.

**THE SOCIETY AND ITS INFLUENCE ON CONDOM USE**

The society as a whole is believed by participants to contribute to the view individuals hold towards condom use. The social structure beyond the individual’s relationship or interpersonal level is perceived to influence youth’s beliefs about condoms. This includes the media and schools. Prevalent discussion about condoms in the community also influences the perceptions of youth about condoms.

**Community norms may influence condom use**

Sweden being a liberal society where people do not find it difficult to talk about sex and related subject was a view shared by all participants. Compared to most societies participants believed that discussions around sex and sexuality in Sweden is not limited only to individual’s privacy. This extends to condom use which is generally accepted in the Swedish society and everyone who is sexually active and without a stable partner is expected to use a condom.

“Cos from what I have seen it’s quite like acceptable, people assume that you will have condoms. So I think that’s a good thing. So it’s just the norm having condoms.” F, 22, Interview

The degree to which condoms are accepted in a society was believed by participants to influence the general attitude of youth towards condoms. Youth form their opinions based on the sexual norms in the community according to participants.

“...there is the norm of what is normal in the society, if it’s expected of everyone to have condoms. Then it’s more likely for everyone to have condoms, if everybody feels like they are expected to have some. Yea, so I think the society has a big part.” M, 22, Interview

**School as a source of information**

Regarding their sexual education and obtaining information about condoms, school was considered to be one of the main sources, if not the main source of information by participants.
Often the first extensive educational session on condom use during the early teenage years is in schools. Participants agreed that a greater percentage of their knowledge about condom use as teenagers were acquired during these educational sessions in schools. To complement the information given in their schools a few participants talked about their school taking them on educational visits to YHCs. Sometimes educators from organisations concerned with youth’s sexual health visited their schools.

“... we have one day when we were 15, we visited RFSU and like looked around and they told us everything about STIs and condoms and different birth controls things. Then we had like one exam in biology, sexuality or something like that...” M, 23, Male only FGD

The level of education on condom use depends on the school participants attended. The content of sexual education varies from school to school. Few participants considered the information they got in school about condoms to be inadequate and that it can be improved.

“Well if I look at my education, what I had, I think it was too little, I remember for me example in like 7th grade we had like one or two lessons about sexual education, I think it should be more....” M, 21, Interview

Offering suggestions on the way education in schools can be improved, it was suggested that the sexual education classes should start earlier, as some youth were already sexually active before their first class. One participant who discussed possible improvements said:

“And also talk again about what you do in different situations when one person says no, or what you can do. Suggestions on how you should act.” F, 22, Interview

On the contrary, two participants expressed the belief that you do not need a lot of information about using condoms; what is more important is how you put act upon the information you got.

The media shapes norms and perceptions

The role of the television and radio media in providing information about condom use was highlighted by participants. The media talking about it may also influence the use of condoms by youth by serving as an occasional reminder, discussing issues around condom use or promoting different types of condoms.
“I think it’s a big part of learning, or well maybe not learning, but you see it more, especially if you are younger. If you see it a lot in the media that you should use it, otherwise this happens to you, maybe it affects that you use condoms. But if you don’t see it at all, maybe you don’t know the risk that you take and you don’t know the disease you risk getting.” M, 19, Male only FGD

The media was perceived to have massive influence on societal norms, however there is little or no information about condoms coming from the media in Sweden. It was stressed that the media could play a bigger role in promoting condom use among youth.

“…The media could do that better because the media doesn’t do anything, right? Like do you see stuff in the media about condoms” M, 20, Male only FGD

Furthermore, social media platforms such as dating apps and websites, according to participants is also likely to influence the use of condoms by youth. The number of potential sexual partners a youth meets increases because of these apps/websites. Participants remarked however, that youth are generally more cautious and likely to use condoms in these situations since they have time to prepare and take condoms with them when meeting the new person.

“Yea exactly and probably some of them like, you bring one. Cos like you said they plan where to meet, how to meet or whatever.” F, 24, Mixed FGD

Despite the opportunity to prepare in advance, few participants thought that meeting more people increases the chance of contracting STIs because there is the possibility to be negligent at some point.

GENDER CONSTRUCTION INFLUENCES CONDOM USE

The influence of gender on condom use came up multiple times when participants were talking. The level of gender equality in Sweden was viewed by participants as affecting the use of condoms, since it is widely acceptable for both males and females to have condoms with them. Participants shared the perceptions that in Sweden, irrespective of the sex, individuals are seen as taking charge of their sexual health when they assume the responsibility for making condoms available. It is better not to presume that the other person, especially the male, is going to bring one. Should in case one of the partners forget there is a 50% chance that a condom will be available if both endeavoured to take responsibility for providing condoms.
“The guy is the one who decides, who has the responsibility to bring the condom, but eh, and I think both of them should bring a condom. Like everyone should have a condom, right? (m18: yea) Because you don’t want to have an STI, and he doesn’t want to have one. It’s not like he is the only one getting the STI, she is going to get it too, so it’s her responsibility too. That will solve the problem.” M, 20, Male only

FGD

Participants perceived that both women and men should take responsibility to make sure there is condom availability. It should be an equally shared responsibility. Few participants said while it sometimes expected for the male to bring the condoms, they think it is better if both female and male take initiative. The expectation that the male should bring condom is often because they are the one to wear the condoms. Although there are female condoms, it was stressed that they are seldom used. In the addition to this, the power balance during the negotiation for condom use may tip towards the male since he has to wear the condom.

Few participants, mostly females, pointed out that often men are the one who usually suggest not using condoms or declining when a woman demands the use of condoms. Males often refer to condoms reducing sexual sensation as an excuse not to use them. They try to compel the female into not using condoms by claiming they do not have any infection and they do not think the female has any infection. Describing her experience a participant commented.

“I mean I feel like almost all the guys I have been with they don’t want to use condoms. Like no we don’t need one, I don’t want to use it. Don’t feel so good with it. I don’t know, all kinds of strange excuses.” F, 23, Interview

The reluctance by males to use condoms may also be because they do not have to be afraid of getting pregnant. The females are the ones who worry more about being pregnant. They were a bit surprised that men show less concern, because if a girl gets pregnant, the decision of what happens to the pregnancy lies with the girl. Beyond that getting a woman pregnant will also have some consequences for the male. They expressed the expectation that the males should be conscious of that too.

“Eh I don’t really know. Maybe it’s the chance of pregnancy where the girl will be the one who would of course have to deal with that afterwards. But that’s really strange reason I think because if I was a guy I’d be super scared of getting somebody pregnant cos then you don’t even get to decide what’s going to happen
next. But I am not sure if a lot of guys think that way. So maybe it’s the pregnancy that, kind of it’s on the girl.” F, 22, Interview

While the immediate scare of pregnancy was said to be usually more of a concern for the girl, the risk of contracting STIs is a concern that affects both sexes.

Although males are not the ones with the immediate scare of pregnancy, they were also concerned about getting someone pregnant. However, these concerns are modified by the availability of other contraceptives that can be used by the women. Participants made reference to the use of emergency contraceptives pills in situations of unprotected sex when the female is not using routine contraceptives. The use of routine contraceptives was discussed as a reason many youth do not use condoms because that minimizes the concerns about pregnancy, thus exposing them to the risk of STIs. This view was expressed during a FGD:

M, 23: that could be that they don’t really think about the STIs, they just think about not getting pregnant, so if you using another birth control thing, hmm you don’t use the condom and you going for the unprotected sex.

M, 20: cos people who use condoms usually think about like not getting her pregnant right? It’s now more than STIs at least. So that could be the reason why they don’t use it, because she uses pills

M, 19: like when you don’t have a condom is like, well we take it tomorrow, we take a pill tomorrow, and it’s like alright

M, 20: and he might have an STIs and even doesn’t know about it

However, doubts about trusting a woman, especially a causal partner, when she says she is regularly using her contraceptives was expressed by male participants. In such occasions, they will prefer to use a condom. Furthermore, males attempt to manage the concerns of pregnancy by suggesting the use of withdrawal method.

Males were viewed as being particularly more influenced by peer pressure to not use condoms. Peers sometimes say using condoms is not cool and nobody want to be the “uncool” member of the group.

**DISCUSSION**

This study explored the perceptions of Swedish youth about the use of condom to protect against STI. Prominent findings from this study indicated that exploring the influence of the media, understanding the role of parents in relation to condom use by youth, having condoms
available all day round with maximum privacy and addressing the effect on gender on condom may contribute to an increased use of condoms by youth. The discussion of these finding will be guided by the theory of planned behaviour.

**Exploring the influence of the media**

The findings from this study show that media is considered be an important source of information to the public and shapes their perceptions about a topic of interest. In relation to condom use behaviour, the media such as television, radio and internet can be regular sources of information to youth and the general population on condom use. Mass media campaigns and infomercials have been used to address health related issues such as smoking (73), HIV prevention (74) and condom use (75). Studies have shown that using mass media as a tool for addressing health issues is beneficial especially if the information is tailored to the target group (76). This involves planning information programs based on a comprehension of the perceptions and needs of the target audience (77).

Media, in line with TPB (62), can influence the intention to use condom by communicating positive views to an individual. Furthermore, information from the mass media may serve to improve self-efficacy by addressing the doubts an individual has about condoms. This study shows that having occasional information about using condoms and about the dangers of STI can serve as a reminder to youth and the general public. This may keep the need to use condoms fresh in people’s mind, thereby possibly influencing their condom use behaviour. Mass media campaigns have direct and indirect influence on the health issue being addressed. Information on a health issue from the media can persuade an individual to evaluate their health behaviour by highlighting positive healthy behaviours and helping them to recognize unhealthy norms. Indirectly the media messages serve to increase the frequency and depth of interpersonal discussion about a heath issue in an individual’s social network. This in combination with exposure to the message might reinforce positive behaviour or undermine a negative one (78). A Swedish study however reported no measurable changes in the attitude of students towards condom use or any increase in routine STI check-up after using media campaigns (79). This could be explained by the short duration of the campaign in this study, which was 3 months.

Information from the media may also serve to reinforce what has been taught in school about condom use. It has been shown that a combination of mass media and other sources of
information such as education in school is an effective way to address health related issues (80).

**The role of parents and condom use by youth**

The crucial role parents play or can potentially play is a prominent finding in this study. They were considered to be important figures in youth’s social context and serve as guides in decision making. Parents are integral part of adolescents’ socialization and the development of attitudes that affect sexual risk behaviour (56). Although sexual engagement and use of condom is largely individual and often practiced in seclusion, it may be influenced by close social contacts. Parent discussing about condom use may provide youth with information that will influence their perception about condoms. Parental influence in general occurs though the transmission of parental values and expectation, role modelling, external reinforcement, parenting styles and the use of different parenting practices (81). In addition, this may create an open atmosphere between youth and their parents, which may enable youth to freely discuss challenges they may encounter regarding condom use and other sexual issues. This may contribute to youth having a sense of support from their parents and likely strengthen their resolve to use condoms. TPB cites social expectation and pressure as possible influences on the intention to perform an action (62). Discussions about condom between youth and their parents may signify expectations for the youth to use condoms. Furthermore, parents may instil positive behavioural attitudes in youth through role playing and discussions. The information provided during these conversations is expected to help address unhealthy norms, while reinforcing positive education from school and other sources.

Parents may help to filter the multitude of information on sexuality, condom use and other related issues. At an early age when youth maybe confused or curious about their sexuality, knowing that they can freely discuss with their parents may be a necessity. Parents have the opportunity to provide their children with information about using condoms before they become sexually active, particularly because condom use at first sex maybe one of the most crucial factor for current/future condom use (82,83). Discussion between mother and child about condom prior to sexual debut has been correlated with adolescent condom use at last sex (84). An American study by Whitaker et al shows that youth who reported having conversation with either parent about condoms had used condom during the most recent intercourse and also reported more frequent condom use than those who had not discussed condom use with a parent (85).
Findings from this study shows that deterrents to parents discussing about condoms with their children includes the sensitivity of the topic and sometimes the peculiarity of the teenage years which may create conflicts between parents and teenagers. The sensitivity of the subject makes it difficult for parents to discuss about condoms with their children and vice versa. However if this awkwardness is dealt with, an open atmosphere to discuss about sexual issues may be created between youth and their parents. In addition to the awkwardness to initiate sexual discussion, what is considered a meaningful discussion may vary between parents and their children (86). This implies that although parents may make efforts to engage their children in discussions about condoms, they may not adequately convey the message to their children. And it has been shown that youth’s perceptions of the discussions they had with their parents is more predictive of their sexual behaviour than their parents’ perceptions (87).

Beyond the conversations, parents can also provide their children with condoms. As often mentioned, embarrassment and cost are barriers for youth to obtain condoms, especially for the younger one (39,47). Parents providing condoms will not only help deal with these challenges, it will also strengthen a positive perception about condoms among youth. This support TPB’s behavioural intention by reinforcing the degree of control youth perceive in order to use condoms (62). Overall this may lead to adoption of healthy condom use behaviour among youth.

**CVMs: 24hr condom availability with maximum privacy**

Ensuring access to condoms has been given high priority by the Swedish government and this was echoed by participants in this study. Despite free condom outlets such as YHCs, schools among others, and the possibility to buy them at stores and pharmacies, the need to further improve access to condoms was highlighted in this study. This is with the aim to improve condom use among youth. Installing condom vending machines (CVM) at different locations in Swedish towns was suggested by participants.

Installing CVMs especially in hot spots such as bars and clubs, according to participants, could improve access for people who may unexpectedly find themselves in need of one. Findings from this study showed that individuals who find themselves without condoms are propably going to progress with having sex. For a youth who meets a new/old casual sex partner, the availability of a vending machine might facilitate their ability to obtain condoms if they do not have one available. Furthermore, vending machines are suitable for individuals who may be
embarrassed to go buy condoms in the pharmacy or even to go pick free condoms in any of the designated outlets. It has been reported that youth feel more comfortable obtaining condoms from vending machines (88). This could partly be attributed to ability to obtain condoms anytime of the day when other outlets might not be accessible (89). They are also afforded more privacy if they choose to buy from the vending machines especially if the machines are installed in places where confidentiality is assured and public visibility is minimal (73). The spontaneity of events that leads to sex in some situations makes the ability to access condoms 24/7 via CMVs important.

Although youth health centres in Sweden perform a significant role in providing free condoms for youth, the limited opening hours may be a constraint to accessing condoms. UK study found that vending machines are the second most frequented outlets by youth to obtain condoms (90). An Ethiopian study found that the procurement of condoms and the use increased among university students when CVMs were installed (91). This may compliment the already existing means of obtaining condoms in Sweden.

**A glimpse of condom use through gender lens**

The discussions around the influence of gender on condom use suggested that males are more likely to suggest having sex without condoms. Reasons given for this include the reduction in sexual pleasure that occurs with the use of condom and the interruption in the sexual continuity that happens in the process of taking a condom or wearing one. These reasons have also been reported in other studies (92,93). This however, is not exclusively a challenge for males, as a study by Williamson et al which explored the non-use of condoms by females reported similar findings (94).

Given the level of gender equality in Sweden (95), the influence of being male or female on the possession of condom is of little or no consequence. The findings from this study show that being male or female does not affect how you are perceived if you have condoms in your possession. Studies have shown that when there is gender equality, condom use self-efficacy increases and women are more likely to use condoms (96,97). In contrast, women in relationships with gender power imbalance experience lower self-efficacy for discussing condoms and confront more difficulties in enacting their desire to use condoms (89,90).
Methodological consideration

According to Lambert et al (64) “the line of questioning pursued in the data gathering sessions and the methods of data analysis, should be derived, where possible, from those that have been successfully utilised in previous comparable projects”. The data collection for this study was done using well established methods such as semi-structured interview and focus group discussion. The combination of semi-structured interviews and FGD is considered a form of data triangulation which strengthens the credibility of this study.

The interview guide for the semi-structured interviews was reviewed by supervising lecturers who gave suggestions on how to improve it. It was then tested during two pilot studies and some changes were made before it was used for research participants. A vignette that was written for the FGDs was also reviewed by the supervising lectures and their suggestions for improvement were implemented before it was used in the study. In addition to the vignette, note cards containing topics that FGD participants were to discuss were placed on a table between them. The use of note cards instead of asking questions during FGD had been previously used by the researcher during a qualitative course assignment. The participants used the note cards to direct the discussion and the researcher just asked a few question during the FGD.

The choice to use thematic analysis was made because it is a well-established and widely accepted method in qualitative research. Furthermore, it is a suitable method of analysis for researchers with limited experience in the field of qualitative studied because of its flexibility and basic steps that are easy to follow (70). The detailed step by step description of the process of conducting thematic analysis by Braun and Clarke (70) makes it easy for researchers to repeat the process of analysis.

Shenton (66) suggested that in order to strengthen the credibility of a qualitative study, “tactics to help ensure honesty in informants when contributing data” should be employed. Participants in this study were informed right from the onset and before they signed the informed consent form that the participation was voluntary. They were also told that they could withdraw from the study at any point without having to give a reason for doing so. In addition to this they were notified that there was no right or wrong question and no offer of incentive were made to them. This was to ensure that participant do not feel pressured or incentivised to give information and hence ensuring honesty in them. All the participants were aware that the researcher is a master’s student conducting a personal academic project.
Development of early familiarity with research context also promotes qualitative research credibility (64). The researcher has been studying in Sweden for more than a year and has been a volunteering member of a well-known Swedish organization concerned with youth’ sexual health. This has given the researcher some degree of familiarity with the study context.

During the course of conducting this research, there were multiple seminars involving the researcher, other colleagues and supervising lecturers. In these seminars the supervising lecturer and other colleagues gave critical appraisal of the ongoing research, focusing on what had been done and giving suggestions on possible adjustments. A critical friend (a colleague who thoroughly read the researcher’s updated draft before every seminar) also gave recommendations for improvement. The feedbacks from these seminars helped the researcher to develop fresh perspectives and conduct a more comprehensive study.

The semi-structured interviews were conducted using the same interview guide, with minor adaptations depending on the course of each interview. Despite the room given for new information developing during the interviews, the interview guide served as a blueprint for the interviewers. Given the sensitivity of discussion around condom use, male participants were interviewed by male (the researcher) and the female participants by a female colleague who has some experience with qualitative research.

My experience as a doctor back in Nigeria and the opportunity to work with HIV/AIDS patients has increased my interest in sexual health especially for youth. This may have influenced my interpretation of the results. Being the main tool in qualitative research, the influence of the researcher in the whole study process and the final result is unavoidable. However, keeping a reflexivity journal had helped me to constantly distance myself from the transcripts and foster the reporting of participants’ ideas and experiences.

To facilitate the transferability of this study, detailed description of the study setting was given in the methodology section. The findings from this study can be transferable to European countries with similar sexual and cultural values. However this must be done with some caution given the small sample size which may not be representative of the youth population.
Study limitations

The participants in this study were all heterosexuals, which means that the perceptions of individuals who may be homosexuals or bisexuals are lacking in this study. It is safe to assume that their perceptions may vary in some ways and could have richly contributed to the data.

The missed opportunity to conduct a female only group discussion can also be seen as limitation, partly because more male voices were represented and partly because this study misses on how a female only FGD could have contributed richly to the study data.

Even though this study used TPB as its theoretical framework, participants were not asked about their intention to use condoms, and behavioural intention is the central component of TPB.

CONCLUSION

The use of condom by youth in Sweden is mediated through a dynamic repertoire of norms and factors. Even though the decision to use condom during sex is often bilateral, it is influenced by factors beyond the individuals making the decision. To improve the use of condoms by youth in Sweden, it is important to give precedence to factors that youth perceived as having the potential to increase condom use within this age group.

Recommendations

This study has identified factors with the potential to improve the use of condoms by youth in Sweden. Exploiting the extensive coverage and power of the media by disseminating information that are tailored for youth. Organizing programs that involves parents in sexual health of their children and that also informs parents on how to deal with the difficulties of discussing such a sensitive topic with their children. Policies that encourage the installation of condom vending machines should be adopted and the municipalities should install CVM in locations that allow maximum privacy, such as toilets in bars. Furthermore, future research will be useful to investigate the condom outlets most often used by youth in Sweden and why they choose to use these outlets.
REFERENCES


23. UMO.se [Internet]. [cited 2016 Apr 20]. Available from: http://www.umo.se/


27. RFSL Ungdom | Ungdomförbundet för homosexuella, bisexuella, transpersoners och queeras rättigheter [Internet]. [cited 2016 May 5]. Available from: http://rfslungdom.se/


64. Lambert SD, Loiselle CG. Combining individual interviews and focus groups to enhance data richness. Journal of advanced nursing. 2008 Apr;62(2):228–37.


ANNEX

Annex 1: Interview guide

Equipment: voice recorder, paper, pen, information and consent sheet.

Prior to commencing the interviews, there will be a social dialogue between the participants and the researcher in order to create a comfortable atmosphere. The researcher will introduce himself (or herself when it my female colleague) stating name, department and also purpose of the study. A brief summary of the information sheet which covers information about anonymity, confidentiality, privacy and recording of the interview will be read to participants. Afterwards, they will be allowed to ask questions and make clarifications about the study. When all questions has been satisfactorily answered, participants will then sign a consent form before commencing the interviews. During the pre-interview dialogue, demographic information will be collected from participants and these will include age, gender, sexual orientation, and level of education.

Interview questions

The participants will be reminded once again that the interview questions will be about their perceptions and not their personal experiences, in order to minimize the discomfort that comes with discussing sensitive personal issues. The interviews will not be rigidly conducted to follow the question order, which means the questions will be asked in line with the trajectory of the interviews. The interviews will start with this question “what are your thoughts on condoms and condom use?” Subsequent questions will be asked as the interview develops and probing questions will be used where necessary.

Other questions include:

- How do youth obtain condoms in Sweden?
- What are the factors that influence the use of condoms by youth in Sweden?
- How safe do you think condoms are against STI?
- How does a person’s gender affect their possession and use of condoms?
- How does a youth’s close social contact (e.g. friends, parents etc.) affect their condom use?
- How does the community a youth live in affect their condom use?

Probing questions/techniques
• Can you explain further .....?
• How will you describe .....?
• Can you be more specific?
• Anything else?
Annex 2: Information sheet

STUDY TITLE: A qualitative study exploring the perception of Swedish youth about the use of condoms in preventing sexually transmitted infections

MAIN RESEARCHER: Oluwadamilare Oladimeji

SUPERVISOR: Prof Beth Maina-Alberg, Dr Jill Trenholm

INSTITUTE: International Maternal and Child Health (IMCH), Uppsala University, Sweden.

Introduction

I am Oluwadamilare Oladimeji, a master student in the department of Women’s and Children’s Heath, Uppsala University. I am going to give you important information about this research and you do not need to decide immediately if you want to participate or not. You can discuss with anyone you feel comfortable with about the research before deciding. If there are words or information that you do not understand or if there are questions you want to ask, I will clarify this before or during this study.

About the research

The aim of this research to explore the perceptions of Swedish youth on the factors that affect their use of condoms to protect against sexually transmitted infections and it is a master thesis from the Uppsala University. You have been invited to participate in this research because you are a youth between the age of 18 and 24 who will have some knowledge about sexual practices among youth in Sweden. We feel your experience and knowledge will contribute to our understanding of the factors that affect the use of condoms by youth in Sweden.
**Voluntary Participation**

Your participation in this study is absolutely voluntary i.e. you can choose to participate or not. You may stop participating during the interview or discussion at any time that you wish, if you decide that you do not want to be further involved. If there are questions that make you uncomfortable, you can choose not to answer them. I will give you opportunity at the end of the interview/discussion to review your remarks, and you can ask to change or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

**Procedure**

We are inviting you to participate in this study, to help us learn more about the factors that determine the use of condoms by youth in Sweden. If you accept to participate, you will be involved in either an interview or a focus group discussion. The interview (technically called semi-structured interview) will involve an interviewer asking you a couple of predetermined questions to guide the discussion around the study topic. There will also be some probing questions the interviewer will ask based on what you say during the interview. As noted earlier, you do not have to answer any question you are not comfortable with. The interview will be conducted by someone of the same sex, to facilitate the ease of discussion.

The interview will be conducted in the place you feel is comfortable or in my department. No one else but the interviewer will be there, unless you want some else to be present. The interviewer will ask you questions about how youth obtain condoms, the influence of friends and parents on condom use by youth, and other related questions. You do not have to share any information you are not comfortable with.

The group discussion will involve a couple of people, usually between 4 and 8, discussing around the study subject. The group discussions will vary between single sex groups and a mixed group. That means there will be male and female only group discussions and also a
group discussion containing female and male participants. The single sex discussions will be
moderated by someone of the same sex, while mixed group will involve myself (male).

The FGD will involve 4 to 8 people within the age group 18-24 and will be conducted in my
department, which is centrally located and has comfortable rooms. No one else apart from the
participants in the discussion will be present. Every participant in the discussion will have time
to talk and we will encourage respect during the discussion.

Both the interviews and the focus group discussions will start with me or my colleague making
sure you are comfortable and we will answer the questions or doubts you may have. The
interviews and the focus group discussions will be tape recorded and will be safely stored so
no one except the research team have access to it. Each participant will have a code which will
prevent any body from recognizing them, either on the recorded tape or when the research is
made publicly available. The recorded information is confidential and will be stored on the
researcher’s laptop which has a password that no other person knows.

You will be informed as soon as possible if you are participating in the interview or group
discussion, so you have time to prepare.

Duration

The research will take place over two months. The interviews will last between 25 and 45
minutes, while the group discussions will last between 45 and 90 minutes.

Risks

We aware that you will be talking about a sensitive subject and you may therefore feel
uncomfortable with discussing some of the questions. If there is a need for clinical advice or
intervention due to participation in this study, you will be referred to ungdomsmottagning.
**Benefits**

You will not receive any direct benefits from participating in this research, however your participation will help us to have better understanding of the factors that influence decisions by youth to use condoms to protect against STI. This may help to advocate for the implementation of sexual health programs that are better suited for the youth.

**Sharing the result**

The results from the research will be made publicly available on DiVA, a website where Uppsala University publishes researches, however it will not be linked to you because we would have protected your identity with codes. It is important that other people learn from the research.

**Reimbursement**

You will not be paid to participate in this study, however if you spent money on transportation, you will be reimbursed. You will also have refreshments either before or after your participation and free condoms will be made available.

**Who to contact**

If you have any question relating to this study or your participation, I can be reached through the contacts given below

**Name**: Oluwadamilare Oladimeji

**E-mail**: doctdoe@yahoo.com

**Phone**: 076******

**Address**: Department of International Maternal and Child Health, floor 4, St: Olofsgatan 4, Uppsala.
Annex 3: Certificate of consent

I have been invited to participate in the research “a qualitative study exploring the perceptions of Swedish youth about the use of condoms in preventing sexually transmitted diseases”. I will be involved in either a semi-structured interview or a focus group discussion. I have read the information sheet and I have had the opportunity to ask questions about it. I have received satisfactory answers to the questions I asked and I consent voluntarily to be a participant in this study.

Print Name of Participant__________________

Signature of Participant ___________________

Date ___________________________

  Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that they will either be interviewed or will be a part of a group discussion

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this information sheet has been provided to the participant.

Print Name of Researcher/person taking the consent________________________

Signature of Researcher /person taking the consent__________________________

Date ___________________________

  Day/month/year