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Master thesis

Young adults' thoughts and experiences
regarding condom use: A qualitative study
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Table of content

ACKNOWLEDGEMENTS.....	3
TABLE OF CONTENT	4
NORSK SAMMENDRAG.....	7
ABSTRACT IN ENGLISH.....	9
1. INTRODUCTION.....	11
1.1 RATIONALE	11
1.2 PURPOSE OF THE STUDY	13
1.2.1 <i>Research questions</i>	14
1.2.2 <i>Theoretical Framework</i>	14
1.3 NOT BEING ADRESSED.....	15
2. LITERATURE REVIEW	16
2.1 DEGREE OF SEXUAL EXPERIENCE AND AGE OF FIRST EXPERIENCE.....	17
2.2 CONDOM USE AND PERCEIVED RISK TO SELF.....	18
2.2.1 <i>In Norway</i>	18
2.2.2 <i>Internationally</i>	21
2.3 KNOWLEDGE ABOUT RISK	22
2.4 THE CONTEXT IN WHICH SEXUAL ENCOUNTERS TAKE PLACE	24
2.5 CONFIDENCE AND SELF-EFFICACY IN RELATION TO DEALING WITH A PARTNER OR BUYING CONDOMS	25
2.6 RELATIONSHIP LENGTH AND TRUST.....	28
3. THEORETICAL CONSIDERATIONS	30
3.1 THE HEALTH BELIEF MODEL.....	30
3.1.1 <i>Threat perceptions</i>	30
3.1.2 <i>Benefits and Barriers</i>	31
3.1.3 <i>Cues to Action</i>	32
3.1.4 <i>Self-efficacy</i>	32
3.1.5 <i>Use of the model</i>	33
4. METHODOLOGY	34
4.1 QUALITATIVE RESEARCH DESIGN	34
4.2 SAMPLE AND SETTING OF THE STUDY	36
4.3 DATA COLLECTION.....	37

4.4	THE INTERVIEWS	38
4.5	DATA ANALYSIS	39
4.5.1	<i>Table 1. Phases of thematic analysis</i>	39
4.6	CHOICE OF METHOD AND THE METHODS STRENGTHS AND WEAKNESSES	41
4.7	ETHICAL CONSIDERATIONS	45
4.7.1	<i>Sensitive issue</i>	45
4.7.2	<i>Authority</i>	46
4.7.3	<i>Storage of data</i>	47
5.	FINDINGS	48
5.1	FADED MEMORY OF STI EDUCATION	49
5.2	TRUST BASED ON HONESTY IN SEXUAL ENCOUNTERS.....	50
5.3	RESPONSIBLE AND ‘KILLING THE MOOD’ - SOCIAL SIGNALS IN RELATION TO CONDOM USE	53
5.3.1	<i>When partner brings up the topic of condom use</i>	53
5.3.2	<i>Thoughts about bringing up the topic of condom use</i>	54
5.4	ALCOHOL AND ONE-NIGHT STANDS- CONTEXTS OF CONDOM USE.....	55
5.5	NO BIG DEAL? THOUGHTS ON THE SEVERITY OF STIS AND PERCEPTION OF RISK	57
6.	DISCUSSION	61
6.1	MAIN FINDINGS.....	61
6.2	THREAT-APPRAISAL	63
6.2.1	<i>Perceived Severity and Perceived Susceptibility</i>	64
6.3	BENEFITS AND BARRIERS	65
6.4	SELF-EFFICACY	66
6.5	CUES TO ACTION.....	67
6.6	ANSWERING THE RESEARCH QUESTIONS.....	68
6.6.1	<i>Context</i>	69
7.	CONCLUSIONS.....	71
7.1	IMPLICATIONS AND LIMITATIONS	71
7.2	FUTURE RESEARCH AND PUBLIC HEALTH PRACTICE RECOMMENDATIONS	73
	REFERENCES	75
8.	APPENDICES.....	84
8.1	APPENDIX 1 - NSD.....	85
8.2	APPENDIX 2 - RECRUITMENT POSTER.....	86
8.3	APPENDIX 3 - CONSENT FORM	87

8.4 APPENDIX 4 - INTERVIEW GUIDE NORWEGIAN.....90

8.5 APPENDIX 5 – INTERVIEW GUIDE ENGLISH.....93

8.6 APPENDIX 6 – SAMPLE BACKGROUND INFORMATION96

Norsk sammendrag

Introduksjon: Folkehelseinstituttet rapporterer en økning av seksuelt overførbare infeksjoner (SOI) som klamydia og gonore i Norge. Flere SOI kan resultere i barnløshet. Det er i aldersgruppen 20-24 hvor majoriteten diagnostiseres. En undersøkelse utført av Helsedirektoratet oppdaget at unge voksne oppgir at å “unngå uønsket graviditet” er deres prioritet når det kommer til bruk av kondom ved samleie. Hormonelle prevensjonsmidler er den mest brukte prevensjonsmetoden blant unge i aldersgruppen 20-24 år, disse beskytter derimot ikke mot SOI. Sett i et folkehelseperspektiv er det relevant å oppnå mer kunnskap om hvilke tanker unge voksne har rundt kondombruk. I fremtiden kan resultatene fra denne oppgaven bli brukt til å bidra med innsikt på temaet fra deltakernes perspektiv, som et supplement til fremtidig forskning.

Metode: Dette er en kvalitativ studie av 7 unge voksne som bor i Oslo, alle deltakerne meldte seg frivillig og ble rekruttert gjennom helsestasjonen Sex og Samfunn og gjennom “snowball-sampling”. Datainnsamlingen ble gjennomført gjennom individuelle intervjuer, ved bruk av en semi-strukturert intervjuguide. Analysen ble gjennomført ved bruk av tematisk analyse av Braun & Clarke (2006).

Resultat: Deltakerne hadde forskjellige tanker og erfaringer med kondombruk, men hadde også flere felles oppfatninger. De fleste deltakerne skilte mellom en ukjent partner og en fast partner. Flere av deltakerne mente alkohol og one-night stands var faktorer som kunne gjøre det mer utfordrende å bruke kondom. “Tillit” i relasjon til en samleiepartner var for det meste forbundet med ærlighet rundt det å fortelle om eventuelle SOI. Samleiepartnerens ukjente reaksjon til kondombruk opplevdes som en barriere for flere av de kvinnelige deltakerne som gjorde det utfordrende for dem å ta opp kondom. De fleste av deltakerne snakket om SOI med en avslappet holdning.

Diskusjon: Resultatene av denne studien støtter tidligere forskning som fremhever at unge voksne har en lav trussel-oppfatning når det kommer til SOI. Konteksten rundt et samleie og flere andre faktorer påvirker unges beslutningsvurdering rundt bruk av kondom. Ytterligere undervisning på skolen som inneholder informasjon om hyppigheten og konsekvensene av SOI, kombinert med grundigere undervisning om det sosiale aspektet rundt sex, som fokuserer på å bygge opp unges mestringstro, og forbreder dem på ulike situasjoner som kan oppstå rundt kondombruk kan vise seg effektive.

Nøkkelord: kondom, unge voksne, SOI, kvalitativ

Abstract in English

Introduction: Recent reports measure an increase of sexually transmitted infections (STIs) such as chlamydia and gonorrhoea in Norway. Untreated, these conditions can lead to infertility. It is in the age group 20-24 where the majority are being diagnosed. A study conducted by the Norwegian directorate of health discovered that young adults do not fear STIs and report “avoiding unwanted pregnancies” to be their priority when deciding to use condoms in sexual encounters. Most young adults use hormonal prevention methods, these do not protect against STIs. In a public health context it is relevant to collect more information about what perspectives young adults have in relation to condom use. In the future the findings can be used to provide some insight on the topic from the participant’s point of view, as a supplement in future research.

Methods: This is a qualitative study of 7 young adults who live in Oslo, all the participants’ volunteered and were recruited through the health clinic Sex og Samfunn and through “snowball-sampling”. The collection of data was done through in-depth interviews completed with a semi-structured interview-guide. The data was analysed by using Braun & Clarke’s (2006) thematic analysis.

Results: The participants of the study had different thoughts and experiences with STIs and condom use, but there were also several common conceptions. Few of the participants had any recollection of the sex education they had received in school. Several of the participants identified alcohol and one-night stands as factors that could make it more challenging to use condoms. “Trust” in a partner was for the most part associated with honesty in terms of disclosing possible STIs. The female participants described uncertainty regarding the partners’ unknown reaction to condom use as a factor that made it challenging to bring up condom use. Most of the participants of the study talked about STIs in a light-hearted manner.

Discussion: The findings of this study support previous research findings that have identified a low threat-perception of STIs among young adults. The context in which the sexual encounter takes place and several other factors influence young people’s decision-making regarding condom use. More elaborate education in schools about the consequences and frequencies of STIs, as well as about the social circumstance surrounding sex, so that they can develop self-efficacy in communicating condom use to a partner and preparing them for

different situations that can arise with condom use, could prove effective in increasing condom use.

Key words: condom, young adults, STIs, qualitative

1. Introduction

The dissertation is presented in seven chapters. *The introduction* is where a short background and rationale of the subject is presented, including research questions and limits of the study, meaning what the study does not address. Next, *the literature review* identifies existing research on the topic, including factors that can influence people's decision-making process regarding condom use. The literature review also outlines how the research questions came to be. A chapter covering *theoretical considerations* is also included, followed by *methods* which explains in detail the research process and what approach the study has taken and why. *The findings* are presented in the following chapter. The last two chapters are *discussion* and *conclusion*; the discussion explores the impact of the findings and where they fit in compared to existing research. The *conclusion* chapter includes limitations of the study and suggestions for future research.

1.1 Rationale

Sexually transmitted infections (STIs) are bacteria, viruses and parasites that can be transmitted through sexual contact (WHO, 2016a). The World Health Organization recognizes STIs as a serious threat to sexual and public health worldwide (WHO, 2016a). Condoms are the only prevention-method that protects against both STIs and unwanted pregnancies. In Norway, the number of young Norwegian adults that are being diagnosed with STIs is increasing (Folkehelseinstituttet, 2015a). In 2015, there were as many as 25000 cases of diagnosed chlamydia. This makes a slight increase from the year before (Folkehelseinstituttet, 2015a; Helse-og omsorgsdepartementet, 2017). Despite this increase of STIs, few young Norwegian adults use condoms, and those who do, use it mainly to avoid unwanted pregnancies (Helsedirektoratet, 2009). Hormonal prevention-methods are most commonly used as form of contraception in the age group 20-24 (Folkehelseinstituttet, 2015a). These do not protect against STIs (Centers for Disease Control and Prevention (CDC), 2016a). A study conducted by the Norwegian directorate of health indicates that

young adults do not perceive STIs as a real threat or concern (Helsedirektoratet, 2009). The aim of this study is to explore in-depth what thoughts and experiences young adults have in relation to condom use. This is interesting in regards to exploring and understanding different contexts and circumstances that can influence young peoples decision-making in regards to condom use. The thesis also aims to explore young peoples reasoning's regarding potentially perceiving STIs as 'non-threatening'. A deeper understanding of young peoples threat perceptions of STIs could contribute to a further understanding condom 'non-use' (Abraham, Conner, Jones & O'Conner, 2008).

Herpes, genital warts, crabs and scabs are all unfortunate conditions that can be transmitted through unprotected sex (Folkehelseinstituttet, 2015a). These can cause severe discomfort and itching. There are however other STIs that can be much more severe. The Norwegian department of health published a strategy for sexual health "Talk about it!" in January this year (Helse-og omsorgsdepartementet, 2017). The strategy reports an increase of STIs such as chlamydia, gonorrhoea and Human papillomavirus (HPV). Besides causing discomfort and embarrassment, untreated, both chlamydia and gonorrhoea can cause infertility (Folkehelseinstituttet, 2015b; WHO, 2016a). HPV can lead to genital warts and even cancer (CDC, 2016b). Chlamydia infections can cause pelvic inflammatory disease and salpingitis; both conditions can lead to infertility and extra-uterine pregnancies (European Centre for Disease Prevention and Control (ECDC), 2016). These STIs are treated with antibiotics, and increased use of antibiotics can lead to an increase of antimicrobial resistance (Helse- og omsorgsdepartementet, 2016).

Worldwide, over one million STIs are acquired every day (WHO, 2016a). Chlamydia is the most commonly diagnosed STI in Europe (Folkehelseinstituttet, 2015b). In 2009, Norway had the third highest chlamydia rate in Europe (ECDC, 2016). Infections such as chlamydia often do not show any symptoms and there is reason to believe that there are many numbers

of undiagnosed cases (ECDC, 2016). The ECDC report that sexually active young people are most at risk of chlamydia and women under the age of 24 have the highest number of chlamydia infections in Europe (ECDC, 2016). People under the age of 25 make 66% of the diagnosed cases of chlamydia and it is in the age group 20-24, where the majority is being diagnosed (Folkehelseinstituttet, 2015a).

The number of diagnosed cases of gonorrhoea in Norway is the highest they have been in 25 years, with 1096 diagnosed cases in 2016 (Folkehelseinstituttet, 2016). Oslo is one of the cities where high percentages are being diagnosed (Folkehelseinstituttet, 2016; 2015a). In 2015 there were 221 new cases of HIV diagnoses in Norway. Without treatment, HIV can develop to AIDS, where the HIV-infection is at a later stage. Despite all this, a study conducted by the Norwegian directorate of health indicates that young Norwegian adults do not consider STIs as a real concern (Helsedirektoratet, 2009). Few young adults use condoms and those who do, use them in order to avoid unwanted pregnancies (Helsedirektoratet, 2009). Consequently, the prevention of STIs is of utter importance and will be the focus onwards, as solely focusing on treating STIs would be a downstream approach (Helse- og omsorgsdepartementet, 2016; WHO, 2016b).

The age group 20-24 years old is identified as the age group with the most people being diagnosed with chlamydia in Norway, and the capital is where the STI rates are the highest (Folkehelseinstituttet, 2016; 2015a). Based on this, the focus of this dissertation will be young adults who live in Oslo, between the ages 20-24.

1.2 Purpose of the study

To explore what factors shape some young peoples thoughts and experiences surrounding condom use qualitative methods will be appropriated. The goal of this dissertation is to

obtain some insight on the thoughts some young adults have relating to condom use and their reasoning's for these. Qualitative research about thoughts and experiences surrounding condom use in Norway is scarce, and the research that does exist is dated. The dissertation aims to provide knowledge to the limited body of qualitative research concerning condom use in Norway. By use of qualitative methods, relevant thoughts and experiences with condom use of a few young adults can come to light. Hopefully, this modest contribution can be added to the body of research on thoughts about condom use among young adults. It is important to understand young peoples thoughts and practices in order to understand how best to increase condom use and consequently decrease the spreading of STIs. Based on the existing literature the following research questions will be attempted answered:

1.2.1 Research questions

Main research question:

What thoughts and experiences do young adults have in regards to condom use?

Secondary research questions:

What are the circumstances that shape peoples decision-making in regards to condom use?

What are the variations in context?

1.2.2 Theoretical Framework

The health belief model (HBM) has frequently been used when trying to understand health protective behaviour such as condom use (Bryan, Aiken & West, 1997; Lin, Simoni & Zemon, 2005; Montanaro & Bryan, 2014). The model accounts for several factors that can influence condom use (Bryan et al., 1997; Hall, 2012). The HBM will be used as the theoretical framework, with emphasis on self-efficacy and threat-perception. The model was used to develop search words for the literature review as well as in developing the interview-guide. The sub-questions aim to explore the links between the factors that can be identified

using the HBM that can influence condom use with the thoughts and experiences the participants describe.

1.3 Not being addressed

There are several ways to prevent STIs (CDC, 2016a). Condoms can be used improperly, expire or break. Abstinence is one method to avoid STIs that has previously been promoted to adolescents (CDC, 2016a). Abstinence is a very effective method, however it can be challenging to maintain absolutely abstinent for a long period of time. Solely focusing on abstinence can be unfortunate in regards to not preparing young people with the knowledge and skills regarding other protection methods (Bruess & Greenberg, 2004). Sexual behaviour without the exchange of bodily fluids is also a way to protect against STIs. Mutual monogamy is another way to prevent STIs (CDC, 2016a). This method is very dependent on trusting that both parties must be certain they are not infected with STIs, remaining faithful and honest with each other (CDC, 2016a). Testing is another important, yet secondary way to prevent STIs (CDC, 2016a). There are varying degrees of risk with all these protection methods. Condoms, even though not fail-safe, will therefore be the main focus onward, in regards to protective measures against STIs. The majority of research that exists on condom use and STIs focuses on HIV/AIDS and is somewhat dated. As these infections had very severe consequences in the 80- and 90's they cannot really be compared with chlamydia or a similar diagnosis today (Norsk Rikskringkasting (NRK), 2015; Pedersen & Samuelsen, 2003). Therefore, most of the research used in this literature review does not focus on HIV/AIDS-research. There are some groups in the population that are more at risk of getting STIs. These groups include men who have sex with men (MSM), sex workers, prison inmates and immigrants (Helsedirektoratet, 2017a). The focus of this dissertation is young adults and these groups will therefore not be explored further.

2. Literature review

The aim of this chapter is to explore the existing literature on condom use and threat-perceptions, especially in relation to how young adults' perceive condom use, and their reasoning's as for using and not using condoms. Exploring the reasoning's young adults have in regards to condom use and threat-perceptions of STIs is an important part of understanding their behaviour. This chapter also highlights the development of the research question and why it needs to be answered. The dissertation includes rapports and studies done by the Norwegian directorate of health and statistics of STI rates from Folkehelseinstituttet. Databases Oria and PubMed were used for finding peer-reviewed articles. The HBM was used to select the search words used for finding the literature. Search words such as 'risk', 'threat', 'barrier' and 'self-efficacy' were directly inspired by the HBM. 'HBM' was also used as a search word. Other search words included 'condom', 'young adults', 'STI' and 'sexual health'. The search strategy also included search words using 'NOT', for e.g. 'condom, risk, young' NOT 'sexworkers'. Exclusion criteria included research focusing on sex workers, MSM, HIV/AIDS-positive. This was done because these are smaller groups with other risk factors than the target group (Helsedirektoratet, 2017a). Research done on the target group, young adults between the ages 20-24, was prioritised over research done on other age groups.

This chapter is divided in to six sub-themes. The themes were inspired by the HBM. They all cover different aspects that can influence "risk behaviour" in relation to condom use/'non-use', and explores the existing literature. It is important to have an understanding of the broader determinants of risky sexual behaviour and condom use in order to attain insight as to in which way these can shape current thoughts and practices regarding condom use.

The first part is about *degree of sexual experience and age of first experience*. It inquires how early sexual debut can be a risk factor in contracting STIs later in life and non-use of condoms. The second part is about *condom use and perceived risk to self*. The third part is about the *knowledge about risk, followed by the context in which sexual encounters take place*, this is found to influence the use of condoms and having unprotected intercourse. Next is the theme *confidence and self-efficacy in relation to dealing with a partner or buying condoms*. Lastly, there is a part covering how *relationship length and trust*, can influence decisions around condom use.

2.1 Degree of sexual experience and age of first experience

The patterns of young people's sexual behaviour in Norway are a difficult thing to measure and map. However a longitudinal study attempted just that by examining approximately 11000 representative Norwegian adolescent's between the ages 13-19 years old (Pedersen & Samuelsson, 2003). The participant's were given a questionnaire with a ten-year span from 1992 to 2002. The study found that the average median age for sexual debut was 16,7 years for girls, which is a year younger compared to ten years previously. The age for boys had not changed much from 18,5 to 18 years (Pedersen & Samuelsson, 2003). Even though sex is a personal act that (mostly) takes place behind closed doors; it is also not beyond the influence of social norms and context. The society we live in will very much influence *when, how* and with *whom* we have sex (Browne & Minichillo, 1994; Traeen, Lewin & Sundet, 1992). Socially constructed gender roles will also influence how we view what is appropriate condom use and influence our views on by *whom, when* and *how* condoms are used and introduced (Browne & Minichillo, 1994; Traeen et al., 1992). Pedersen & Samuelsen's (2003) longitudinal study found that oral sex was introduced at the same time as intercourse

and that girls were more and earlier sexually experienced compared to boys. The study also found that girls reported being sexually experienced without ever being in a steady relationship (Pedersen & Samuelsen, 2003). Early sexual debut has been associated a higher probability of having unprotected sex later in life (Davis & Lay-Yee, 1999; Leval et al., 2011). Especially women's young age at sexual debut has been associated with a higher risk of condom non-use later in life (Leval et al., 2011). Having a high number of sexual partners is also considered to be a risk factor of STIs (CDC, 2016a). Factors such as age, perception of a partners level of sexual experience and the length of relationship, has also been shown to influence condom use (Jørgensen, Andersen, Olesen & Maindal, 2013; Ku, Sonenstein & Pleck, 1994). Young men are more likely to use condoms compared to older men (Ku et al., 1994). These factors will be further explored under the heading "*Relationship length and trust*".

2.2 Condom use and Perceived risk to self

2.2.1 In Norway

One could imagine that the awkward and sometimes painful consequences and threat of STIs would be the main motivator for young adults to use condoms. This does not seem to be the case. In 2009, the Norwegian directorate of health developed a web-survey in order to examine young people's relations to sexuality and prevention methods (Helsedirektoratet, 2009). The target group were Norwegian representative youth in the age group 16-24. A total number of 871 responded to the survey. The survey found that with the first sexual experience, 'lack of access to condoms' was listed as a main reason for not using condoms. As they developed more experience the reasoning changed to 'having trust in partner' as the main reason for not using condoms. As the target group of this study are young adults in the age group 20-24 it is the latter that will be the focus onwards. Amongst those who had more

than one sexpartner, 49% reported that they did not use condoms with their latest sex partner (Helsedirektoratet, 2009). The group that reported not using a condom at this occasion were asked follow-up questions as to how accurate a number of statements coincided with their reasons for not using condoms. Statements such as ‘I trust the partner’ (79% coincides very well) and ‘we had other prevention’ (71% coincides very well) were most commonly reported. These findings indicate that young adults are not too concerned with STIs, and as long as they use other contraceptive measures, condoms are unnecessary. The Norwegian directorate of health (2009) concluded that their findings indicate young adults are more concerned with avoiding unwanted pregnancies, and mainly use condoms with this purpose, rather than for STI protection. Further, the statement ‘condoms are unnecessary because I know the partner well’ (32% coincides well) was also used followed by ‘if I pull out a condom it will be unromantic’ (29%). These answers could be explained by the fact that 61% of the respondents were in a steady relationship. 19% had their last intercourse with a friend, 9% with a former partner and only 8% had intercourse with an unknown partner (Helsedirektoratet, 2009). The great agreement to the statement “I trust my partner” indicates a low level of perceived susceptibility.

In order to attain more insight as to why young people are dropping the condom, it is important to have an idea of what they care less about when it comes to condom use. Statements that the respondents did not feel resonated with their reasoning’s for not using condoms were ‘If I pull out a condom my partner will think I have a STI that I’m not disclosing’ (82%), ‘If I pull out a condom my partner will think that I am not interested in entering a relationship with him/her’ (81%), ‘If I pull out a condom my partner will think I have been with many before him/her’ (78%) and ‘If I pull out a condom the partner will think that I am only interested in sex’ (74%)(Helsedirektoratet, 2009). These are statements the respondents did not feel resonated with their reasoning’s for not using condoms. This

further strengthens the possibility of the main reason for not using condoms amongst young adults are due to a low threat perception of STIs and not due to other reasons. However, the findings of the study might indicate that using a condom could be perceived as a signal of distrust in partner.

During their last intercourse 15% of the respondents reported not using any form of contraceptive or protection (Helsedirektoratet, 2009). Hormonal prevention methods such as pills, rings etc. were amongst the most frequently used with 53%, followed by condoms (23%). The majority of the group that did not use condoms during their latest intercourse reported that the reason for this was 'not worried about getting infected with STIs' (55%). 42% reported their reasoning was 'it feels better without', whilst 16% 'did not have a condom at hand'. Only 10% reported that they 'were unprepared for the situation'. Amongst the few who did use a condom during their latest intercourse 64% did this 'to avoid pregnancy'. Only 23% of the small group that used a condom the last time they had sex, did this 'to avoid getting an STI' (Helsedirektoratet, 2009). The responses indicate that few young adults use condoms, and those who do mainly use them to avoid unwanted pregnancies. It was also very few who perceive STIs as a serious threat. The level of perceived severity and perceived susceptibility of contracting a STI seemed to be low amongst the respondents. Almost 8 out of 10 (79%) of the young respondents considered that there is no or low risk of them getting infected with chlamydia (Helsedirektoratet, 2009). Only 19% assessed the risk to be mediocre or greater, and none of the respondents considered the risk of contamination to be high. Regarding assessment of risk of contracting HIV, 96% perceived this as 'non-existent' or low (Helsedirektoratet, 2009).

The study done by directorate of health shows young Norwegian adults trusts their partners and do not fear catching STIs (Helsedirektoratet, 2009). The study done by directorate of health used a Web-survey with prewritten-reasons for not using condoms and did not let the

participants speak freely. Also, many of the participants were in a steady relationship, which could influence their perception of susceptibility. The study did not specify the meaning of “trust”. Therefore, further research is needed to obtain insight into young people’s thoughts and reasoning’s surrounding condom use. From the survey it seems that there is a low threat-appraisal of STIs among young adults, and that there main reason for using condoms is to avoid pregnancy (Helsedirektoratet, 2009).

2.2.2 Internationally

Also in Australia and in the United Kingdom, adolescents seem more concerned with avoiding pregnancy then with STI prevention (Civid, 2000; Donald, Lucke, Dunne, O’Toole & Raphael, 1994). Besides the study done by Norwegian directorate of health, very little attention has been given to factors and reasons for not fearing STIs in Norway. International research has found a relationship between a high threat-appraisal of STIs and condom use (Bryan et al., 1997; Ndabarora & Mchunu, 2014). Perceived susceptibility to STIs has been related to intentions and indirectly related through perceived benefits and attitudes about condom use (Bryan et al., 1997). A study from 2014 used the HBM as theoretical framework and found that adolescent youth with a high level of Perceived Severity and Susceptibility for contraction of HIV/Aids use condoms more often compared to those who do not (Ndabarora & Mchunu, 2014). A Swedish study from 2011, researched perceived risk and STI prevention behaviour (Leval et al., 2011). Their main focus was human papillomavirus (HPV). The participants were young adults (18-30) with 1712 men and 8855 women participating. They used a national population-based survey on HPV and sexual habits. In their analysis, they found that men's condom use was not associated with STI risk perception while women's was (Leval et al., 2011). Awareness of and disease severity perceptions were not associated with either condom use or risk perception though higher education level correlated with condom use. Sweden is quite similar to Norway when it comes to culture and

women's positions in society. These findings might possibly be transferable to Norway. If so, they indicate that risk perceptions of STIs do not affect men's condom use, but they do for women. Differences in gender have been shown to influence condom use and condom perception (Buysse & Van Oost, 2010). This will be further explored under the theme concerning *confidence and self-efficacy*.

2.3 Knowledge about risk

According to CDC, there are several reasons for young people being at greater risk of contracting STIs, compared to other age groups (CDC, 2016a). The bodies of young women are biologically more susceptible to STIs and young people tend to be very sexually active (CDC, 2016a). This could mean that some young people have multiple sex partners, which puts them more at risk (CDC, 2016b). Developing various social skills in connection to dealing with romantic and sexual relationship is important in relation to having the "tools" to handle situations that can lead to STIs (Bruess & Greenberg, 2004). Young people are less likely to have unprotected sex if they have acquired such skills (Schaalma et al., 2004). In Norway, sexual education has long been introduced to students from the 7.th to 10th grade, which is too late according to Tore Holte Follestad, assistant manager at the youth clinic Sex og Samfunn. In august last year, he shared his views in an interview with the newspaper 'Aftenposten'. He believes that sexual education should start as early as in kindergarten and follow the children through school, adapting language and content as they develop (Aftenposten, 2016). The Norwegian government has developed broad guidelines for the content of sexual education (Helsedirektoratet, 2017a). It is the local schools responsibility to go through with the sexual education. In 2015 the Norwegian government extended the sexual education content from the 4.th to the 10.th grade in a national sexual education campaign named "Uke Sex" (Helsedirektoratet, 2017a). On the official web page of the

Norwegian directorate of health it is stated that in cases where the sexual education in schools are lacking, the municipality can supplement the education by campaigns such as “Uke Sex” (Helsedirektoratet, 2017a). It is unclear however, who decides if the education the schools provide is sufficient and how this is measured. It is also unclear if there is a routine set in place to evaluate the quality of the education given. Due to the high numbers of chlamydia diagnoses, abortions and high numbers of rape in Oslo, Sex og Samfunn is now supplementing the schools sexual education with three hours per class (Aftenposten, 2016). “This education is often not a priority”, Tore says. In addition, teachers do not get the proper education themselves and are not properly trained to teach sexual education. “Could you imagine having a teacher in mathematics without having a relevant education on the subject?” he asks (Aftenposten, 2016). In addition to having these “extra” sexual educational lessons, there are several other measures that are aimed at young people to prevent STIs. There are several youth and health clinics in Oslo that provide free condoms, and free testing for STIs. Most of these are for young people but there is also Olafiaklinikken, which specifically aims at adults from 25 and older. Free condoms are also handed out at places that are considered to be “high risk” of contracting STIs, such as festivals, prisons, gay nightclubs, “russetreff”, etc. (Dinside.no, 2016).

In Norway, condoms are available for free through the webpage Helsenorge.no (Helsedirektoratet, 2017b). The providing of free condoms started by the directorate of health as early as in 1999, but it was not until 2010 the service became available online (Dinside.no, 2016). Today, anyone can order condoms through the Internet free of charge (Dinside.no, 2016). Condoms are delivered to any assigned address in a discreet package, within a week of ordering. Different sizes and types of condoms are available on the webpage (Helsedirektoratet, 2017b). The free condoms are primarily aimed at young people under the age of 25 and other “high risk” groups such as men who have sex with men

(MSM), sex workers and sex customers, prison inmates, asylum seekers and people with HIV and their partners (Helsedirektoratet, 2017b). However, the website is also for anyone who wishes to order free condoms (Dinside.no, 2016). When the service providing free condoms first started in 1999, 400.000 condoms were distributed. Last year more than 5 million condoms were distributed and 35% of these were ordered by ordinary people (not organizations) compared to 28% the year before (Dinside.no, 2016). But exactly who and what social demographic background the people ordering the condoms have is unclear.

2.4 The context in which sexual encounters take place

Just as a societies view on sexual and social norms is likely to influence people's behaviour when it comes to having sex, so will the context of the act itself. In a Danish study from 2013, researchers conducted focus groups with a total of 19 participants to explore young Danes experience with unsafe sex (Jørgensen et al., 2013). The participants ranged from 18-23 years. By using qualitative data analyses, the researchers identified four main reasons for not using condoms; being under the influence of alcohol, one-nightstands after a night out partying/vacation, low self-esteem and being very sexually experienced (Jørgensen et al., 2013). The Danish study identified the context in which the act takes place as a risk factor for having unprotected intercourse, such as being on vacation (Jørgensen et al., 2013). Internationally, there exists a lot of research concerning alcohol as a risk factor for having unprotected intercourse. Rehm et al. conducted a meta-analysis, which identified alcohol as an independent risk factor for intentions to engage in unprotected sex (Rehm, Shield, Joharchi & Shuper, 2012). There have been shown an association between intentions to use condoms and actual condom use (Sheeran, Abraham & Orbell, 1999). Davis et al. (2014) aimed to investigate how alcohol intoxication and condom use self-efficacy affects women's condom use intentions. They discovered that alcohol decreased women's intentions to use

condoms in the future (Davis et al., 2014).

2.5 Confidence and self-efficacy in relation to dealing with a partner or buying condoms

Self-efficacy is another factor that has been linked with STI risk (Lin et al., 2005). Self-efficacy refers to how confident one feels that one has the ability to go through with the health-protecting behaviour, for instance if one has the confidence in ones ability to correctly apply a condom or the ability and confidence to tell your partner that you want to use a condom (Wright, Randall & Grace Hayes, 2012). A study from 2005 found that participants who had lower self-efficacy for maintaining a monogamous relationship were likely to have more sexual partners (Lin et al., 2005). Having a high number of sexual partners is considered to be a risk factor of STIs (CDC, 2016a). They also found that participants who used condoms less consistently tended to have less self-efficacy for using a condom consistently, even if they perceived AIDS as a more severe disease compared to the other participants (Lin et al., 2005).

Developing various social skills in connection to dealing with romantic and sexual relationship is important in relation to having the “tools” to handle situations that can require condom use. Being prepared for situations and possible scenarios that require condom use before they occur can be useful in going through with condom use intentions (Schaalma, Abraham, Gillmore & Kok, 2004). A meta-analysis from 1999 identified ‘attitudes toward condoms’, ‘behavioural intentions’ and ‘communication about condoms’ as the most important predictors of condom use (Sheeran et al., 1999). Visualizing the scenario and deciding prior to the sexual encounter what outcome is desirable and how this outcome is attainable can be a useful way to feel more in control when the situation takes place. By deciding how one wants to act, what is considered unacceptable and what is a deal-breaker

etc., can give a sense of being prepared for the situation. Young people are less likely to have unprotected sex if they have acquired such skills (Schaalma et al., 2004). Kordoutis et al. wished to examine whether sexual relationship characteristics were associated with condom use (Kordoutis, Loumakeou & Sarafidou, 2010). The respondents were 458 Greek, sexually active, young adults between the ages 18-25 (Kordoutis et al., 2010). From a questionnaire on sexual and condom practices in their relationships of the past 12 months, the researchers found that when condoms had not been used, they had not been negotiated in 80% of the cases (Kordoutis et al., 2010). Bryan et al. (1997) found that having control over the sexual encounter was related to condom use self-efficacy, which predicted condom use intentions. Intentions predicted reported condom use (Bryan et al., 1997). The education that is given on sex and relationship in Norway does not focus on the social aspects surrounding sex. Being able to express to a sexual partner that one wants to use a condom can for some be difficult. It can prove a challenging task, especially in relations with an unknown partner (Fridlund, Stenqvist & Nordvik, 2014).

In an American study from 2012, researchers used the Health Belief Model to understand why certain female college-students are better at insisting on condom use, while others are less consistent (Wright, et al., 2012). The study found that women who insist on using condoms have a higher perception of level of susceptibility of STIs, higher levels of self-efficacy and confidence in their ability to let their partner know, and are more convinced that condoms are affective as protection against STIs (Wright et al., 2012). The study also found that these women felt that people in their social circle share their views on condom use and that the use of condoms can be beneficial in a relationship (Wright et al., 2012).

Gender differences can also influence sexual practices (Buysse & Van Oost, 2010). Buysse & Van Oost (2010) conducted 448 structured interviews with young adults in order to explore how traditional gender role socialization influences safer sex practices. They found

that it was more challenging for females to practice safe sex. Where the males could implement condom use in a sexual encounter without negotiation, the females had to start negotiating safer sex prior to the sexual encounter in order to be as successful as males (Buysse & Van Oost, 2010). It seems that women experience a higher degree of sexual pressure in regards to condom use, compared to men. A study from the US studied the moderating effect of sexual pressure on young urban women's condom use (Gakumo, Moneyham, Enah & Childs, 2012). The authors found that positive attitudes toward condom use and condom negotiation skills were predictors of condom use. However, they also found that sexual pressure had the effect of decreasing the likelihood of condom use. The study indicates that even if a woman displays sexually protective behaviours, these can be challenged by sexual pressure (Gakumo et al., 2012).

Self-efficacy is also important in regards to having the confidence in ones ability to correctly apply a condom or buy condoms. In 2008, the Norwegian directorate of health conducted an evaluation of their service that provides young people with free condoms. By combining web surveys, focus group and individual interviews; they sought to evaluate how the target group viewed the service providing free condoms (Helsedirektoratet, 2008). Based on the findings of this evaluation, the age group (20-25) seem to have good knowledge of how to access free condoms (Helsedirektoratet, 2008). This age group was less concerned with anonymity when obtaining condoms compared to younger age groups and felt comfortable with this task (Helsedirektoratet, 2008). From this it seems that getting a hold of condoms is not a barrier for young adults, and that they have a high degree of self-efficacy in this regard. The evaluation did not examine the respondents self-efficacy regarding condom use. However, it did find that few of the respondents had practiced putting on a condom (Helsedirektoratet, 2008).

2.6 Relationship length and trust

The literature review has explored how several factors can influence the probability of condom use. The last factor this chapter will explore is how relationship length and trust can influence decisions surrounding condom use. There can be a discrepancy between practice and behavioural expectations regarding condom use (Fridlund et al., 2014). Fridlund et al. (2014) concluded that participants had greater expectations of condom use that actually occurred, especially in relation with casual unknown partners. A longitudinal study conducted in the US, followed young men between the ages 17-22 (Ku et al., 1994). The authors wanted to explore the dynamics of young men's condom use during and across relationships. They found that men who thought their partners were inexperienced would be less likely to use condoms. Condom use declined during a relationship, even though the pregnancy protection level stayed the same (Ku et al., 1994). For people who are in steady monogamous relationships, unprotected intercourse is often the norm. Condom use has been shown to decline with the length of a relationship (Civic, 1999; Fridlund et al., 2014; Ku et al., 1994). Being in a steady relationship does not equal being safe against STIs. In a study with 2807 Norwegian participants, 52% reported experience with extra dyadic relationships during the course of their life (Træen, Holmen & Stigum, 2007). Of the participants between the ages 18-49 ages 42% of the men from Oslo reported having at least one extra dyadic sexual relationship while 34% of the women reported the same (Træen et al., 2007). Around 50 % of the participants reported not using any form of contraception with the extra dyadic partner. Having unprotected intercourse with partners outside the relationship can increase the potential risk of contracting STIs, and also increases the risk of infecting the long-time partner (Træen et al., 2007). The Norwegian health department's strategy "Talk about it!" reports that women more often contract HIV by a steady partner, while men more often contract HIV through a casual partner (Helse- og omsorgsdepartementet, 2017, p. 37).

Civic from the United Kingdom has written numeral studies on the subject of relationships and protection against STIs (Civic, 1999; 2000). Civic studied the association between characteristics of dating relationships and condom use by using data from 210 undergraduates, between the ages 18-25 (Civic, 1999). The study found that relationship length predicted condom use. Condom use declined with the length of the relationships (Civic, 1999). The study concluded that STI interventions should include components that address relationship characteristics (Civic, 1999). A year later, the same author conducted a study with the purpose of exploring college students reasons for non-use of condoms within dating relationships (Civic, 2000). She found that subjective assessments of partner safety and the belief that sufficient measures were being taken to avoid pregnancy were main reasons for not using condoms (Civic, 2000). This reflects the findings in Norway, identifying "avoiding pregnancy" as young adults number one priority and trusting their partner. Age-differences greater than two years between partners in relationships have been found to differentiate consistent from inconsistent condom use (Kordoutis et al., 2010).

This chapter has explored multiple factors that can influence decision-making around condom use. Several of the factors were identified using the HBM, such as perceived severity, susceptibility, barriers and self-efficacy. The next chapter will explain more about the theory and the HBM. There is limited existing qualitative research on condom use in Norway. Exploring how the aspects of the HBM are implicated in young people's experiences and decision-making processes and what aspects about the context of the sexual encounters are important in explaining the way those factors operate are the secondary aims of the thesis.

3. Theoretical considerations

3.1 The Health Belief Model

Based on previous research and a literature review, the Health Belief Model will be used as a theoretical framework, with emphasis on threat-appraisal and self-efficacy. The Health Belief Model date back to 1958 and was developed by researchers Hochbaum, Rosenstock and Kegels (Abraham, Conner, Jones & O'Conner, 2008, p. 140). The backdrop for the models development was to understand why so few people attended health-promotion programmes like vaccinations. What drives some to vaccinate while others choose not to? The model is relevant in exploring the same question in regards to condom use. The model focuses on the individual perceptions and is based on the construct that people will perform a cost-benefit analysis weighing perceived benefits of the health protective method and perceived barriers of the method (Abraham et al., 2008). According to the model, individuals are more likely to go through with a health protective behaviour if they believe they are susceptible to a disease or condition (Abraham et al., 2008). Perceived severity of the consequences of the disease combined with the individuals' perceived susceptibility is the bases of their threat perceptions. The model explains that these perceptions will be influenced by both internal and external cues to action, together with other modifying and enabling factors (Abraham et al., 2008). These are factors such as demographic, psychological, personality, social and structural. All these factors are believed to influence the people's decision-making and behaviour.

3.1.1 Threat perceptions

The threat-appraisal or threat-perception, of the model mainly consists of two parts: Perceived Severity and Perceived Susceptibility (Abraham et al., 2008). Perceived severity involves how seriously one views the outcome of not going through with health-protecting

measures, for instance, how seriously one views chlamydia as a dangerous infection that can lead to infertility. Perceived susceptibility is how likely a person thinks it is that a disease might affect them, for instance how likely they think it is that they will contract chlamydia. Together, these factors will influence one's threat-appraisal, and in theory be an indicator of how likely one is to go through with a health protective measure, such as condom use. A study from 2014 found that adolescent youth with a high level of Perceived Severity and Susceptibility for contraction of HIV/Aids, use condoms more often compared to those who do not (Ndabarora & Mchunu, 2014).

3.1.2 Benefits and Barriers

The other part of the model consists of response effectiveness (Abraham et al., 2008). It consists of weighing the benefits with the barriers and whether one believes that the health protective-measure is necessary and effective. Perceived benefits (such as avoiding risk of contamination, avoiding a mess, not having to go through devious testing for STIs) and different barriers (such as embarrassment, can reduce pleasure, costs, difficult to get a hand of condoms etc.) will give a total effectiveness assessment when weighed against each other. Believing the health protective behaviour is effective against the disease is also a part of this, for instance, the belief that condoms are an effective barrier method against STIs (Abraham et al., 2008). Socioeconomic status and other factors such as sex, age, sexual orientation, education, ethnicity, other psychological factors and demographic differences can influence how one perceives threat and response effectiveness (Abraham et al., 2008, p. 140). This project will not explore nor will it take into consideration all of these factors due to resource and time limitations. The target-group for the project is young Norwegian adults, age 20-24, who live in Oslo.

3.1.3 Cues to Action

Cues to Action are strategies to activate “readiness” or how ready one feels in order to go through with the health protective behaviour. This can be implemented by awareness campaigns that provide the recipients with a reminder of the health protective behaviour. This is relevant when considering external motivation. Motivation here means; factors that can contribute to going through with the health-protecting behaviour. Media-coverage and messages are also in the motivational category. Observing condom use in movies or pornography can be considered cues to action. Internal motivation can arise in the form of itching in the pelvic area, earlier experiences with STIs and can also lead to an increased motivation to implement health-protecting behaviour, like condom use.

3.1.4 Self-efficacy

‘Self-efficacy’ is a term that was later added to the Health Belief Model (Abraham et al., 2008). Self-efficacy refers to how confident one feels that one has the ability to go through with the health-protecting behaviour, for instance if one has the confidence in ones ability to correctly apply a condom or the ability and confidence to tell your partner that you want to use a condom (Wright et al., 2012). In an American study from 2012, researchers used the Health Belief Model to understand why certain female college-students are better at insisting on condom use, while others are less consistent (Wright, Randall & Hayes, 2012). The study found that women who insist on using condoms have higher levels of self-efficacy and confidence in their ability to let their partner know (Wright et al., 2012). The study also found that these women felt that people in their social circle share their views on condom use and that the use of condoms can be beneficial in a relationship (Wright et al., 2012).

3.1.5 Use of the model

The Health Belief Model is a well-known and popular model, yet it has been criticized for oversimplifying complex situations (Montanaro & Bryan, 2014). It is difficult to find a “one size fits all” solution, especially regarding sex. A person might have a high sense of susceptibility and severity of STIs, yet still have unprotected sex due to apathy or not caring. Some might be going through a rough time in their life while others might enjoy the risk. As identified in the literature review there are several factors such as alcohol and an early sexual debut that can increase the risk of having unprotected sex (Davis & Lay-Yee, 1999; Staras, Livingston, Maldonado-Molina & Komro, 2013). The model does not account for how these different factors interact and influence one another. Despite these limitations, the model does identify several key issues that are relevant in relation to young people and condom use. The model focuses on individual perceptions and is relevant as framework for qualitative research. As the model is based on the construct that people will perform a cost-benefit analysis weighing perceived benefits of the health protective method and perceived barriers of the method, it is relevant to explore how young people experience and define these benefits and barriers. This dissertation will explore the contextual issues affecting young peoples’ ability to act of the beliefs identified by the HBM. The model was used in the development of the interview guide, literature review, and generated interesting and relevant data.

4. Methodology

The following chapter will further describe the methodological choices made in this dissertation and decisions made in regards to these. Firstly, the research design will be accounted for, then the dissertations sample and data collection method will be described and discussed. This will also contain a short description of how the data was analysed. Lastly, the quality of the data and ethical issues as well as strengths and weaknesses of the research design and methods will be discussed.

4.1 Qualitative research design

The research questions and the theoretical framework have lead to the choices made in developing the research design. The method of collecting the data was qualitative as it emphasizes on exploring subjective thoughts of young adults in-depth (Bryan, 2015, p. 398). Sex is not simple to isolate as an event that happens in a vacuum, it is rather interpersonal and multifaceted. It is differently viewed and defined by people and thus will the evaluation and assessment of condom use be assessed differently (Civic, 2000; Hiltabiddle, 1996). There is no one reason for having sex or for using or not using condoms (Hiltabiddle, 1996). The aim of the dissertation is to obtain some insight to young adults thought-processes. The aim is to understand their decision-making process regarding condom use, rather than attempting to isolate a single risk factor or reason for condom use. In this regards there is not a single truth but multiple truths (Krefting, 1991, p. 215). Therefore the most suitable way to explore the research questions is by exploring and talking to the target group (Krefting, 1991, p. 216). In this case, young adults in the age group 20-24, who live in Oslo and are willing and comfortable with sharing their thoughts and experiences with condom use. The research question is as follows: What thoughts and experiences do young adults have in regards to condom use?

The findings of this study provide some interesting insight in the participants' thoughts and experiences with condom use. The study is deductive as it uses existing literature to develop research questions. The overall study is a qualitative study with individual in-depth semi-structured interviews. The main purpose of using qualitative methods as an instrument of collecting the data is to collect data that could not be collected through a simple questionnaire (Krefting, 1991). Using existing literature to identify gaps and topics of interest, open-ended questions for the semi-structured interviews were developed. Semi-structured interviews are well suited for studies with a clear focus, and where it is desirable to have a certain comparability of the developed information (Bryman, 2015). This was deemed an appropriate method for the objectives of this dissertation. In this interview-method, the researcher develops an interview guide before the interviews take place, consisting of several predetermined questions, probes and follow-up questions (Leech, Baumgartner, Berry, Hojnacki & Kimbal, 2013). The questions are relatively open-ended, which provides the participants with considerable freedom to answer based on their own perception of reality, formulated independently in their own words (Leech et al., 2013).

The semi-structured interview guide was also used to maintain the main topic and theme yet leave space to manoeuvre topics that might emerge along the way (Kvale & Brinkmann, 2009). This flexibility also allowed more of a natural "flow" in the interviews, by having the possibility of "shuffling" the order in which the questions were asked. According to Leech et al. (2013) there is a trade-off between the loss of reliability across interviews and the loss of validity in the current interview. If an interviewer asks all the same questions in the exact same manner and order, it increases the reliability, as all the participants would have had the same experience. By doing this however, the interviewer ignores previous answers given by the participants, and the quality of the answers is likely to diminish. The author had this in mind during interviews and made an effort to balance these out. It is worth mentioning that

during some of the interviews, several questions were left out, whilst others included the lot. The probes that were used also varied depending on the participants answer.

4.2 Sample and setting of the study

Purposive sampling was used with the following criteria for selecting individuals, formed by the research question: Young adults between the ages 20-24, based in Oslo, who were comfortable with sharing their thoughts and experiences about condom use and STIs. The criteria for the sample were developed by other research identifying this group as at higher risk for STI infections (ECDC, 2016; Folkehelseinstituttet, 2015a). The sample is therefore somewhat theoretically informed and relevant to the research question (Mays & Pope, 1995, p. 110). In order to reach the target group recruitment posters were put up in places where young adults could be expected to be. The participants were recruited through a health clinic Sex og Samfunn, through the University of Oslo, Bjørknes High school, through a public library and through “snowball-sampling” (Bryman, 2015, p. 419). Asking participants who had already been interviewed by e-mail, if they could forward information about the project to friends who might be interested resulted in snowball sampling. Two participants were recruited this way. The health clinic is a place where young people up to the age of 25 can get tested for STIs free of charge, acquire free condoms and ask questions about sex and sexuality (Sex og Samfunn, n.d). Recruitment-posters were put up in the places listed above, containing information about what participation entailed and contact information. The researcher also visited the clinic at one point and recruited participants directly by handing out recruitment posters and asking if anyone would be interested to take part of the study. The people, who were interested in participating, contacted the author by e-mail and were then sent additional information about participation by e-mail. Date, time and place for the interviews were arranged with the participants.

4.3 Data collection

Data was collected through in-depth-interviewing the participants, n=7 in total. Before the interviews, participants were asked to sign a consent-form. They were also informed orally regarding what would transpire and how the data would be stored. The interviews were audio-recorded. The interviews lasted between 25 to 60 minutes. After the interviews, the participants were asked to fill out a form containing questions relating to their background, including, relationship-status, level of education, age, sexual orientation and ethnicity (As depicted in Appendix 6). This was done to be aware of factors that might influence their thoughts and experiences. As was discussed in the literature review, age and sexual orientation can influence how one perceives severity of risk. Different cultures can view sex and STIs differently and therefore the question about ethnicity was included. This was also to have a description of the sample. The participants' were also given the contact-information to assistant manager at the clinic by e-mail, in case they felt the need to talk to someone about the experience of being part of an interview. A gift-card to a cafe-chain of a 100KR was awarded to all the participants' as a token of appreciation for participating. The participants were not aware of the gift-card until the end of the interviews. This is a tangible way to recognize the value of the participants' contributions and time (Steel & Simons, 2010, p. 1). This was also done to encourage further participation and involvement from the public in public health research. The gift card was given with a handwritten note that stated "Thank you for participating!" and included the relevant amount and cafe (Steel & Simons, 2010, p. 3). The amount of a 100 KR was deemed appropriate considering the time commitment and travel time (Steel & Simons, 2010, p. 8). Participants' were also sent a recruitment poster and asked to tell their friends who might be interested in participating about participation.

4.4 The interviews

The interview guide was developed and written in Norwegian (as shown in Appendix 4). The interviews were also conducted in Norwegian, and later translated into English. The interview guide had three main themes; *Education on sex and relationships*: This was to introduce and ease the participants into the topic and to make them comfortable. It was also part of exploring what the participants' thoughts of the education that is given on the topic in school. The second main theme concerned *Condom use in relation to a sexual partner*. This part contained more personal questions, amongst others, on how the participants viewed social signals when condoms were introduced, what they take "trust" to mean in relation to a partner, and experiences with condoms, experiences with relaying to a partner a wish to use a condom, and challenges they might have encountered. The last theme concerned *condom use and STIs in general*, and they were asked about what they thought about STIs. This part was inspired by the HBM, from the aspect of threat-appraisal. How severely people view STIs could impact if they consider condom use (Abraham et al., 2008). They were also asked to explain and elaborate on their answers, and give reasons as to why they might feel this way. The volunteers were also asked about if they thought their friends share their views on STIs. Research has found indication that women who are adamant on using condoms believe their peers' share their views on condom use (Wright et al., 2012). All the participants appeared comfortable and eager to share their personal thoughts and experiences. Some participants elaborated and revealed more than others, however all contributed with interesting and personal content. Probing questions were used during the interviews to gather as accurate and fulfilling information as possible. These probes were questions such as "could you elaborate on that?" and "What makes you say that?". In order to increase the validity of the findings, the researcher would summarize the responses during the interviews beginning with "If I have understood you correctly...". Participants were also in some cases

asked hypothetical cases and questions in order to help elicit ore personal responses (Krefting, 1991, p. 218). Participants were given time to add anything they would like to say before being asked the next question. A period of approximately 10 seconds were given the participants between each question in order to give them time to reflect and elaborate on the question and answer given. Probes such as “Is there anything else you would like to add to your answer?” were sometimes asked before moving on to another topic.

4.5 Data analysis

The data were analysed by using a thematic analysis as proposed by Braune & Clarke (2006). Their proposals for analysis of qualitative data consists of six phases, see Table 1.

4.5.1 Table 1. Phases of thematic analysis

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 1. Using thematic analysis in psychology, Braun & Clarke (2006, p. 87).

After the data was collected and recorded, the raw data was transcribed verbatim in Norwegian. This was the first step of familiarizing with the data (Bird, 2005). The transcription from sound to text was done immediately after each interview so that the interviews were fresh in the researchers mind. This proved useful, as during one interview the battery of the recorder discharged. This meant that only half of the interview was recorded. Having the interview fresh in mind, it was quite easy to recall exactly what the participant had said. To ensure that this recollection was accurate, a summary was sent to the participant for them to confirm the statements. The statements were confirmed accurate. After transcription, the data was thoroughly re-read numerous times in order for the researcher to familiarize with the data and obtain the general meaning in the participants statements. The raw data was later “cleaned up”, by excluding irrelevant content or pauses and sounds such as “Ehm...”. The place where this kind of editing was done was marked in the text as (...). If a participant abruptly stopped mid-sentence this sign was used-. In places where there was laughter or coughing or any other sounds or gestures were marked with a* followed by a description of the sound.

Notes were written down with initial impressions and recurring themes. The data was printed on paper and a marker was used to highlight reoccurring themes. Differing opinions were also highlighted. After familiarization, the data was analysed into initial codes. Braun & Clarke (2006) define the purpose of initiating codes as to identify a feature of the data, though not as broadly as a theme, that appears interesting to the analyst and that can be assessed in a meaningful way (p. 88). The interview-guide was used as a tool in order to group together similar statements and replies to questions, which resulted in the codes used in developing the themes. All answers concerning a certain topic, for e.g. ‘trust’ were put together in one word-document, and all answers concerning ‘condom use with a one-night

stand' in another. The selection on themes and statements were chosen by relevance in regards to the research questions. Braun & Clarke (2006), define a theme as something that "captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set". According to Braun & Clarke it is challenging to define what number of times a theme has to occur in a data set before it is identified as a theme (Braun & Clarke, 2006, p. 82). In qualitative analysis there is no set-in-stone answer in regards to the prevalence in relation to developing themes (Braun & Clarke, 2006, p. 82). Therefor the main focus in developing the themes was in relevance to the research questions. This resulted in themes such as Faded memory of STI education, trust based on honesty in sexual encounter, alcohol and one night stands, etc. The themes were developed in manners that describe the participants' thoughts and experiences. In some cases, the theoretical framework presented in chapter 3 inspired the themes. This resulted in themes reflecting the participants' thoughts within the theoretical framework. An example of this is the theme "No big deal? Thoughts on the severity of STIs and perception of risk". Finally, the participants' statements were extracted to illustrate and support the findings. The illustrative statements were translated to English, without altering the original content.

4.6 Choice of method and the methods strengths and weaknesses

As qualitative and quantitative research differs in many aspects, different methods must be used in order to ensure trustworthiness (Krefting, 1991). *Truth-value* examines to which extent the truth of the findings are based on the informants, research design and context. In qualitative research this truth stems from the discovery of human experiences described by informants (Krefting, 1991, p. 215). Lincoln & Guba (1985) named this *credibility*. It is

important that the right informants are chosen to explore the topic that is of interest (Krefting, 1991, p. 216). As the thoughts and experiences of young adults in regards to condom use was the interest of this dissertation, the sample was carefully selected to include people of the relevant age group, with willingness to talk about the topic.

The data was analysed by using Braune & Clarkes' qualitative thematic analysis (2006). This is a challenging way of analysing the data, as the analytic process will inevitably involve some subjective choices and interpretations (Bryman, 2015, p. 398). In order to achieve neutrality, possible biases were attempted discovered (Guba, 1981). *Neutrality* refers to which extent the findings are represented from the informants and not from other biases and motivations (Guba, 1981). By writing in a reflexive journal throughout the process, biases were attempted discovered (Lincoln & Guba, 1985). The journal included thoughts, feelings and impressions generated by contact with the informants (Lincoln & Guba, 1985). By reflecting on the biases emerging from the journal, the researcher had the ability to alter any bias in the data collection process (Lincoln & Guba, 1985). One example of this is when during one interview, the researcher was taken-aback by one statement made by the informant and reacted with a facial expression. The informant was describing their partners' behaviour that the researcher found shocking. The researcher was careful to remain as neutral as possible during the remaining interviews, by not expressing personal views in any noticeable way.

The process of choosing what literature to include was also affected by subjective views and choices of the author. To limit this as much as possible, these choices were documented by writing down exclusion and inclusion criteria. These criteria are specified in chapter 2. Search words used to find the research and which databases were used, were noted in a word-document.

Applicability is to which extent the findings can be applied to other contexts and settings (Krefting, 1991, p. 216). In general, qualitative research is difficult to replicate, and there are often problems of generalization and lack of transparency (Bryman, 2015, p. 398). It is not a question of generability as qualitative methods generates subjective data, but rather of attaining some transferability (Guba, 1981). This of course, needs a thorough and very detailed description of the steps taken during the entire process (Mays & Pope, 1995, p. 110). There is no single truth that can be discovered, but multiple truths (Lincoln & Guba, 1985). Qualitative findings seldom are generalizable, as the aim is to get some in-sight to individuals' thoughts and opinions (Bryman, 2015, p. 384). Where quantitative methods deals with hard "facts", numbers, and assumes there is a single reality, qualitative research is much more subjective (Lincoln & Guba, 1985). *Reliability* is to which extent the research process will produce the same findings if repeated by other researchers, with different informants (Krefting, 1991). If one assumes there are multiple truths and realities, the issue of reliability is no longer relevant (Lincoln & Guba, 1985). Both the researcher and interviewee are such large parts of the research-process and findings in qualitative research, that it would be impossible to exactly replicate the study without them (Krefting, 1991, p. 216).

Recruitment-bias is also a factor to consider. The sample was not randomly selected and the informants volunteered themselves. Often times, self-selection will cause the sample to be "influenced" and not represent the general population. The recruitment posters used in this study were put up in a health clinic, a university and libraries. The sample will therefore reflect the people who reside at such institutions. Nearly all of the participants were recruited through the health clinic, this can indicate that the sample consists of people who are aware of public health services and who actively use them.

To ensure credibility, it is important to be with the informants long enough to discover the situational characteristics and elements most relevant to the issue (Krefting, 1991, p. 218). Ideally, the data collection would continue to the point of saturation, meaning similar points being repeated, and no new data added (Leininger, 1985). This proved difficult with the time-restriction, constricting how many participants were interviewed. To ensure credibility in the findings, member checks were done during the interviews (Lincoln & Guba, 1985; Mays & Pope, 1995, p. 111). This was done by repeating back what the informants said and asking them if this was correct/if I had understood them right (Mays & Pope, 1995, p. 111). Member checking decreases the chances of misrepresentation and is important in order to ensure that the final representation of the data reflects the participants' thoughts and experiences accurately (Lincoln & Guba, 1985). Triangulation of sources was also used to confirm that the findings were not due to chance or circumstance (Mays & Pope, 1995, p. 110). This was done by interviewing the assistant manager of the health clinic "Sex og Samfunn" on his take on how he encounters young adults experiences with the clinic and with STI testing. Triangulation of sources minimizes chances for researches bias, and enhances the range of data that contributes to a further understanding of the topic (Krefting, 1991, p. 219). To enrich the data, using observation methods were planned by arranging a fellow-student to sit in during the interviews to observe the body language and tone of the participants. However this was not done during the data-collection due to limited time and resources. The different times did not suit the fellow-student and so the researcher made some notes about body language during the interviews. Besides this limitation, the interview method was successful in collecting information about thoughts and experiences young adults have concerning condom use. Peer debriefing done by exposing the methods and findings to fellow master students was done to ensure higher credibility (Mays & Pope, 1995, p. 110). This was done by meeting two fellow students of masters in public health and

exchanging opinions with them. According to Lincoln & Guba (1985), discussing the research process and findings with impartial colleagues can increase the credibility of the data and contribute to a deeper analysis. In order to maintain the participants confidentiality, no raw data or identifiable information was shared with the public health students.

4.7 Ethical considerations

4.7.1 Sensitive issue

Thoughts and experiences with condom use might for some be considered an intimate and sensitive subject. Therefore, being comfortable with sharing thoughts surrounding the subject was stressed as an inclusion criterion. This point was clearly specified in the information and recruitment-process. Before the recruitment-process begun, approval was awaited from Hedmark University College and Norwegian Social Science Data Service (NSD). The study has been approved by NSD. The participants gave both oral and written consent before the data-collection commenced. Before the participants signed the consent-forms they were informed about what participation entailed and about their right to at any given time pass on questions, or quit, without any hard feelings. They were also assured about their anonymity. None of the participants chose to pass on any questions or to stop mid-way. One individual scheduled an interview but had to cancel due to work. They did not have the opportunity to reschedule.

During interviews, participants may say things they otherwise would not in other situations. As sex, condom use, and STIs are by many people considered sensitive topics, there might be a risk of participants leaving the interview with a feeling that they had “over shared”, in other words: a feeling of disclosing more information than they intended. Even though participation is anonymous they might leave with a feeling of second-guessing their

statements. This could include comments about friends, partners, family, sexual encounters, etc. To avoid any concern, before the interviews started the participants were orally informed how if they at any point felt uncomfortable, in general, or with certain questions, that they could pass or choose to end the interview without any hard feelings from the interviewer. They were also assured that they would not be recognizable in the paper, and that only the author would have access to data and personal information. Before the audio recorder was switched on, the participants were asked if they had any questions before the interview begun. After the interview the participants were also asked if there was anything they wished to add or change, so that in case they did feel they had “over shared”, they would not leave the interview feeling uneasy. None of the participants chose to change or retract any of their statements.

4.7.2 Authority

As the participants were young people, it was likely that the interview might be their first experience being part of a research study. They might therefore view the author as an authoritative figure and feel pressure to follow instructions, such as filling out the background information-form (De Nasjonale Forskningsetiske Komiteene, 2015). To avoid this, several measures were taken. Firstly, the interviewer dressed as neutral as possible, avoiding flashy clothing, too formal clothing or heavy make-up. Secondly, the interview set-up was always such, that the interviewer was facing the interviewee in equal chairs, slightly skewed from one another. This was done so that it was not too intense, with the chairs not facing straight on. The aim with the equal chairs was to defuse the idea of authority (De Nasjonale Forskningsetiske Komiteene, 2015). The participants also had influence of where and when the interviews would take place. As topics surrounding sex and condom use are considered a sensitive subject, the interviews took place in a secluded, quiet room. One participant

preferred having the interview at the privacy of her own apartment, where she was more comfortable and convenient.

4.7.3 Storage of data

The data comprised of audio recordings of the interviews, background information and consent-forms on paper, and a transcribed version of the interviews stored on a computer.

The data was stored in a lockable room, available only to the author. The computer was protected with a password, known only by the author. Identifiable information such as names also existed on the authors e-mail inbox, which was also protected by a different password.

5. Findings

The purpose of this dissertation was to explore young adults thoughts and experiences concerning condom use.

This chapter begins with a short description of the sample. The findings are then presented in the following five main themes; the themes are all issues that can influence decisions regarding condom use.

Faded memory of STI education

Trust based on honesty in sexual encounters

Responsible and 'killing the mood' -Social signals in relations to condom use

Alcohol and one-night stands- contexts of condom use

No big deal? Thoughts on the severity of STIs and perception of risk

The themes are described with the references that underpin them alongside illustrative extracts from the empirical data.

The sample consisted of 2 male and 5 female participants', in addition; assistant manager of the health clinic Sex & Samfunn was interviewed. Four of the participants were 24 years old, two were 23 and one was 22 years old. Five of the participants considered themselves "single", one "in a monogamous relationship", and one in an "open relationship". Six of the participants defined themselves as "heterosexual" whilst one as "bisexual". Four of the participants defined themselves as "Norwegian", two participants checked the box "other nationality" and one "mix".

5.1 Faded memory of STI education

The first part of the interview guide sought to explore the participants' thoughts on the education that is given on condom use in the subject "sex and relationships". The first question in the interview guide seeks to ease the participants into the topic of condom use and investigate how they view the education given on the subject. By exploring their own thoughts on the quality of the education given, it could reflect on how much they feel they learned about condom use and STIs during school. The question could also uncover common misconceptions participants might have concerning condom use and STIs. The participants were vague in their descriptions of sexual education they had received. Almost all the participants had trouble remembering the content of the education and report the Internet as their main source of information about STIs. Nearly all the participants thought the education was lacking, and expressed a desire of more education, and more about the social practice around sex. A word that was used by several of the participants to describe the sex education was "awkward". The participants themselves seemed relaxed and comfortable whilst discussing various intimate topics during the interview. The following excerpts are examples of how the participants described if they remembered having sexual education in school:

"Eeehm...Eh, I actually don't think we had it. Eeehm, we learned like how you could make babies in elementary school, that's all I remember." (F, 2).

"If I remember? Having it? Yes, I suppose I had it in, well, 7th grade, 6th, 7th, I think? Ehm, and I suppose it was fairly awkward, as usual. Eeh, yeah, I don't know, do you have it high school as well? Or secondary school? That's the one I remember the best. I don't remember any details about it. Mhm." (F, 4).

It is difficult to evaluate something you have little memory of. However, nearly all of the participants thought that the education should include more information about specific STIs and how to prevent them. This was due to the fact that several participants did not feel they

had sufficient knowledge about the range of STIs. The participants also expressed a wish for more education around the social practices surrounding sex. Below is an example of what participant 2 replied when asked what they thought of the content of the sexual education:

“Well, you learn, well, society is so characterized by it, so you learn that way. But when it comes to STIs, for instance, I think it’s way too little information about it, and too little about the consequences of it. Eeh, and you’ll find it if you want. But yeah...So I don’t know, like you shouldn’t use scare-tactics, but just explain to students how serious they actually can be (...).” (F, 2)

As far as misconceptions concerning STIs, none of significance was noted during the interviews. One participant mentioned getting herpes from a toilet-seat, however more in a joking manner. Put in context, it was clear that the participant knew this was not a possibility. Most of the participants seem to have good knowledge about the most common STIs. This came through during several of the interviews, where participants listed STIs or treatment-methods. Statements in support of these findings are presented under the theme *No big deal? Thoughts on the severity of STIs and perception of risk*

5.2 Trust based on honesty in sexual encounters

As described in further detail in the literature review, a study done by the Norwegian directorate of health found that young Norwegian adults report, “having trust in their partner” as the main reason for not using condoms (Helsedirektoratet, 2009). The study did not specify the meaning of “trust” and was a Web-survey with prewritten-reasons for not using condoms. This theme explores the topic of trust in relation to a decision-making around condom use with a partner, allowing the participants to define the meaning of trust in their own words, and exploring their thoughts on the topic.

The participants distinguished the meaning of “trust” when used with a casual partner compared to a long-term partner. Most of the participants did not think that one could establish a real sense of trust with a “one-night stand”. In a long-term partner “trust” was considered very important. “Trust” implied that they could trust that their partner would disclose information about any possible STIs, so that they could feel safe when having unprotected sex. The male participants thought that their partner should disclose if they were not on hormonal prevention. Many of the participants came back to the theme of trust in later parts of the interview. A few of the participants described sex, as being in a vulnerable position, therefore trust was important in order to feel comfortable and safe. Being in a relationship and being single were separated. Being single meant for many, that they needed to be more aware of STIs and condom use. The participants seemed to associate “being in a steady relationship” with hormonal prevention methods. When asked if they would consider using protection in a different manner with a long-time partner compared to a one-night stand several participants answered “yes”. Below is an example that illustrates this:

“It depends right, if it’s a “one night” relation then trust is, well, eh, then you make that choice before hand, I think. Or at least for me, trust is not a big part of it then, but you have to take certain precautions, if you’re thinking about STIs. But when it comes to a relationship or someone you’ve been seeing more long-term, maybe even without being in a steady relationship, then I would say trust is very important. Mhm.” (F, 2).

When probed further about that:

“If you have a one-night stand or a short-term thing, then, it’s often very random and spontaneous. Eh, and so I feel you can’t build any trust, eh, and, I mean, I guess you can, but I think you’re pretty naive if you do, if you have trust in a person you’ve talked to for two hours, that you go home with. Eh, then, yeah, you

can't believe everything that's being said (...), but when it comes to a more long-term relationship or when it happens when you get to know each other better, then I think trust is very important.” (F, 2).

Not having trust in a one-night stand was thought to mean that one could not trust a one-night stand would disclose any potential infections. Nearly all the participants thought that “trust” was important to have in a sexual partner and a reoccurring factor was trusting that the partner would disclose any potential infections. An example that represents the statements made by the young adults is presented here by participant 3:

“I think that you have to trust each other, especially if you have sex without using a condom, then you have a type of “trust” in a way that you won't give each other any diseases (...) That you've gotten tested and stuff. The way I see it is that you usually use condoms, and if you go over to not using condoms, then you trust that the other person is telling the truth when they say “ I've gotten tested. I've got nothing.”” (F,3).

“Well, it's everything, really, you trust that the other person is honest and (...) gives you the information you need to know, it's like, it's fine if some things are private and none of you're business, but, since it's shared, I don't know, It's a shared thing, it's not just about one person, so then you have to trust each other, yeah. It's very important.” (M, 7)

The distinction in the meaning of trust with a casual partner compared with a long term, steady partner was made by several of the participants:

“I think that's the base to, unless it's a one-night stand, but if you're in a steady relationship, then I feel it's very important. I know of friends, of friends who haven't told their boyfriends of four years that they have herpes. That gives me anxiety (...)” (F,4).

By these statements it seems that trust was not something associated with one-night stands. The participants described, “trust” as important and implied that trust meant the partner would disclose potential STIs. The participants seemed to feel more at risk of STIs with a one-night stand, as they did not trust them to disclose potential STIs.

5.3 Responsible and ‘Killing the mood’ - Social signals in relation to condom use

5.3.1 When partner brings up the topic of condom use

According to the HBM, the way in which people view a health protective behaviour or method can influence whether or not they go through with it (Abraham et al., 2008). This theme explores the participants’ thoughts in regards to condom use. The majority of the participants viewed the partner expressing the wish to use a condom as a positive, yet somewhat rare event. Several of the participants used the word “responsible” to describe how they would view their partner if they expressed a wish to use a condom. A few participants thought that it might signal that their partner had a STI and had to use protection because of this. But even these participants had an overall positive view on the partner bringing up protection.

“I’m actually very happy if the guy in a way... requires that. Because, that just means that they’re responsible.” (F, 1).

(...) “I would be in heaven, if a guy initiated that, maybe because I feel it’s solely the woman who does it, or, at least from my experiences, but I might be mistaken, so yes. In a more casual relationship, I would not view it as anything distrustful, no. Just very reasonable, really.” (F, 4).

“Mmh....I guess, I don’t know, for me it seems like a smart thing to do, it seems responsible...but, I don’t know, it’s like whatever. It’s, it’s not like I’m like “good for

*you, dude, you brought up protection!” like, it’s like, yeah, it’s just what you do, it’s not... *chuckles” (M, 7).*

5.3.2 Thoughts about bringing up the topic of condom use

The word “awkward” was used by several of the participants when asked what they thought about bringing up the topic of protection with their partner. The same number of people however, did not find this problematic what so ever. Again, the distinction between a one-night stand and a steady partner was made. Several of the female participants’ thought it more difficult to bring up the topic of protection with a one-night stand. “Not knowing that person” and how that person might react, fear of “killing the mood”, and “not wanting to be perceived as a “nag”” were some of the reoccurring reasons that made bringing up protection with a one-night stand more challenging. Several of the participants’ thought that it was at times too threatening to the sexual encounter to raise the issue of condom use. They feared the partner would be turned off if condoms were brought up and end the encounter. Several participants had experienced ending up in a back-and-forth discussion when they brought up condom use. In contrast, the male participants did not view this as challenging what so ever.

“I think that it can be a bit awkward? (...) Even though, it shouldn’t be that awkward, but it just is. I think it’s a lot easier in a relationship (...). I think in like one-night stands it’s pretty awkward, even though it shouldn’t be, or like you’re an adult but you just think like “oh no, it’s such a hassle” or like, one has to like, interrupt the entire situation to find a condom and like, bring it up, and then he might say something like “no, let’s just screw it” and then you have to argue for it. (...). I think it’s very easy to just be like “yeahyeah, but of course you should do it”, but at the same time it often turns out a little awkward after all.” (F, 3)

“Næ, I don’t have any issues talking about it at all. Like, I do it! It’s like, no I don’t see any stigma attached to that, I don’t have a problem talking about anything. (.) I hope people let me know, if they, like, want me to use something, or whatever.” (M, 7).

A couple of the participants expressed that they used condoms consequently and bringing up protection was just something that had to be done. All the participants thought that either “both parties” or “oneself” should be responsible for bringing protection in the form of condoms and other contraceptives. All the female participants added a “but” to this topic, and in unison described how they felt like it often became the “woman’s” responsibility. The female participants had experiences with male partners being “lax” about condom use, and failing to bring up protection both physically and figuratively speaking. Several of the female participants had also experienced challenges with partners expressing negative reactions towards condom use. These participants had experiences with partners expressing that condoms reduced their pleasure and them trying to convince them not to use a condom. The male participants thought that their partner should disclose if they were not on hormonal prevention. Absence of hormonal prevention methods was mentioned as incentives to use condoms. The participants seemed comfortable and familiar with getting a hold of condoms, this did not seem like a barrier for condom use. Several of the participants mentioned the web site “gratiskondomer.no”, a site that delivers free condoms.

5.4 Alcohol and one-night stands- contexts of condom use

The context of which a sexual encounter occurs can influence the risk of having unprotected sex (Staras, 2013). This theme explores the contexts thought to influence condom use by the participants. When asked about experiences with challenges in regards to condom use several participants brought up alcohol as a factor that makes this challenging. Alcohol and one-night stands were associated with each other by the participants. Several of the participants thought and had experiences with that most “one-night stands” happen when under the influence of alcohol. Although many of the participants did not have a lot of trust in “one night stand” partners, and thought it was important to use condoms with them, they

felt it was more difficult to bring up the topic of protection with a one-night stand. The fear of an “awkward” situation and fear of the topic of protection “killing the mood” was also mentioned by several participants. The reaction of the sexual partner was also thought to make protection more difficult if the partner expressed negative reactions to using condoms. Not wanting to “nag” or “kill the mood” were factors that could influence the decision of not using condoms.

Participant 5 had this to say in regards to factors that could make it challenging to use condoms:

“Alcohol. That I believe most definitely influences it. And one-night stands.” (F, 5).

When probed further about in what way she thought these factors made condom use more challenging she elaborated:

*“(…) Your decision-making-skills become weakened with alcohol. And I think you become more like “It’ll be fine”*waves hand. That you do things you otherwise wouldn’t. And it’s a higher probability for a night-night stand. And then you don’t know that person, it can be more difficult to bring up protection, because you don’t know how they’ll react. And if the goal is to have sex, which it often is with a one-night stand, then it’s like a damper, bringing up a condom. It can kill the mood, and if that’s the only goal, well then, it’s easier to drop the condom.” (F, 5).*

Several participants brought up the fear of the unpredictable reaction of an unknown partner. The participants again linked this with trust, as they thought they could trust a known partner with being understanding when expressing a wish to use a condom. Not knowing a one-night stand was thought to make it more challenging to bring up the topic of condoms. Fear of the partner ending the sexual encounter was a factor that could influence their decision to bring up condoms. The “awkward” fumbling that can ensue with condom use was also described as more terrifying with unknown partners, a situation feared to “kill the mood”. With steady partners this could be made to a merry and humorous experience, although few of the

participants mentioned or thought about condoms in regards to steady relationships. In a steady relationship, a sudden expressed wish to use a condom was considered suspicious.

Being unprepared for the sexual encounter and thus condoms not being available was also brought up by several of the participants as a challenging factor that could influence condom use. Especially the male participants:

“It’s maybe more likely that I don’t use a condom if I have been drinking. But it’s like, most times I have hooked up with someone I have been drinking so it’s like, I don’t feel that’s...so, I don’t know, availability. If it’s not available then it’s...I think it’s mostly that, for me.” (M, 7).

“When you drink, you become stupid. You become more short-sighted, and if it suddenly happens that you need a condom but you don’t have one then it’s maybe easier to be like “screw it”(...) not like when you’re sober, but most one-night stands don’t happen when you’re sober regardless (...).“ (M, 6)

5.5 No big deal? Thoughts on the severity of STIs and perception of risk

A high perceived severity and susceptibility of a disease is in theory considered to lead to a higher probability of going through with health protective behaviour (Abraham et al., 2008). This theme explores the participants’ threat-perceptions of STIs and their thoughts about using/not using condoms. Most of the participants described STIs as something they do not think too much about. Several of the participants said that STIs and condom use was something they thought more about when being single and not when in a steady relationship. A few of the participants associated STIs with stigma and viewed STIs as a sign of promiscuity. These participants seemed to be more worried about STIs compared to the other participants. They described STIs as something they “stressed” about and wanted to avoid. These participants admitted to having had unprotected sex, and seemed to share the

challenges the other participants described in relation to condom use. In reflecting and elaborating on their answers, these participants concluded that STIs could happen to anyone, regardless of “promiscuity”. All the participants shared the topic of STIs with their friends and felt comfortable with talking about STIs. When talking about STIs with friends, most of the participants’ experienced this as a “light-hearted” topic, often infused with humour.

Several of the participants expressed that protecting one self against unwanted pregnancies was the first priority when it comes to having protected sex. This point seemed to emerge by itself in several of the interviews. Absence of hormonal prevention methods was mentioned as incentives to use condoms. The male participants thought that their partner should disclose if they were not on hormonal prevention. Some of the participants often slipped from talking about STI prevention to avoiding pregnancy. These participants often used protection against STIs and unwanted pregnancies interchangeably. When asked about challenges in regards to protecting themselves against STIs participant 6 had this to say:

“There was this one girl I was about to have sex with, who didn’t say anything, anything about me using or not using a condom, so I assumed she was on the pill, but she wasn’t. That was scary, and not good at all. So I should’ve been more on it and asked, but I was...I wasn’t sober. (...) You don’t think as much when there’s alcohol in your blood. (...) It’s happened several times so it’s important for the guy to make sure before-I’ve learned from the times, there weren’t that many times, but I’ve learned from those experiences to always bring it up.” (M, 6)

This answer illustrates that even though the topic was protection against STIs, the participant seemed to be more worried about unwanted pregnancies rather than STIs, and associated condom use with contraceptives. This comes through in the fact that he seemed comfortable with having unprotected intercourse as long as there was hormonal protection in place. The answer again highlights alcohol as a factor that can influence ones judgement in regards to condom use.

The overall threat-perception of STIs seemed low amongst the participants. It appeared that the participants did not view the consequences of having sex without condoms as severe. The participants did not seem to think that they were particularly likely to be infected with STIs, especially any other than chlamydia. The participants often brought up ‘chlamydia’ when they used examples of STIs, often in a light-hearted manner. One participant expressed that they experienced sex without condoms as more pleasurable. Sexual desire eliminating any thoughts of STIs in that moment was also described by some of the participants. When asked about experiences with challenges in regards to protecting themselves against STIs participant 2 revealed some thoughts in regards to her threat-appraisal of STIs:

“It’s a bit of a hassle with condoms, it’s...It’s better without, and that can influence situations when you’re in the mood and you just think “it will be fine”, and then you might think “All you have to do is get tested” and “most likely it won’t be anything worse than chlamydia, for instance, and you can just take a cure for that and it’s gone.” (F, 2).

Participant 3 had similar thoughts about the risk of STIs, when asked about her thoughts on STIs in general she replied that it was not something she thought too much about. When further probed about if STIs is something she worries about she had this to say:

“(…) No, it’s not something I worry too much about. Or I guess maybe I think that if I do get a STI, then I’ll get chlamydia, then I’ll go to the doctor and I’ll get some antibiotics, and it will be fine. I think, it’s just chlamydia I think about when I think about STIs. I don’t think about, what, like, AIDS and stuff, I don’t think I’ll ever get it. I don’t know why, or, chlamydia is more common so I guess that’s why. Mhm.” (F, 3).

This resonates with the experiences Tore Follestad describes of his 17 years of working as assistant manager at the health clinic “Sex og Samfunn”. He describes a change in young peoples reaction to infections such as chlamydia:

(...) “In these 17 years it’s gone from being where they almost started crying if they had a positive chlamydia-test, to now, where they can have chlamydia for the third time and it’s “no big deal”. So generally speaking, most people do not get very upset because of an chlamydia infection, they don’t, at least they don’t express it.”
(Assistant manager, Tore Follestand.)

6. Discussion

This chapter starts off with a summary of the main findings. It then combines the empirical data presented in Analyses and the theoretical framework described in chapter 3. It will also contain an attempt to assess to which extent the research questions have been answered by referencing to the empirical findings and comparing them to previous research.

Main findings

Threat-appraisal: Perceived Severity, Perceived susceptibility

Benefits and Barriers

Self-efficacy

Cues to Action

Answering the research question

Context

6.1 Main findings

The major finding of this study was the participants' thoughts and experiences regarding condom use. The participants related partner bringing up condoms or the topic of protection as 'responsible'. The participants had little trust in one-night stands, yet found bringing up the topic of condom use more challenging with them. This corroborates with the findings of Fridlund et al. (2014) that concluded participants had greater expectations of condom use that actually occurred, especially in relation with casual unknown partners.

The participants also often distinguished their answers by their social status. Being in a relationship and being single were separated. Being single meant for many, that they needed to be more aware of STIs and condom use. The participants seemed to associate “being in a steady relationship” with hormonal prevention methods. The participants distinguished nearly all their answers by “it depends” if it’s a one-night stand or a steady relationship. This indicates that the participants view trust and protection against STIs differently with different sexual interactions. These findings corroborate with previous research findings on condom use and length of a relationship (Fridlund et al., 2014; Ku et al., 1994). Condom use has been shown to decline with the length of a relationship (Fridlund et al., 2014; Ku et al., 1994). Ku et al. (1994) found that condom use declined during a relationship, even though the pregnancy protection level stayed the same.

The dimensions of the HBM model are relevant in shaping young peoples experiences. Using the HBM developed the questions in the interview guide, and the interview guide was successful in providing some relevant and interesting data. The model does not explain how the relationship between these different factors affects people’s decision-making process. It does not explain how perceived threat-perception is related to self-efficacy etc. By using in-depth qualitative methods, the participants provided insight and linked these aspects directly themselves. The context in which the sexual encounter takes place, level of trust, one-night stand and alcohol are all factors that also affect people’s decision-making process. Understanding that is a step towards understanding a link between perceived threat and self-efficacy. A development of the HBM that takes into account social context to a further extent could be useful when applying the model to sex and condom use. Various contexts include factors that were identified in the literature review as factors that can influence condom use, such as alcohol, relationship length, etc. The model could be expanded by taking context into account.

6.2 Threat-appraisal

It is difficult to pinpoint why there has been an increase of STI diagnosis. The Norwegian strategy “Talk about it!” that was developed by the Norwegian department of health discusses whether the increased rate of STIs is due to more effective testing and more people getting tested, or if it is indeed higher (Helse- og omsorgsdepartementet, 2017). In either case, the rates of STI diagnosis in Oslo are 30% above the national average (Aftenposten, 2016). One possible explanation as to why there has been an increase in STI rates is that the fear of contracting “permanent” STIs like HIV/AIDS has diminished since the 80- and 90’s (NRK, 2015; Pedersen & Samuelsen, 2003). It is not long ago that the diagnoses HIV and AIDS were considered a death-sentence. Today, there are treatments and medicine that can keep HIV in check, so it does not develop to AIDS, and in the western hemisphere where most people have access to such treatments, HIV is a condition people can live a long life with. It is possible that this medical development has influenced young adults assessment of severity and perceived susceptibility of STI contraction (NRK, 2015; Pedersen & Samuelsen, 2003). Another possible reason is that the treatments for other STIs are so effective and available, that even if one contracts an STI, it is no longer considered “a big deal”. Based on the analyses, the participants had an overall low threat-appraisal of STIs and did not seem too concerned with them. Protecting themselves from unwanted pregnancy seemed to be a priority for the participants as they often slipped from talking about STI prevention to avoiding pregnancy. The participants often used protection against STIs and unwanted pregnancies interchangeably. Absence of hormonal prevention methods was mentioned as incentives to use condoms. These findings could be interpreted as the participants not fearing having sex without condoms as long as there were hormonal prevention methods in place. Unlike condoms, hormonal prevention methods do not protect against STIs. These findings support previous research findings indicating that young adults

are more concerned with avoiding unwanted pregnancies rather than they are with STIs (Civic, 2000; Helsedirektoratet, 2009).

6.2.1 Perceived Severity and Perceived Susceptibility

The participants appeared to perceive STIs as something not too severe. They often used chlamydia as an example of STIs, indicating that this was what they related to STIs. Chlamydia is one of the most common STIs, so this finding is perhaps not surprising (ECDC, 2016). Several of the participants described the treatment of chlamydia very matter of factly. This corroborates other research findings. The Norwegian directorate of health reported that nearly 8 out of 10 of the young respondents considered that there is no or low risk of them getting infected with chlamydia (Helsedirektoratet, 2009). Others have argued that young people deny or suppress the risk of chlamydia contamination (Andersen, Olesen, Møller & Østergaard, 2002). It was clear that going through with a chlamydia-treatment was not unfamiliar to them, and it was not a particularly daunting prospect. As illustrated in the findings, one of the participants weighed the outcomes in her head before deciding not to use condoms. Chlamydia being the “worst that could happen” was described as a factor that did not encourage condom use. The participants did not describe themselves as particularly susceptible to STIs. One participant expressed specifically that she did not think it was likely for her to contract “serious” STIs such as HIV/AIDS. She was somewhat uncertain as to why she thought so, but reasoned that it was likely because chlamydia is so much more common. The participants seemed aware of chlamydia being the most common spread STI. The participants appeared to have a low level of perceived susceptibility of STIs, especially when in a steady relationship. Several of the participant’s described how condom use and STIs was something they thought less about when in a steady relationship. Condom use has been shown to decrease with the length of relationships (Civic, 1999; Fridlund et al., 2014; Ku et al., 1994). A review of articles using the HBM found that perceived susceptibility was

a stronger factor to understanding protective health behaviour, rather than sick-role behaviour (Janz & Becker, 1984).

From the stands of a public health perspective, increasing people's threat-perception of STIs in order to increase the use of condoms might hypothetically decrease the STI rates. There is some evidence that suggest using threat-perceptions in campaigns together with high-efficacy and providing a solution can be effective (Witte & Allen, 2000). Increased threat-appraisal does not necessarily lead to increased condom use (Janz & Becker, 1984; Montanaro & Bryan, 2014; Sheeran et al., 1999). Janz & Becker (1984) found that perceived severity produced the lowest overall significant ratios. Montaro & Bryan (2014) discovered that threat-perceptions were not constructs that predicted condom use intentions. The few participants, who expressed that they viewed condom use as very important, also illustrated this, as they still found it challenging to follow through with condom use.

6.3 Benefits and Barriers

Condoms “not being available in the moment” seemed to be a barrier for some of the participants, yet they seem to have good knowledge of where to access condoms. This supports the findings of the evaluation conducted by the Norwegian directorate of health, of their services providing free condoms (Helsedirektoratet, 2008). They found that young adults have good knowledge on how to access condoms and do not feel embarrassment in regards to this (Helsedirektoratet, 2008). It appeared that purchasing or getting a hold of condoms was not a barrier for the participants. The participants described the issue being more about the fact that they were unprepared for the sexual encounter.

Based on their statements, the participants seemed to believe that condoms are effective both in preventing unwanted pregnancies and STIs. None of the participants expressed mistrust of

scepticism to condoms as an effective barrier method. A few participants did mention that they preferred sex without condoms because they had experienced that it felt better without.

6.4 Self-efficacy

Many of the participants thought that alcohol and “one-night stands” could increase the probability of having unprotected intercourse. They explained that this was because alcohol could impact one's decision-making process, leading to a more “lax” attitude. They also thought that alcohol consumption could lead to one-night stands. Alcohol has previously been identified as a risk factor for having unprotected sex (Rehm et al., 2012). Nearly all the participants described that one-night stands and alcohol went hand in hand. The participants also thought that it was more challenging to bring up condom use with a one-night stand. This was due to fear of “killing the mood” and fear of the reaction of the unknown partner. Fear that the partner might end the sexual encounter was a factor that made some of the participants decide not to bring up the topic of condoms.

Challenges in regards to condom use can be perceived differently based on gender (Buysse & Van Oost, 2010). The male participants for example, did not view bringing up the topic of protection as challenging, where most of the female participants did. Fear of the unknown partner's reaction to condoms and fear of “killing the mood” were factors that several of the female participants thought made it difficult to bring up and insist on condom use. Several of the female participants had experiences with having to negotiate condom use with their partner. The participants, who had experienced such negotiations, described how their sex partners would try to convince them not to use condoms. Either by trying to reassure them they did not have STIs or by expressing how much better it felt without condoms. Some of the participants described how this resistance of condom use from their partner made the prospect of bringing up condoms in the future more daunting. This supports the findings of

Gakumo et al. (2012), who found that sexual pressure had the effect of decreasing the likelihood of condom use.

6.5 Cues to action

Sexuality and *sex* is a topic that dominates media, both social and mainstream (Bruess & Greenberg, 2004). The HBM describes how reminders of protective health behaviour can influence the decision to actually go through with the behaviour (Abraham et al., 2008). There is no visibly on-going campaign promoting sexual health in the mainstream media in Norway today. At the moment, Folkehelseinstituttet have few measures to promote condom use amongst young adults in Norway. They produced a short video in 2015 aimed at adolescents between the ages 16-19 (Folkehelseinstituttet, 2015c). The video uses humour depicting a guy in a condom suit making advances at women passing by. He is unsuccessful and has a heart-to-heart with the cameraman telling him that times are tough with the high STI rates and some general information about STIs. In the end, he ends up going to the doctor, and receives treatment for the STI in the form of pills and is also given a condom on his head. After this, the girls he approaches are much friendlier to him, and it ends with a happy ending. Besides this video, which is intended to be shown in health class, other measures include pamphlets on condoms use and STIs and a video about HIV-infections in different languages (Folkehelseinstituttet, 2015c). Current Norwegian guidelines recommend screening of chlamydia for women under the age of 25, after every new sexual partner (Steen et al., 2005). Screening of women who seek getting an abortion is also recommended. For men it is mainly recommended that they seek the source of the infection if they test positive (Aavitsland & Lystad, 1995). A cross-sectional study investigating the chlamydia prevalence amongst young people between the ages 18-29 in Oslo, recommends that men are to be included in the screening recommendation of chlamydia (Steen et al., 2005). Providing

people with free condoms is also part of the strategy to decrease STIs in Norway (Helsedirektoratet, 2008).

6.6 Answering the research questions

The aim of this dissertation was to explore young adults thoughts and experiences regarding condom use. In regards to this, the aims were met and the study was successful. The qualitative methods allowed for elaborate inquiry of the participants thoughts surrounding condom use. The main research question was: What thoughts and experiences do young adults have in regards to condom use?

The empirical data depicts how the participants think of condom use as something to mainly avoid unwanted pregnancies. They associate condom use with not being in a relationship. Regarding perceptions of STI, the participants appeared to associate STIs mostly with chlamydia, and did not seem to think too much about them. The participants feel more at risk of STIs with a one-night stand; this is due to the fact that they did not believe they could trust a one-night stand to disclose possible STIs. The unknown reaction of the one-night stand made it more challenging to use protection in these situations. The data also indicates that the participants were familiar with the treatment of chlamydia and felt that it was an easy process. Based on this and in regards to the main research question, the participants seem to have relaxed thoughts about condom use and the risks and consequences of STIs. The female participants appeared to have experienced more challenges with bringing up condom use with a partner. Overall, the participant's threat-appraisal appeared to be low. Even though their threat-appraisal appears low, the empirical data indicates that the decision whether to use or not use condoms is influenced by multiple factors. Different contexts in which the sexual encounter takes place can affect some peoples' decision-making process regarding condom use (Jørgensen et al., 2013). The participants described how alcohol and

having intercourse with a somewhat unfamiliar partner could influence the choice to use condoms. Sexual desire and not wanting to interrupt or risk the sexual encounter was also mentioned as a reason for not using condoms. They viewed these factors as “challenges” in regards of using condoms. Simply focusing on raising young adults threat-appraisal in order to increase condom use and decrease STI rates, would probably be less then effective.

6.6.1 Context

In regards to the secondary research questions, what are the circumstances that shape peoples decision-making in regards to condom use? What are the variations in context? It seems that there are several aspects about the context of the sexual encounter that are important in explaining the process of young people’s decision-making. It is also apparent that these factors do not operate alone, but need to be viewed as interacting rather than isolated events. The participants expressed how alcohol and unfamiliar partners could influence their decision as to whether or not to use condoms. Even though alcohol has been identified as a risk factor for unprotected intercourse this will not be the case for everyone who drinks alcohol (Davis et al., 2014). Having hormonal prevention methods was enough for some of the participants to feel comfortable with having intercourse without condoms. This corroborates other research findings where hormonal prevention methods were associated with non-use of condoms (Helsedirektoratet, 2009; Hiltabiddle, 1996). Sexual desire eliminating any thoughts of STIs in that moment was also described by some of the participants. The answers also varied on bases of gender, this could impact what is perceived as barriers or motivators for condom use. Several of the female participants had experienced partners expressing negative reactions towards condom use. The male participants did not relate to this issue. They had however, experiences with not being prepared for a sexual encounter and not having condoms available. The variations in context in which a sexual encounter takes place and different combinations of factors that can influence the final

outcome of condom use are endless. Having an understanding of what motivates condom use and what hinders young people from using them is therefore important if one is to develop strategies to increase condom use. A review of 22 articles addressing issues influencing condom use, found that the perception that one can enjoy sex with condoms and that condoms allow for spur of the moment-sex had a positive association with intention to use condoms among adolescents (Hiltabiddle, 1996). A meta-analysis comparing the success of interventions of preparatory condom use behaviour concluded that attitudes toward condoms and condom use self-efficacy were two of the most important predictors of condom use intentions (Montanaro & Bryan, 2014). Intentions of condom use have been linked to actual condom use (Bryan et al., 1997).

To summarize, there is a trade-off between all the different aspects that can influence the decision-making process regarding condom use. The participants make an assessment of the threat and the severity but then they also make some decisions around trust as well. Self-efficacy appears to be an important factor in negotiating condom use (Montanaro & Bryan, 2014). A few of the respondents were determined to use condoms and were prepared to end a sexual encounter if their partner refused to use a condom. However, self-efficacy might not be enough when alcohol is involved. Solely focusing on self-efficacy or solely focusing on threat-perceptions is inadequate (Montanaro & Bryan, 2014). The HBM should be expanded to include contextual factors as well as viewing them as interlinked.

7. Conclusions

This chapter contains an evaluation of the generalizability and impact of the findings as well as the dissertation limitations. Finally, this chapter includes proposals for further research.

7.1 Implications and limitations

The dissertation offers a humble contribution to the limited body of qualitative research on the topic of condom use in Norway. But are the findings of this study, in regards to the young adults thoughts and experiences surrounding condom use, valid for other studies or similar cases? To generalize the findings from this study to other cases would be problematic (Guba, 1981). However, as highlighted in the previous section of this chapter, some of the findings of this study do corroborate with findings from other studies. The findings of this study echo previous research findings, this strengthens the possibility for the results to be valid for other investigations. The findings of this study can be used as a supplement to other research. This study contributes to a deeper and broader insight to the thoughts of some young adults in regards to condom use. In my opinion, even though the sample is small, and the findings are subjective, the findings can contribute to a deeper understanding of the participants' thought and decision-making- process. This is important to understand in order to develop *possible* strategies to increase the use of condoms. The study is however, not without limitations. The small sample used in this study does not provide a base to generalize the findings to all young adults in Oslo. With only seven participants, most recruited from the same health clinic, their subjective views and experiences cannot be generalized to all young adults in Oslo. There were a skewed number of participating men compared to women, with 2 male and 5 female participants. Gender-roles could possibly influence the findings. Perhaps men and women view condom use differently? Leval et al. (2011) found that women with a high level of perceived severity were more likely to condom

use compared to men. The motivations and nature of sex can also be viewed differently based on gender (Banfield & McCabe, 2001; Baumeister, Catanese & Vohs, 2001). Challenges in regards to condom use can also be perceived differently based on gender (Buisse & Van Oost, 2010). The sample was too small to compare, however there were differences in some of the answers based on sex. The male participants for example, did not view bringing up the topic of protection as challenging, where most of the female participants did. The sample also contained none younger than of the age 22. This means that the study failed to include the thoughts and experiences of young adults between the ages 20-21. There is a possibility that these are different from the slightly older age group. Furthermore, researchers bias might have influenced the findings, as is often the risk with qualitative research. “Cherry-picking” some of the findings could influence the final results. It is therefore important to highlight the limitations of the study and to describe the process as thoroughly and transparently as possible (Guba, 1981). There is a possibility that the probes that were used during the interviews could influence the participants’ answers. This could go both ways, as some of the participants might of added that they thought condom use is important because maybe that is what they thought would be the “right thing” to say. The researchers hypothesis and research questions were not disclosed to the participants in order to avoid this from occurring.

Due to time and resource restraints certain restrictions had to be made. The researcher acknowledges that other prevention methods exist other than condoms. This is briefly mentioned in the introduction. Other interesting topics and themes emerged during the analyses of the empirical data. These were set aside as they were slightly beyond the focus of the dissertation.

According to the HBM external variables such as personality traits, socioeconomic status, religion etc., can influence behaviour and decision-making in regards to health protective

behaviour (Abraham et al., 2008). These aspects were not taken into consideration when analysing the data. This should be taken into account when reading the dissertation.

Despite these limitations, the findings provide insight and addition to an empirical field that has previously been somewhat unexplored. In this regard, the study can be used as a stepping-stone for further research on similar issues.

7.2 Future research and public health practice recommendations

Nearly all the participants expressed a wish for more education being given in school about STIs. Investing more time in educating young people about the severity and consequences of STIs could be an effective measure to increase young peoples threat-appraisal of STIs and provide them with a more realistic risk assessment (Hiltabiddle, 1996). However research has proven that a high threat-appraisal does not necessarily result in protective action (Newby, French, Brown & Wallace, 2013; Sheeran et al., 1999). Sex is something so multifaceted that is difficult to isolate one solution or reason for having unprotected intercourse (Civic, 2000; Dawson, Shih, De Moor & Shrier, 2008). Education focusing on removing social stigma around STIs and focusing more on developing social skills to initiate condom use could prove effective (Hiltabiddle, 1996; Newby et al., 2013). The participants related partner bringing up condoms or the topic of protection as “responsible”. This could be played up in a potential campaign designed to increase condom use. Hiltabiddle (1996) found that the perception that condoms are popular with peers and condoms require the male to be responsible were associated with intentions for condom use.

Sexual encounters that included alcohol was also a factor that seemed to increase the probability of having unprotected intercourse. Previous studies have identified alcohol as a risk factor when it comes to having unprotected sex (Rehm et al., 2012; Staras et al., 2013).

A possible solution could be to place condoms in places where alcohol is being served, such as nightclubs and bars. Several of the participants expressed that having access to a condom in the moment is important. This is being done in several homosexual and lesbian nightclubs in Oslo. Further research assessing the effectiveness of such kinds of measures should be done. Perhaps a similar approach could be implemented in nightclubs in Oslo, with messages reminding visitors to “be responsible”, with a condom dispenser underneath. The majority of the participants made a distinction in answering most of the questions, between a long-term and a casual partner. This ought to be taken into account when designing future research.

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8. Appendices

8.1 Appendix 1 - NSD



Miranda Thurston
Institutt for idrett og aktiv livsstil Høgskolen i Hedmark, campus Elverum
Postboks 400
2418 ELVERUM

Vår dato: 06.01.2017

Vår ref: 51456 / 3 / KH

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 06.12.2016. Meldingen gjelder prosjektet:

<i>51456</i>	<i>Unge voksnes (20-24) tanker og holdninger til seksuelt overførbare infeksjoner (SOI) og kondombruk</i>
<i>Behandlingsansvarlig</i>	<i>Høgskolen i Hedmark, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Miranda Thurston</i>
<i>Student</i>	<i>Amelia Tinsja Haile</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 30.06.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Kjersti Haugstvedt

Kontaktperson: Kjersti Haugstvedt tlf: 55 58 29 53

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

8.2 Appendix 2 - Recruitment poster

Vil du dele dine tanker og erfaringer med kondombruk?

Til prosjektet søkes unge voksne i alderen 20-24 år, som er bosatt i Oslo og som er komfortable med å snakke om kondombruk og seksuelt overførbare infeksjoner. Prosjektet inngår i en masteroppgave i folkehelsevitenskap.

Deltakelsen innebærer å være del av et individuelt intervju. Intervjuet vil vare omtrent en time og finne sted på Sex og Samfunn. Tid blir avtalt med deltakere.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Amelia Haile på 97965820 eller send e-post til

amelia_haile@hotmail.com



Deltakere vil ikke kunne gjenkjennes i prosjektet.

8.3 Appendix 3 - Consent form

Informasjonsskriv og samtykke

” Unge voksnes tanker og erfaringer med kondombruk og seksuelt overførbare infeksjoner”

Bakgrunn og formål

Formålet med studien er å undersøke unge voksnes holdninger til kondombruk og seksuelt overførbare infeksjoner (SOI). Prosjektet inngår i en masteroppgave på studiet master i folkehelsevitenskap, på Hedmark Høyskole, avdeling Elverum og blir gjennomført av Amelia T. Haile med Katie Powell som veileder.

Til prosjektet søkes unge voksne i alderen 20-24 år, som er bosatt i Oslo og som er komfortable med å snakke om sine tanker og erfaringer med kondombruk og SOI. Sex & Samfunn er en institusjon som formidler kontakten med utvalget, prosjektleder kjenner ikke de som forespørres sin identitet før de eventuelt samtykker til deltagelse.

Hva innebærer deltagelse i studien?

For å belyse problemstillingen vil det gjennomføres individuelle intervju. Deltagelse innebærer å være en aktiv deltaker i et intervju hvor emnet vil være kondombruk og SOI. Spørsmålene vil blant annet omhandle tanker rundt SOI og erfaringer med kondombruk. Det vil bli gjort et lydopptak av intervjuet. Estimert varighet for intervjuet er rundt 60 minutter. Dato og tid blir avtalt med deltaker. Intervjuene vil finne sted på Sex & Samfunn, eller et annet sted avtalt med deltaker.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt. Det er kun prosjektleder som vil ha tilgang til personopplysningene. Etter at intervjuet er transkribert (lydopptaket blir omgjort fra lyd til tekst) vil all informasjon anonymiseres. Det vil si at dine svar vil ikke kunne kobles tilbake til deg i den endelige oppgaven. Intervjuet vil brukes som en del av et skoleprosjekt og vil ikke brukes til andre formål.

Deltakerne vil ikke kunne gjenkjennes i prosjektet.

Prosjektet skal etter planen avsluttes 30.06.17. Etter prosjektet avsluttes vil personopplysninger og lydopptak slettes.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli slettet.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Amelia Haile på 97965820 eller send en e-post til amelia_haile@hotmail.com. Andre spørsmål kan også stilles til veileder for oppgaven Katie Powell, k.powell@sheffield.ac.uk.

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien

Jeg har mottatt skriftlig og muntlig informasjon om studien, og er villig til å delta i intervju.

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert av prosjektleder, dato)

8.4 Appendix 4 - Interview guide Norwegian

Intervjuguide

Start: Hei! Jeg setter pris på at du tok deg tid til å møte meg. Masteroppgaven min handler da om unge voknes tanker og erfaringer rundt kondombruk så spørsmålene vil for det meste omhandle dette. Intervjuet vil vare rundt en time. Før vi starter vil jeg be deg om å underskrive et samtykkeskjema. Hvis du på noe tidspunkt føler at det blir ubehagelig å svare på spørsmålene eller dersom noe er uklart, ikke nøl med å si ifra til meg. Svarene dine vil ikke kunne gjenkjennes i oppgaven. Dersom du har noen spørsmål angående studien så kan du kontakte meg når som helst. Du kan også snakke med Tore som er assisterende daglig leder her på Sex og Samfunn.

Har du noen spørsmål før jeg skrur på lydopptakeren?

Åpningsspørsmål: Kunne du vennligst fortalt meg om du husker å ha hatt noe undervisning på skolen om sex og forhold?

Hva tenkte om innholdet i seksualundervisningen man får på skolen?

Hvilke tanker har du om hva faget burde inneholde?

Husker du om dere lærte noe om det sosiale rundt sex?

For å oppsummere...*stemmer det?*

Er det noe du vil tilføye da, før jeg går litt videre?

Nå vil jeg gjerne gå over til å snakke litt om kondombruk i forhold til en samleiepartner.

Hva legger du i begrepet “tillit” i relasjon til en samleiepartner?

Hva tenker du om å ta opp temaet om beskyttelse (kondom) med en samleiepartner? *Kan du utdype det?*

I relasjon til en partner, hvilke signaler tenker du det gir når man uttrykker et ønske om å bruke kondom? *Hva får deg til å si det?*

Hva tenker du om det å spørre en partner om å bruke beskyttelse? *Kan du si litt mer om det?*

Har du erfaringer med utfordringer rundt det å ta opp temaet om kondombruk?

Du nevnte tidligere.....på hvilken måte da?

Hvem mener du burde være ansvarlig for å skaffe beskyttelse mot SOI?

For å forsikre meg om at jeg har forstått deg riktig, mener du at ...?

Hvordan ville du reagert hvis partneren din uttrykket ønske om å bruke kondom?

Når mener du det er passende å ta opp temaet om beskyttelse med en samleiepartner?

Ville du brukt beskyttelse annerledes med en ny partner sammenlignet med en du kjente fra før? *Kan du utdype det?*

Nå vil jeg gå litt mer over til å snakke om kondombruk og SOI generelt.

Hvilke tanker har du rundt seksuelt overførbare infeksjoner generelt? *Kan du utdype det litt?*

Hvilke faktorer mener du kan påvirke valget om å bruke kondom? *På hvilken måte...?*

Da vil jeg avslutte med å spørre deg et par spørsmål angående dine jevnaldrende.

Er SOI noe dere snakker om med vennene dine?

(Hvis en venn av deg hadde F.eks klamydia, hvordan ville du reagert da?)

Siste spørsmål, tror du dine venner deler dine tanker rundt kondombruk?

For å oppsummere.... stemmer det?

Er det noe du ønsker å tilføye før vi avslutter?

Slutt

Se tidsramme

Se om alle spørsmålene er dekket

Summer hovedpoengene.

Helt til slutt vil jeg be deg om å fylle ut noen få spørsmål om bakgrunn.

Takk for at du deltok! Håper du synes det har vært en grei opplevelse. Hadde satt pris på om du nevnte studien for venner som kanskje kunne tenkt seg å være med. Gavekort. Ikke nøl med å ta kontakt dersom det er noe du lurer på.

8.5 Appendix 5 – Interview guide English

Interview guide

Start: I appreciate you taking the time to meet me. My master thesis is about young adults and thoughts surrounding condom use, so the questions will mainly reflect that. The interview will last for about one hour. Before we start I'll ask you to sign this consent form. If you at any point feel uncomfortable, wish to stop or if anything is unclear, please let me know. The results are completely anonymous and you will not be recognized in the thesis. If you have any concerns regarding the interview or the study, you can contact me at any time. You can also talk to Tore Follestad here at the clinic, he will be available to you after the interview, or you can contact him at this number-*Give number on paper* at a later time.

Do you have any questions before I turn on the audio-recorder?

Opening question: Please tell me, do you recall having the subject “sex and relationship education” in school?

What are your views on the content of the “sex education” class?

What thoughts do you have regarding what the class should cover?

To summarise...is that correct?

Is there anything you would like to add before I move on to another subject?

Could I now move on to discuss condom use in relation to a sex partner?

What does “trust” mean to you in relation to a sex partner? *Follow-up: Could you elaborate?*

What are your thoughts on bringing up the topic of protection (condom use) with a sex partner?

In relation to partner, what signals do you perceive by somebody expressing the desire to use condoms? *Could you elaborate?*

(What reactions are expected?)

What thoughts do you have regarding asking a partner to use condoms? *Probe: Could you say more about that?*

Have you experienced any challenges regarding bringing up the topic of condom use with a sex partner? *Follow-up: Can you expand on that?*

Who do you think should be responsible for providing condoms? *Could you say more about that?*

How would you react if your partner expressed a wish to use condoms?

When do you think it is appropriate to bring up the topic of protection with a sex partner?

Would you consider using protection differently with a new sexual partner compared to somebody you have had prior relations to? *Probe: What makes you say that?*

To summarize...have I understood you right?

I would now like to move on to talk about **condom use and STIs in general**.

What are your views on STIs in general? *Probe: What makes you say that?*

What factors do you think can influence the decision to use condoms? *In what way?*

The last questions are regarding your **peers**.

Are STIs something you talk about with your friends?

(If a friend of yours told you they got a chlamydia infection, how would you react?)

Last question: Do you think your friends share your views on condom use? *Probe: What makes you say that?*

To summarize.... summarize back main points, have I understood you correct?

Is there anything you would like to add?

End

Time-check

Check if all points and questions are covered

Summarize back main points

Thank you for participating! Please feel comfortable contacting me at any time if you have any questions or concerns. Gift card.

8.6 Appendix 6 – Sample background information

Spørsmål om bakgrunn

Vennligst marker det mest passende svaret med en X

Hvor gammel er du?

- Under 20 år
- 20 år
- 21 år
- 22 år
- 23 år
- 24 år
- Over 24 år

Hva er din høyeste fullførte utdanning?

- Ungdomskole
- Videregående
- Bachelor
- Master

Hva er din status?

- Singel
- I et åpent forhold
- I et monogamt forhold
- Gift

Hva er din etniske bakgrunn?

- Norsk
- Norsk, andre generasjon
- Annen nasjonalitet
- Mix

Hva er din seksuelle legning?

- Heteroseksuell
- Homoseksuell
- Bi-seksuell
- Annet

Hvor hørte på om studien?

- "Sex og Samfunn"
- Deichmanske Bibliotek
- Universitet i Oslo
- Gjennom venner