The Work of Contracepting

Young people's experiences and practices with contraceptives in Sweden

Larsson, Marie

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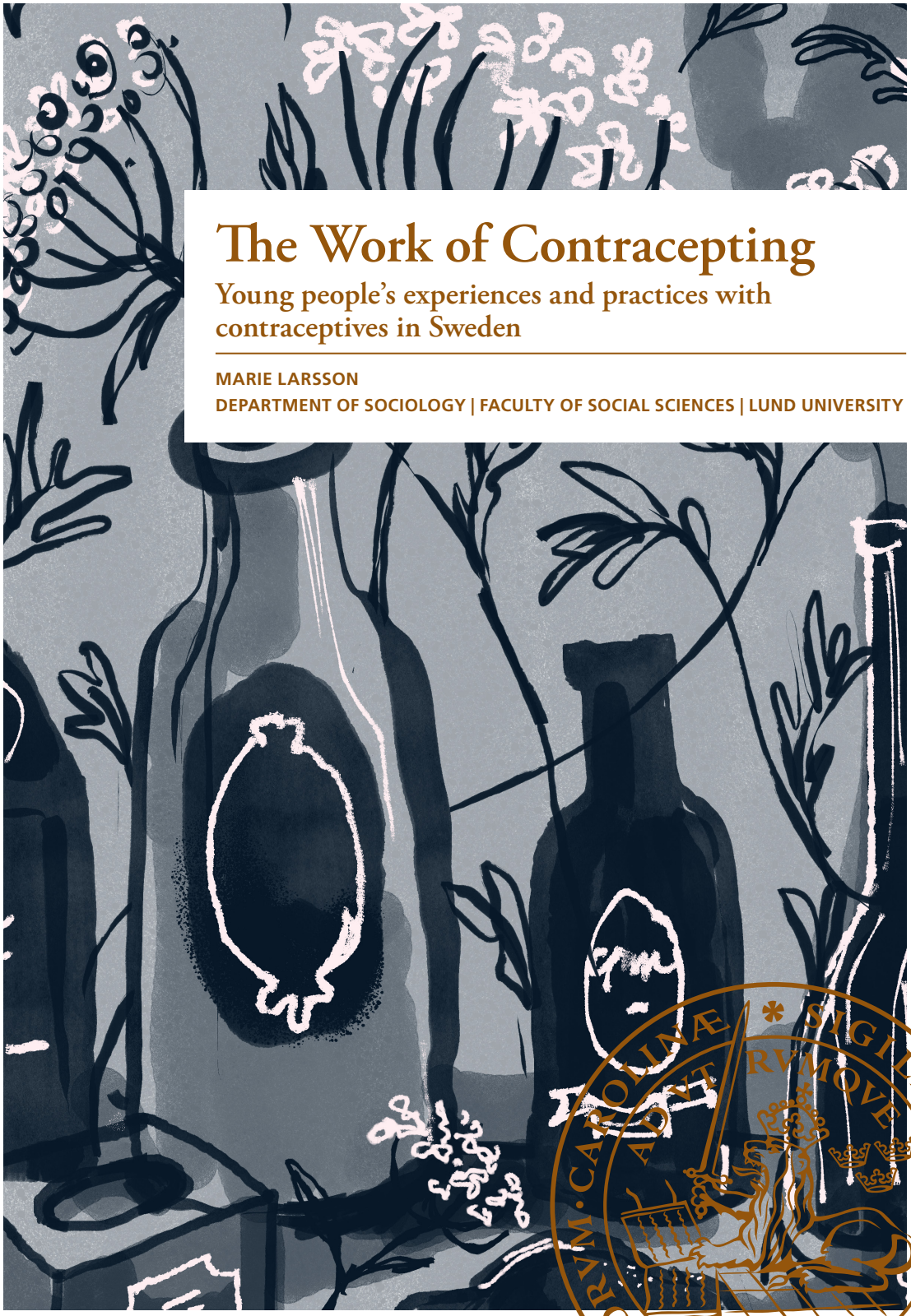

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MARIE LARSSON
DEPARTMENT OF SOCIOLOGY | FACULTY OF SOCIAL SCIENCES | LUND UNIVERSITY

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Marie Larsson

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Abstract:

Contraception is a complex phenomenon with differing meanings, expressions, and materialities depending on its historical, social, and cultural context. In this thesis, I depart from the conceptualisation of contraception as the prevention of both pregnancies and sexually transmitted infections (STIs) and I name these practices through the collective term of contracepting.

Previous research on young people and contraceptives has centred on cis women and, to a lesser extent, men who have sex with men. Studies on young people and contraceptives tend to focus on use and choice-making, with an emphasis on the medical risks that these may pose. The sociological and more critical studies on contraceptives largely emerge from the US context, and usually separate pregnancy and STI prevention efforts, which is problematic as it obscures the fact that many young people are or have been concerned with both of those elements of contraception. The Swedish context presents some similar criticalities, as there are extremely few studies that explore contraceptive use and experiences beyond the medical sphere, and even fewer that look beyond the practices of cisgender women. More critical and sociological studies are needed to explore how young people with various gender and sexual identities experience contracepting practices.

This dissertation contributes to the literature on contraceptives by drawing on the stories and accounts generated from 27 interviews with 13 women, men, and non-binary people aged 18 to 29, with different sexual identities living in Sweden, and who had some experience with pregnancy and/or STI prevention. The aim of this research project has been to explore young people's diverse practices and experiences with pregnancy and STI prevention (i.e. contracepting). Participants' stories and accounts were analysed through a critical, relational lens and based on a conceptual understanding of contracepting as involving multifaceted work. Analytical leads were identified using a broadly thematic approach, further influenced by narrative inquiry and critical optimism.

My main empirical contributions highlight that participants described doing different elements of the work of contracepting across different relational contexts and in relation to a range of actors. First, I explored the important role friends played in these practices, followed by the possibilities and challenges detailed by young people of trying to negotiate sharing the work of contracepting in longer-term sexual relationships. Through my analysis, I also found that contracepting as a young person in Sweden involved a great deal of work around becoming informed and making contraceptive choices.

Ultimately, participants' stories and accounts of contracepting highlight the ongoing, everyday work often involved in pregnancy and STI prevention. Contracepting as a young person in Sweden involves considerable negotiation and navigation of interpersonal relationships and relationalities with a range of actors, including others' ideas, thoughts, feelings, understandings, and beliefs about what are right/wrong, in/appropriate, un/reasonable, un/fair, and ir/rational contraceptive practices across a multitude of different situations.

Through this study, I cast light on activities and efforts that often remain invisible and unrecognised, but that are integral parts of young people's contracepting experiences and practices. The conceptual understanding and lens of contracepting as work has been key in this endeavour and provides an important shift in perspective. Through this critical relational lens, different conversations and imaginations are made possible, illustrating that there is more that can be done to make the work of contracepting easier, less burdensome, more shareable, more enjoyable, and fairer for all.

Key words: Contraceptives, contracepting, work, pregnancy prevention, STI prevention, young people, Sweden, relationality, critical, feminist theory, technoscience, qualitative methods

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Marie Larsson

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Faculty of Social Sciences
Department of Sociology

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To friends, the ones that have been, are, and will be there *for us - for me, my participants and all young people navigating the work of contracepting everywhere.*

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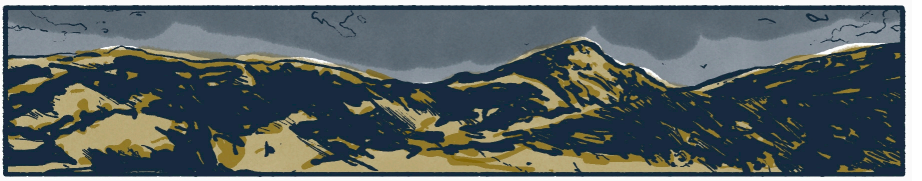


Abbreviations

GP	General practitioner or practice (in Swedish, “vårdcentral”)
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
PMS	Premenstrual syndrome
PMDD	Premenstrual dysphoric disorder
PrEP	Pre-exposure prophylaxis
RFSL	The Swedish Federation for Lesbian, Gay, Bisexual and Transgender
RFSU	The Swedish Association for Sexuality Education
SRHR	Sexual and reproductive rights and health
STI	Sexually transmitted infection
WSW	Women who have sex with women

Chapter 1. Introduction

Throughout human history, there has always been a desire and need to contracept. That is, a desire to prevent or be able to plan pregnancies or prevent against sexually transmitted infections (STIs). Contraceptives have existed in some form or another for several thousands of years. As Norman E. Himes states in his classic *Medical History of Contraception*, '[t]he *desire for,* as distinct from the *achievement of*, reliable contraception has been characteristic of many societies widely removed in time and place' (Himes 1963, xxxvi). Historians of reproduction and sexuality, like Himes and others (McLaren 1990; Riddle 1992, 1997), have illustrated the multitude of contraceptive methods people have used throughout history. Examples range considerably, from plugs and tampons made of 'pulp of pomegranates with alum' as documented by early Islamic physicians (Himes 1963, 148) to the hard glans[1] condoms made of tortoise shell reported to have been used in Japan (Himes 1963, 131-132).

In his research, Himes outlines and classifies a range of contraceptive techniques used throughout history across different geographic and cultural contexts. Ultimately, without judging their relative efficiency, and one finds that a variety of methods and strategies have been employed across history and contexts: natural methods such as withdrawal or non-vaginal intercourse, different types of plugs and pessaries, douching[2], condoms made from everything from

[1] The glans is the head or tip of the penis.

[2] Douching in this context refers to rinsing the vagina of sperm with water or some other liquid. The Greek gynaecologist Soranus wrote about this as early as the 1st-2nd century which he describes as: 'And during the sexual act, at the critical moment of coitus when the man is about to discharge the seed, the woman must hold her breath and draw herself away a little, so that the seed may not be hurled too deep into the cavity of the uterus. And getting up immediately and squatting down, she should induce sneezing and carefully wipe the vagina all round; she might even drink something cold.' (McLaren, 1990, 58)

animal intestines to fabrics, and other methods such as sterilisations or the use of herbs as abortifacients[3] to end unwanted pregnancies.

In reading accounts of contraceptive practices throughout different historical periods and places, contraception emerges as a multifaced phenomenon, that comes with differing meanings, expressions and materialities depending on its context. Moreover, what is particularly interesting to the sociologically inclined like me, is *how* contraception has been possible or impossible, done or carried out, by *whom*, under what *circumstances,* and with what associated *meanings* and *consequences*. These are the questions I will explore within this thesis, through the experiences and stories of young people in the Swedish context.

In this introductory chapter I will familiarise the readers to the issue and phenomenon of contraception as a whole and within the Swedish context. First, I will introduce more broadly what contraceptives are and clarify some central terms. I will then go on to outline common contraceptive methods for preventing pregnancies as well as methods for preventing STIs and what these can involve. Second, I will introduce the wider Swedish contraceptive landscape, that is, what access and provision of contraceptive information, sexual education as well as contraceptive methods and care look like. I will also describe current trends and patterns around contraceptive use in Sweden among young people and outline some recent relevant societal debates around young people and sex. Finally, I will outline the overall study including my motivations and interests in studying contraception as a social scientist. I will present my research aims, purpose and questions that have guided and informed my work, and the wider relevance and significant of this research.

1. What are contraceptives?

Contraception and contraceptives as words stem from *contra,* meaning against, and *conception*, essentially meaning fertilisation, altogether equating to the prevention of conception (in the womb). The ubiquitous fertility and pregnancy focus on this term has at times caused confusion to participants, colleagues, and wider audiences during this research process. Contraceptives and contraception as words do not adequately include STI preventing efforts and have raised the issue

[3] Substances that will induce an abortion.

of whether contraception should even be used at all in this project. Unfortunately, the English language offers few viable or satisfactory alternatives. In fact, alternative terms such as birth control, birth prevention, family planning, and fertility control spotlight pregnancy prevention even more overtly than contraception does.

In Swedish, my native tongue and the language of most my interviews, the word for contraceptives is "preventivmedel" or "preventivmetoder", directly translating to preventive means or preventive methods, which has felt more fitting within the context of that language. Whilst still often being defined and associated primarily with pregnancy prevention endeavours, these Swedish words are not as intimately tied – linguistically speaking – with pregnancy and fertility and they open up more for referring to both pregnancy and STI prevention. While I wish there was a word in English like "preventivmetoder", I ended up concluding that contraception and contraceptives were the best options at this moment in time, for this project.

Most existing contraceptive methods are designed only for preventing pregnancies and a lesser amount designed only with STI prevention in mind, though the most commonly used contraceptive method – condoms – can have dual purpose: pregnancy and STI prevention. While existing contraceptive technologies and methods for pregnancy and STI prevention are almost completely separated, the individual experience or concern with pregnancy and STI prevention is often far more intertwined practically, socially and structurally. Wanting to be able to capture experiences of both STI and pregnancy prevention, I have therefore instead opted for a broader definition of contraceptives. I also use the term *contracepting* as a verb to emphasise that contraception is an activity and doing.

Within this research I use the terms contraceptives or contraception to refer to all methods or strategies that can be used to attempt to prevent a pregnancy or STI. I also include different abortion methods as part of the contraceptive repertoires, as they are used to prevent a pregnancy from being carried out and are important tools in sexual and reproductive health.

When it comes to contraceptive methods there are a few important distinctions and categorisations that I want to highlight to help the reader understand the experiences of contracepting explored in this study. These distinctions are particularly relevant for distinguishing and making sense of different pregnancy preventing contraceptive methods.

Firstly, there is the distinction between contraceptive methods that are *technologies* or *devices*, such as condoms or the pill, and contraceptive strategies that are *practice-based* such as fertility awareness or withdrawal methods. Contraceptive technologies or devices are more tangible material objects that are either worn, consumed, or injected into the body while more practice-based methods are techniques that are not necessarily dependent on anything other than, for example, paper and pen to track menstrual cycles. This distinction, however, is not always clearcut.

The second distinction I want to note is a temporal one: between *short-term* and *long acting*. A short-term or one-off contraceptive method includes contraceptives that are used only immediately after or shortly before a sexual activity, such as condoms, and only have an effect for a shorter period of time. Longer acting contraceptive methods, on the other hand, are ones that are active constantly for a longer period of time, such as the pill. Most long-acting contraceptive methods are *reversible*, that is, after you stop using them your ability to get or make someone pregnant returns. Non-reversible or permanent contraceptive strategies include different sterilisation methods. A common categorisation of contraceptive methods used today within contraceptive counselling and wider conversation around pregnancy prevention relating to these terms are so-called *Long-Acting Reversible Contraceptives*, or in short, LARCs. LARCs can be both hormonal and non-hormonal and are categorised as pregnancy preventing contracepting methods used over an extended period without requiring user action.

Methods for preventing pregnancies and what they involve

When it comes to contraceptive methods aimed at preventing an unwanted pregnancy, the vast range of existing technologies and devices as well as practice-based methods are aimed at people with a uterus that can get pregnant. For people with penises, there are currently only two methods they can employ themselves to prevent pregnancies: condoms and vasectomies.

The effectiveness of contraceptive methods is usually measured through the Pearl Index, which is measured by the number of pregnancies per 100 women using the method per year. Pearl Index measures usually distinguishes between typical and perfect use. Perfect use means that the contraceptive method is used correctly and consistently, that is, it is a hypothetical number. Typical use on the

other hand is meant to capture the effectiveness of the method when used in real-life contexts. It is common that methods are not used perfectly, especially those that require a lot of human interaction and action such as condoms or the pill. LARCs such as hormonal and copper IUDs or the implant tend to have more similar levels of effectiveness when it comes to perfect and typical use. As such, they are often deemed the most effective contraceptive methods currently accessible when it comes to pregnancy prevention (Läkemedelsverket 2014, 14). On the Pearl Index, methods are considered highly effective at 0-0.9, effective at 1-9, moderately effective at 10-19, and less effective at 20 or higher.

In table 1, I have outlined the most common contraceptive methods for pregnancy prevention, including how they are used, how they work and their effectiveness when typically used. I find it both medically and sociologically more relevant to provide the level of effectiveness of the methods in terms of actual or typical use, which is why I chose to exclude the numbers for perfect use. As seen in the table, there are a range of methods. The Pearl Index numbers (that is, effectiveness in typical use) can be seen in the most right-hand column. These numbers are estimated largely from the United States, and cannot, as such, be directly assumed to translate to the Swedish context or other contexts. However, they give some indication to the relative efficacy of different methods. The table is a not a complete list of all existing methods or strategies. For example, there are a variety of different natural or fertility-awareness methods that slightly differ from each other, though all involve practises of trying to prevent a pregnancy by avoiding unprotected vaginal sex during fertile days.

One method missing from the table that is part of the pregnancy prevention repertoire is abortions. The Swedish abortion law today gives all people in Sweden (whether or not you are a citizen or resident) the right to terminate a pregnancy. Until week 18 of the pregnancy, you can freely request an abortion without needing to provide reasoning. After week 18, you need permission from the National Board of Social Affairs and Health and there needs to be special reasons, such as detecting a foetal abnormality or if the pregnant person is very young. There are two different kinds of abortion methods: medical abortion (by taking a pill) and surgical abortion.

Table 1. Common contraceptive methods for pregnancy prevention, how they are used, how they work and their effectiveness (Pearl Index)

Method	How it is used	How it works*	Effectiveness, typical use**
Implant	Small plastic rod placed under the skin of your upper arm, where it releases a type of hormone.	Thickens cervical mucous to block sperm and egg from meeting, and prevents ovulation	0,1
Male sterilisation (vasectomy)	Surgical procedure to cut or seal tubes that carry sperm.	Keeps sperm out of ejaculated semen.	0,15
Female sterilisation (tubal ligation)	Surgical procedure to block, seal or remove fallopian tubes.	Eggs are blocked from meeting sperm.	0,5
Intrauterine device (IUD) levonorgestrel	T-shaped plastic device that's inserted into the uterus, where it releases a type of hormone.	Thickens cervical mucous to block sperm and egg from meeting.	0,7
Intrauterine device (IUD): copper containing	T-shaped plastic device wrapped in copper inserted into the uterus.	Copper component damages sperm and prevents it from meeting the egg.	0,8
Lactational amenorrhea method (LAM) (for 6 months)	While breastfeeding exclusively, your body naturally stops ovulation.	Prevents the release of eggs from the ovaries (ovulation).	2
Monthly injectables or combined injectable contraceptives	A type of hormonal injection that you take every month.	Prevents the release of eggs from the ovaries (ovulation).	3
Progestogen only injectables	A type of hormonal injection that lasts up to 2-3 months (depending on the type).	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation.	4
Combined oral contraceptives or "the pill"	Hormonal pills taken every day orally.	Prevents the release of eggs from the ovaries (ovulation).	7
Progestogen-only pills or "the minipill"	Hormonal pills taken every day orally.	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	7
Combined contraceptive patch	Small sticky patch applied to leg, arm, back, or similar, where it releases a type of hormone.	Prevents the release of eggs from the ovaries (ovulation).	7

Combined contraceptive vaginal ring	Soft, plastic ring that you place inside your vagina, where it releases a type of hormone.	Prevents the release of eggs from the ovaries (ovulation).	7
Fertility awareness-based methods* **	Tracking your menstrual cycle to predict when you'll ovulate and be most fertile.	Avoiding unprotected vaginal sex during estimated fertile days.	12 - 15
External condoms	Sheath-shaped barrier device worn on penis, commonly made of latex.	Forms a barrier to prevent sperm and egg from meeting.	13
Diaphram/pessary, with spermicide	A barrier method placed inside the vagina.	Forms a barrier to block sperm from passing through the cervix.	17
Withdrawal (coitus interruptus)	Taking the penis out of the vagina before ejaculation.	Tries to keep sperm out of the vagina, preventing fertilization.	20
Internal condoms	Barrier device worn inside the vagina.	Forms a barrier to prevent sperm and egg from meeting.	21
Emergency contraception pills	A type of hormonal pill taken soon after sexual intercourse.	Prevents or delays the release of eggs from the ovaries. Pills taken up to 5 days after unprotected sex in order to prevent a pregnancy.	-
No method			85

*The explanations of how the different methods work are based on World Health Organization (2020) descriptors.
**These estimations for effectiveness of contraceptive methods (i.e. Pearl Index) is based on Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project and World Health Organization Department of Reproductive Health and Research (WHO/RHR) (2018).
***Examples of natural or fertility awareness methods include: Standard Days Method, Basal Body Temperature Method, TwoDay Method, and Sympto-thermal Method.

The first contraceptive pill (the combined oral contraceptive) was approved by the US Food and Drug Administration (FDA) in 1960 for commercial use (Marks 2001). Soon after, in 1964, the pill was approved for prescription in Sweden (Folkhälsomyndigheten 2019, 209) followed by the hormonal coil in 1966. During the 1970s we saw several more contraceptive developments in Sweden: emergency contraceptives became available (Folkhälsomyndigheten 2019, 209) and the copper coil and minipill were approved for prescription (RFSU 2017). In

1975 the law legalising free abortion came into force for Swedish citizens, however, it was only in 2007 that non-citizens were given the right to get an abortion in Sweden (RFSU 2017).

In contrast to these contraceptive methods, which mainly involved legal change to allow them to be prescribed and used in Sweden, sterilisation as a contraceptive method has a more complicated history. For much of the 20th century in Sweden, performing involuntary sterilisations on specific marginalised groups was both socially and legally sanctioned[4]. In the mid-1970s these laws were changed so that sterilisation procedures could only be carried out if an individual is 25 years old (or older) requests one themselves (Tydén 2000, 16), with some notable exceptions. Specifically, it was only in 2013 that the requirement to get sterilised was removed in order to receive gender affirming care.

Most contraceptive methods, and the most commonly used methods for preventing pregnancies, involve some form and level of hormone. Like with any pharmaceutical product, hormonal contraceptives can have a series of side effects. While they have reduced in severity compared to early hormonal methods, they can seriously impact a person's health. As such, while the introduction of the pill and having access contraceptive technologies contributed immensely to women's liberation and autonomy in the 1960s, these were increasingly scrutinised and criticised in the 1970s and 1980s by women's health advocates (Hardon 1992, 735).

In Sweden there have been two randomised double-blind studies on the combined hormonal pill (Folkhälsomyndigheten 2019, 209). One of these studies showed that the pill affected the overall wellbeing in a negative way, and the other indicated an increase in anxiety, irritability, and mood swings (Folkhälsomyndigheten 2019, 209). Regarding positive side effects, one of the studies saw an improvement in premenstrual depression associated with the pill.

[4] In 1934, an amended sterilisation law was introduced making it possible to carry out sterilisation procedures if a person was deemed lacking the ability to understand the meaning of the sterilisation, what was referred to at the time as legal incapacitation (Tydén 2000). This bill came from the State Institute for Racial Biology, established in 1922. In 2000 the Swedish government conducted a public investigation into the sterilisation laws, including the role and responsibility of different actors in developing and administering it from the 1930s until 1976 (when the then most recent sterilisation law entered into force). The majority of those sterilised were women (93%), and as they note in their findings, the application of these sterilisation laws have particularly affected 'vulnerable and underprivileged groups" such as individuals with mental or physical disabilities or 'members of ethnic minorities and indigenous groups (Tydén 2000, 17).

While these two studies did not see any impact on sexual libido, other studies in Sweden have found people using hormonal methods report a decrease in libido twice as much as those on hormone-free contraceptives (Folkhälsomyndigheten 2019, 209).

With that said, there is much researchers do not know about the impact of different type of hormonal methods and assessing side effect involves a lot of uncertainty (Littlejohn and Kimport 2017). In fact, it has been shown that it is common for there to be disparities and differences between the views of providers and users regarding the presence and severity of side effects associated with hormonal contraception as well as methods such as the copper coil (Harrington et al. 2015; Stevens 2018; Berndt and Bell 2021; Gunnarsson and Wemrell 2022). The development of new hormonal contraceptive methods for pregnancy prevention is ongoing, and with it our knowledge of their short-term and long-term impact on the body, whether negative or positive.

Methods for preventing STIs and what they involve

When it comes to contraceptive methods aimed at preventing an unwanted STIs, there are far fewer methods available compared to pregnancy prevention options. The most common method used for STI prevention is the condom. There are broadly speaking, two different types of condoms: the external and the internal condom, with the prior being more common. The modern condom was first developed in the 19th century after the discovery of the rubber vulcanization process by Charles Goodyear (Khan et al. 2013, 14). However, it was not until the invention of the stretchy material latex (derived from natural rubber) in the 1920s that condoms developed into what they are today (Khan et al. 2013, 14). For people with a latex allergy there are latex-free condoms, usually made from a flexible type of plastic. The external condom (sometimes referred to as the "male" condom) is a barrier method worn over the penis but can also be used on sex toys such as dildos or vibrators. The internal condom (sometimes referred to as the "female" condom or Femidom) can be used by inserting it into the vagina or anus before having sex. Besides condoms, the dental dam is another barrier method that can be used to prevent STIs. Dental dams are made from similar materials to condoms, but in the shape of a thin sheet that is used between the mouth and vagina or anus during oral sex.

In the beginning of the 20th century in Sweden, condoms were known by names such as *Eros* and were likely mostly aimed at men who had sex with sex workers and wanted to avoid STIs (RFSU 2014, 10). In 1946 Swedish pharmacies were mandated to sell condoms and in 1959 selling condoms via vending machines became allowed (RFSU 2014, 10). Today, condoms can be found in various sizes, colours, flavours, and functions.

More recent developments when it comes to methods for preventing specifically HIV[5] (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) is found in the development of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). PrEP is a type of medicine that can be taken by HIV-negative people before and after sex to reduce the risk of getting HIV. PEP is a medicine you can take to prevent HIV after a possible exposure, thus being used along similar lines as the emergency contraceptive pill does for pregnancies. The first PrEP drug Truvada was approved by the FDA in 2012. The use of PrEP in Sweden was approved in 2016 by the Swedish Medical Products Agency (Hansson et al. 2020, 2). However, as Disa Hansson et al., note, 'very few clinics started offering PrEP at this time due to logistical and funding concerns' (2020, 2).

Besides barrier methods like condoms and drugs like PrEP, it is also relevant to mention STI testing as important tools for preventing, detecting, treating, and reducing the spread of STIs. The most common method of testing for STIs is to provide a urine sample. In some cases, you may need to leave a blood sample or have a physical examination by a healthcare professional (1177 2019). The most recent of various legal frameworks in Sweden regulating disease control and communicable diseases is The Communicable Diseases Act (SFS 2004:168) from 2004. It mandates certain serious highly infectious diseases to be reported and contact traced, including the following STIs: Gonorrhoea, Hepatitis B, HIV, Chlamydia, and Syphilis. As such, legally you must get tested if you know or suspect that you have one of these. All STIs can be cured except for HIV, herpes, and chronic hepatis B, for which one can take inhibitor drugs, though you will always continue to carry the disease (1177 2019).

The final existing type of method aimed at preventing STIs is vaccines. According to the World Health Organisation, there are currently only two safe

[5] HIV is technically not a sexually transmitted infection but a virus that can be sexually transmitted.

and highly effective vaccines for viral STIs: hepatitis B and HPV (human papillomavirus) (World Health Organization 2023). The public awareness of the latter, HPV, has increased in recent years due to the roll out of vaccines in many countries to children ages 11 and 12 (Pfizer 2022). The HPV vaccine was first offered in Sweden in 2010, though only to girls in school year five and six. Since fall of 2020, the vaccination is offered to both girls and boys in year five (Folkhälsomyndigheten 2022a).

2. Entering the Swedish contraceptive landscape

It is challenging to quickly and succinctly paint a picture of a country, especially one such as Sweden which has worked so deliberately on its public profile and brand, both internationally and domestically (Glover 2009), with strongly established stereotypes and images (Simons 2011; Christensen 2013). One of these images, or discursive concepts, is of Sweden as a 'progressive model country' (Glover 2009, 247). In fact, Sweden has long been painted as a progressive utopia on a range matters, including sex. In the 1950s and 1960s, Sweden was considered by 'its admirers to exemplify the type of progressive, modern, 'permissive' society' that English-speaking campaigners for greater liberation' desired in their respective countries (Fennell in Zetterberg 2021b, 11). Swedish reforms around, for example, sex education as well as Swedish films (like *The Mistress* and *Summer with Monica*) drew international attention 'making 'Swedish sin' an international concept' (2014, 29). As Lena Lennerhed writes, Sweden was at this time 'sometimes described as a social laboratory where rationality and science had replaced traditional values and Christian morality' (2014, 29) in which the state was seen to have 'pushed through a sexual revolution from above' (2014, 29).

Sensationalist accounts of Sweden and its sexual history are appealing and common, yet simplistic and one-dimensional. I agree with Lennerhed's conclusion that 'it is more meaningful to speak of a sexual revolution in the context of long-term changes in the regulation of sexuality' (2014, 42). She continues,

> (…) one might start with the 1880s neo-Malthusian fight for contraceptives, go on to the RFSU's 1930s battle for contraceptives and the government's concurrent reforms in favour of 'enlightened and healthy' sexuality, continue through the

> decriminalisation of homosexual contacts in the 1940s, the introduction in the 1950s of mandatory sex education in school, and end with the many liberation projects started and carried through during the 1960s and 1970s. (Lennerhed 2014, 42)

As Lennerhed notes, change and development is gradual, and the development she describes was neither 'straightforward nor uniform' (2014, 43). However, despite acknowledging conflicting ideas and ideals regarding sexuality, Lennerhed argues that these historical events still point in a particular direction of change, 'towards democratisation, individualisation and a policy of rights' (2014, 43) in which a new path has been paved 'for pleasure but also for a new norm: the well-informed individual who decides when, with whom and how to have sex' (2014, 43).

Contraceptive information and sexual education

As already mentioned, sexual education (including contraception and pregnancy and STI prevention) has been mandatory in Swedish schools for a long time. In 1901, the first classes in 'sexual hygiene' (the pre-cursor to sexual education) were held for girls in Stockholm. In 1910, the *Lex Hinke* law took effect, prohibiting spreading information around contraceptive methods, which was subsequently abolished in 1938 (Svensk Förening för Obstetrik och Gynekologi 2013). In 1942 sexual education was introduced on a voluntary basis in primary school. In 1945 the first official teacher training in sexual education was held by the school board, and in 1955 sexual education became mandatory in schools (RFSU 2017).

Of course, what this sex education has involved has changed over time and continues to do so, as norms around sex, gender, and sexuality continue developing. Although Sweden was deemed advanced for its sexual education programs in the 1960s, 'the official content and delivery was still moralistic and repressive' (Fennell in Zetterberg 2021b, 13). For a long time, sexual education was called *sex and coexistence* with a somewhat unique and defining feature in recent years being the emphasis on including and integrating it across different subjects. However, during the autumn of 2022, there were extensive changes made to the way sexual education is structured and taught. This included changing the name from *sex and coexistence* to *sexuality, consent and relationships* (Skolverket 2023).

This change reflects several interesting issues. It signals taking sexual education seriously as an area of distinct knowledge, that must be provided to teachers and

not assumed to be possessed by virtue of being adults. Secondly, it responds to calls from across society – including from young people – who have been asking for more emphasis on interpersonal relationships, practices around consent, and about the diversity of gender and sexual identities: topics that they have found to be missing in past sex education classes. Brian David Unis and Christina Sällström noted in 2019 that young people's rating of sex education in schools has been decreasing over time, falling behind the internet and youth clinics as sources for information about contraception and STIs (Unis and Sällström 2019, 27).

When it comes to receiving and accessing information around contraception and pregnancy and STI prevention, sexual education matters a great deal. Yet, time and time again, it is reported that young people are dissatisfied with their experiences of sexual education (Bolander 2015; Folkhälsomyndigheten 2017; Kramsjö 2020). In 2017, through their report[6] on sexuality and health among young people in Sweden, the Public Health Agency found that 49% of young people felt that they had received adequate knowledge or understanding of their sexual health while 44% felt they got too little and 7% that they had not received any sexual education at all (Folkhälsomyndigheten 2017, 80). More boys (58%) than girls (41%) reported that their school had provided them adequate education to maintain their sexual health, and among non-binary students only 32% felt it was adequate (2017, 80).

In the report, it was highlighted that young people felt that schools were better at providing adequate education around certain subjects, such as on how to get pregnant (75%), knowledge of the body (64%) and knowledge of condom usage (62%) (2017, 80). On the other hand, they felt that the areas in which schools had not provided adequate education included gender, relationships and gender equality (35%), HIV (31%), and norms and LGBT perspectives (25%) (2017, 80). The report highlights three main areas where young people wanted more information. This included how to make a relationship work well (30%), the current situation for those living with HIV (28%), and how to find someone to have a relationship with (21%) (2017, 81). Finally, the two main areas where young people saw a need for health promotion and prevention work included cheaper contraceptives (46%) and free condoms (41%) (2017, 81).

As I will go on to illustrate and explain in this thesis, the everyday experience, and practices of becoming informed about contraception as a young person can

[6] The report was based on a randomised survey-based population study conducted in 2015.

look quite different from what is imagined or enforced by the state, schools, healthcare institutions, parents. and the adult world. Of course, recent such changes to sexual education efforts in schools do not become implemented completely overnight and considering the many decades that sexual education has been mandatory in Swedish schools, I suspect it will take some time before we can see the extent to which recent changes bear fruit. As a result, the participants in my study had not experienced the most recent changes to sexual education in schools.

Accessing contraceptive methods and care as a young person

When it comes to young people, and contraceptive counselling, access, and praxis in Sweden there are a few actors, worth familiarising oneself with. Central actors that work explicitly with sexual and reproductive healthcare provision around contraception and STIs include (depending on the region a young person lives in): midwife clinics, gynaecology clinics, women's health clinics, clinics for sexual health, local general practices, and pharmacies. There are also influential member-based organisations around sexual education and sexual politics like The Swedish Association for Sexuality Education (RFSU) and The Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights (RFSL). In some locations (mainly the larger cities) these organisations run sexual health clinics or provide other support services.

However, no actor is more impactful than the Youth Centre or Youth Guidance Centre (in Swedish, "Ungdomsmottagning"). The first Youth Centre was opened in 1970 (RFSU 2017) and is a clinic where young people can seek help with questions around the body, sex, or contraceptives or to receive counselling. Depending on the region, the ages vary for who can access their services ranging from 12-13 years old up until you are 20 or 25 years old[7] (UMO 2020). It is a free service until you are 18, and in most places when you are over 18 as well. What is unique, is that children at any age can access their services and book an appointment without needing a guardian's permission or approval. Privacy and confidentiality has been shown to be a vital factor for visiting the Youth Centre (Thomson et al. 2022) and being able to be more comfortable discussing sensitive issues (Thomson et al. 2022, 6).

[7] Sweden's legal age of consent to have sex is 15 years old.

According to The Swedish Society for Youth Centres, there are more than 250 clinics across Sweden (FSUM 2018b, 3). The overarching goal for Youth Centres is to 'promote physical and mental well-being, focusing mainly on sexual and reproductive health and the rights of youth and young adults (…) achieved through a comprehensive medical, psychological, and psychosocial perspective' (FSUM 2016, 3). A mixture of professions makes up those working at these centres, with the most common ones being counsellors and midwives. Midwives were given the right to provide contraceptive counselling in 1972 (RFSU 2017) and are usually the ones providing contraceptive counselling.

When it comes to accessing contraceptive methods as well as information about contraceptives, pregnancy prevention and STI prevention as a young person, the youth centres have played a central role. One of the most common reasons for visiting a youth centre is the desire for contraceptives, and those mostly seeking out contraceptive counselling here are girls, sometimes accompanied by boyfriends (Svensk Förening för Obstetrik och Gynekologi 2013, 65). As Claes Gottleib writes in SFOG's report, while youth centres are frequented much more by girls than boys, when young men do go the most common reasons include STIs or concerns about their genitalia (Svensk Förening för Obstetrik och Gynekologi 2013, 61).

In 2013, The Swedish Association of Local Authorities and Regions adopted a general recommendation around contraceptive subsidisation across all regions. They proposed that individuals below the age of 26 should access contraceptive methods for a maximum price of 100 SEK[8] per year, providing that the method was covered by the drug benefit system (RFSU 2019, 5). Until 2015, each region decided the age cap for women able to access subsidised contraceptive methods which meant that it could vary greatly how much you paid for contraceptive methods depending on where you lived. As a result of these recommendations, from January 2017, most contraceptive methods became free for young people under the age of 21 across Sweden – in some regions contraceptives are also cheaper until you turn 26 (RFSU 2019; 1177 2022). The 2017 state subsidy enabled all young women and/or people able to get pregnant to freely access hormonal contraceptive methods such as the pill or the hormonal coil. Before this, hormonal contraceptive methods were subsidised within the so-called drug benefit, which caps the amount an individual may pay for medical drugs per year.

[8] Swedish krona, the national currency of Sweden.

Since condoms are not classified as a medical drug, they are not covered by drug benefit systems. However, condoms are often free (or at a low price) at youth centres or sexual health clinics. They are also sold at pharmacies, convenience shops, and grocery stores as well as online vendors. Depending on the size of packet and brand, RFSU estimated that a box of condoms cost around 50 to 150 SEK, equating to around 5 SEK per condom (RFSU 2016). Dental dams and femidoms can only be bought and found in more specialised shops, usually online, and more expensively. Emergency contraceptives, like the morning after pill, can be bought without a prescription at pharmacies or at Youth Centres.

Testing for STIs can be done in a variety of places and ways in Sweden, including Youth Centres, sexual health clinics and GPs (UMO 2023). In some locations, there are specific clinics where men who have sex with men can get tested, and for people with a uterus you can also visit a midwife or gynaecological clinic. More recently and increasingly, you can also order or buy home-tests at the pharmacy for certain STIs. All treatments and medicines for diseases that are covered by Communicable Diseases Act are free (Folkhälsomyndigheten 2023), while other STI treatments need to be paid for (1177 2019). In 2017, the most common places young people went to get tested for STIs were Youth Centres (46%), GP (20%), midwives clinics (113%) or by ordering a home-test online (7%), other venereal, gynaecological or similar clinics (7%), and infectious disease clinic (7%) (Folkhälsomyndigheten 2017, 70).

Contraceptive use and recent contraceptive trends in Sweden

Sweden, like many countries, is committed to implementing the Sustainable Development Goals (SDGs) of the UN 2030 Agenda, which includes ensuring 'universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes' (Berg et al. 2021, 17). One of the indicators for this goal is SDG Indicator 3.7.1. on Contraceptive Use: 'Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods' (United Nations Statistics Division 2023). Sweden does not have statistics for this measurement, only for 'use of contraceptive methods among women' (SCB 2021), which in 2017 they calculated to be 78% among women aged 16-29 years old.

Based on official sales statistics, the most common contraceptive method in Sweden since 2010 is combined hormonal methods (the pill, patch, or vaginal ring) followed by the hormonal coil (Lindh 2014, 32) which is steadily increasing while the sale of the copper coil is somewhat decreasing (2014, 33). The group with most prescription for hormonal contraceptive methods since 2010 was young people aged 20-24 years old (2014, 32). According to The National Board of Health and Welfare, the proportion of women that have picked up prescriptions for long-acting contraceptive methods (specifically, the hormonal coil and implant) has increased by more than 60% between 2011 and 2019 (Socialstyrelsen 2020, 1). During the same time, short-term contraceptive methods – of which the pill was the most common – decreased by almost 20%. The National Board of Health and Welfare speculate that a contributing factor to this trend is that it is increasingly common to offer the coil to women who have not been pregnant, contributing to the increasing use of the hormonal coil among young women (Socialstyrelsen 2020, 2)[9].

In a large study[10] carried out in 2015 called UNGKAB15 on sexuality and health among young people aged 16-29 years old in Sweden, questions were asked about the contraceptive methods that were used during the most recent sexual activity (Folkhälsomyndigheten 2017, 64). Among respondents, 50% had used a hormonal method, 25% had used a condom throughout the sexual activity, 8% had used withdrawal, 4% had used a condom that was worn just before ejaculation, 4% used a copper coil, and 3% used so-called safe periods. A very small percentage had used the internal condom or pessary while 8% reported that they had not used any method since the type of sex they had did not require protection. Another 7% indicated that another type of method than the available survey responses was used, with the fertility computer[11] particularly being given as the method used (Folkhälsomyndigheten 2017, 64). When it came to emergency contraceptive method use among young people, 1% responded that they had used it after their last sexual instance (2017, 74). Amongst people who

[9] This statistics include contraceptive methods that are prescribed and picked up from a pharmacy, which means that prescription-free methods, such as the copper coil, pessary and condom were not included (Socialstyrelsen 2020, 2).

[10] This was a randomised survey-based population study.

[11] A fertility computer is a technological device used to measure basal body temperature and calculate when, during the menstrual cycle, one is at most risk of becoming pregnant. It is a type of fertility awareness method.

did not want to categorise themselves based on sex or gender[12] this was more common (4%) and as well as among girls aged 16–19-year olds (3%) (2017, 74).

Other national statistics have suggested that 71-76% of young people used some sort of contraceptive method during their first time having sex, with condom (60-70%) being the most common method (Lindh 2014, 32). However, while condoms are by far the most commonly used methods at the first sexual encounter, it has been shown to decrease in use, often replaced by other contraceptive methods (Tydén and Larsson 2014, 71). In a report from the Swedish Medical Products Agency, written by a series of well-established Swedish researchers and scholars on contraceptives, it was argued that the 'sexual risk behaviours' among the group 16-24 year olds have increased, especially among women (Tydén and Larsson 2014, 71). This referred to things such as having anal sex without condoms and having sexual intercourse on '"the first night"' without using condom (2014, 71). It was suggested that the most important factor for young people not using condoms was because the woman is on the pill (2014, 71).

Most young people surveyed in the UNGKAB15 study did answer that they find it important to protect yourself with contraceptive methods to avoid getting pregnant or an STI (if there is such a need within the sexual relationship) (Folkhälsomyndigheten 2017, 62). They also found that 89% of respondents felt that they could suggest using condoms or another contraceptive if they wanted the last time they had sex (Folkhälsomyndigheten 2017, 63). There was no statistically significant difference between girls and boys (90% and 89%), but a marked decrease for those who did not want to categorise themselves based on sex or gender (78%). Another noteworthy finding from this study was that the highest proportion (13%) that did not know if it was important with pregnancy prevention methods in a sexual relationship was found among boys aged 16-19 years old (Folkhälsomyndigheten 2017, 63).

Determining trends in condoms use is quite tricky, such as whether their use is increasing or decreasing, and whether it differs among people. In the nation-wide population 2017 study on sexual and reproductive health in Sweden, it was found that among women aged 16-44 years old, 27-42% had used condoms during the last year and 70-82% at some point of time during their life. Among men the proportion that had used condoms at some point was 71-87%

[12] In Swedish the term "kön" was used which technically means sex but is often used to speak of gender as well. A direct translation of gender exists ("genus") but is not as commonly used as gender is in English.

(Folkhälsomyndigheten 2019, 213). Adding further nuance to condom trends in Sweden, UNGKAB15 found that (among young people) a higher percentage of girls (73%) compared to boys (66%) and people who did not want to categorise themselves based on gender (68%) thought that a partner that suggests using condoms is responsible and caring (2017, 64).

The most common STIs young people reported to have or have had were chlamydia (11%), condyloma (4%) and genital herpes (2%), followed by gonorrhoea, hepatitis B, hepatitis C, and syphilis. A higher percentage of girls reported having had STIs (15%) than boys (7%) and those who did not want to categorise themselves based on sex or gender (4%) (Folkhälsomyndigheten 2017, 68). One can only speculate whether this difference is due to higher actual rates in the population or because girls are more likely to get tested for STIs, which the study also found. Most young people (89%) believed that it was important to protect yourself against STIs if needed in a sexual relationship (2017, 63). However, when it came to whether you thought it was important to get tested in a sexual relationship, the number the was lower (71%) and again more commonly believed among girls (79%) compared to boys (63%) (2017, 69). A higher number of boys reported that they did not find it important to get tested, especially amongst young men aged 25-29 (2017, 69). In total, 53% of all respondents in this study had gotten tested for an STI, HIV, or hepatitis. In relation to chlamydia specifically, the proportion of girls (64%) that had gotten tested for it was almost double compared to boys (31%) with the largest gendered difference to be found in the 16-19 age group (2017, 70).

Finally, the levels of abortion in Sweden have been relatively constant across the population according to The National Board of Health and Welfare, whereas abortion among younger people continue to decrease (Socialstyrelsen 2023, 1). In 2021, they report that around 8 abortions were done per 1000 girls aged 15-19 years old, which is a drop from the 25 per 1000 in 2006. Amongst women aged 20-24 years old abortions have dropped from 35 per 1000 women in 2008 to 22 per 1000 in 2021 (Socialstyrelsen 2023, 1). Since 2016, abortions are most commonly used among women aged 25-29 years old. In their report, The National Board of Health and Welfare suggest that an important contributing factors to this trend is the increased use of long-acting contraceptive methods among younger women (Socialstyrelsen 2023, 2).

Some recent societal debates around young people and sex

In 2019 the Swedish government tasked the Public Health Agency to develop a national strategy for sexual and reproductive health and rights. One year later it was published (Folkhälsomyndigheten 2020) with an overarching goal: 'good, fair, and equal sexual and reproductive health throughout the population' (Folkhälsomyndigheten 2022[13]) with sub-targets related to contracepting such as that everyone has the freedom and/or right to: 'have pleasurable sexual experiences without risk of sexually transmitted infections and unwanted pregnancies' as well as 'safe and secure healthcare during pregnancy, childbirth, and abortion' (2022, 6).

Specifically related to young people and young adults, sexuality was noted as particularly significant and something 'that impacts the development of a person's identity in various ways, as well as their social development, meaning it is significant to sexual health throughout life' (2022, 19). They also highlighted that young people and young adults 'tend to have more sexual partners and take more sexual risks' which exposes them to 'greater risk of contracting sexually transmitted infections' and unwanted pregnancies (2022, 19), thus making them a demographic group of particular concern and importance. Other recent policy developments and changes concerning young people's sexual and reproductive health include the state subsidising of contraceptives for women up to 21 years old in 2017 (RFSU 2017).

In 2020, sexual education become a mandatory element in teacher training courses (Öhman 2021) after heated societal debates around young people and sex. The triggering event for this debate and change was a viral Facebook post made by a Youth Centre midwife in mid-August 2020 raising the alarm about young people seeking care after, and young girls especially being pressured into, what was referred to as rough sex, in large part due to the rising influence of violent porn. This garnered significant attention, ultimately leading to the Swedish Minister for Higher Education and Research making the following public statement in early September of the same year: 'children and youth must get a reasonable and good image of sex, you must get that from school, not the porn

[13] The original strategy was published in 2020 in Swedish. An English version of the strategy came out in 2022.

industry[14] (Matilda Ernkrans, Minister for Higher Education and Research, quoted in: Jonasdotter Nilsson 2020).

This is not the only recent societal debate around children and young people's sexuality in Sweden. In recent years, there has been increasing call for the necessity of having conversations around bodies, boundaries, consent and sexuality with children, with a myriad of articles on the topic of how you talk to your children about sex (Sjöström 2009; Persson 2013; Lund 2016; Von Knorring 2017). Following the heated debate and anxiety around young people having rough sex which began during the end of summer of 2020, there have been more recent calls focusing on how you talk to your child about porn (Svedlund 2020; Hammenstig 2021; Welin 2021). This cultural shift is partly the result of significant campaigning from children's rights organisations like Save the Children encouraging parents to speak to their children about sexuality and boundaries through campaigns like *Stopp! Min kropp!* (which translates to, Respect! My body!) based on sharing resources developed specifically for parents on how to communicate with children from an early age about the body, boundaries, and sexual violence. It can also be attributed to feminist organisations like Fatta[15] campaigning around consent on modernising the sexual offence legislation including the 2018 culmination of a successful campaign for a so-called consent law.

I call it a cultural shift; however, this move still fundamentally originates from a more long-standing concern and historical societal fear around children's vulnerability to sexual victimisation. And while there have been many arguments for more open dialogue about sex with children and young people, there has also been backlash against some of this discourse, including against sexual and reproductive rights organisations like RFSU and RFSL, especially regarding the former's advocacy around sexual education. In a sense, this cultural shift has therefore also been accompanied by a renewed fanning of anxieties around children's and young people's sexual lives and sexuality, resting on the oft-used logic of letting children be children with the implication that this means being non-sexual.

[14] Translation of quote: "– Barn och unga ska få en rimlig och bra bild av sex, man ska få det av skolan, inte av porrindustrin" made by the Minister for Higher Education and Research, Matilda Ernkrans, on September 3rd 2020 to SVT (Swedish national public television broadcaster)

[15] "Fatta" broadly translates as understand or comprehend, or more colloquial connotations like "get it".

The current landscape in Sweden contains shifting discourses and new narratives around the relationship and responsibility of the family when it comes to children and sex, but also persisting historical narratives echoing moral panics and fears over children's innocence at risk of corruption. Ultimately, societal debates around young people's sexual and reproductive lives in Sweden has tended to focus on the worries, fear and perceptions of adults and society as a whole rather than engaging with young people themselves and trying to understand their experiences and practices around sex. This thesis aims to strike a different course by focusing on young people's stories around sexual and reproductive health matters, and experiences with contraceptives more specifically.

3. Outlining this study and its research puzzle

After having familiarised the readers with contraceptives as a phenomenon and the sexual and reproductive landscape in Sweden for young people, I will now turn to outlining my own study and the research puzzle I set out to explore.

Why study contraception as a social scientist?

I entered this research project with an interest in deepening and nuancing academic understandings of what it means to use contraceptives, to be responsible for contraceptive use and manage one's own (and in some cases other people's) sexual and/or reproductive health. My fascination with contraceptives is not straightforwardly a positive or sceptical one, but one containing a multitude of emotions and ambivalence. This ambivalence has only grown the more I have researched this topic, listened to people's stories, and reflected on current sexual and reproductive healthcare systems. As a feminist researcher, I believe that it is vital that anyone in any body is able to have control over their fertility and prevent getting STIs. However, pregnancy preventing continues to be primarily constructed as women's work, issue, and responsibility and many groups of people are not equally or adequately supported on a structural level in their effort to prevent unwanted pregnancies and/or STIs.

This is evident in many ways, including the fact that while there is a continued development of female contraceptives – with 13 distinct new technologies on the market since the Second World War (Oudshoorn 2003) – the development of

male equivalents remains stunted. This is perplexing considering research into male hormonal contraceptives, for example, have been ongoing since the early 1970s (Eberhardt, van Wersch, et al. 2009). Research is ongoing into new male methods, including the recent Nestorone®/Testosterone Transdermal Gel for Male Contraception with trials being conducted in several countries including Sweden (Population Council 2022; Myer 2023). However, there has yet to be any new male pregnancy preventing contraceptive method available for use.

Contraceptives have been called 'social constructs' or 'social conceptions as well as physical facts' (Russell and Thompson 2000, 6). As a scholar informed by the field of Feminist STS (Science and Technology Studies) or Technoscience, however, I would also trouble the fact-ness of the physical and maintain that contraceptive technologies, while material, are social phenomenon. As critical STS and biomedical scholars have shown, the development and articulation of contraceptives are not natural or self-evident but socially produced (Pinch and Bijker 1984; Martin 1987, 1999; Haraway 1988, 1991; Clarke and Montini 1993; Cockburn and Ormrod 1993; Clarke and Olesen 1999; Ihde and Selinger 2003; Oudshoorn 2003; van Oost, Elizabeth C.J. et al. 2003; Oudshoorn et al. 2004; Åsberg and Lykke 2010; Ernst and Horwath 2013). What is referred to here, is the human subjectivity and power dynamics that shapes and produces the ways in which science and technologies are imagined, developed, researched, designed, promoted, marketed, used, and understood. As such, the reason for why there are vastly more female contraceptives for pregnancy prevention compared to male ones is a matter of complex social factors.

As Marcia C. Inhorn et al. argue, there is an urgent need (both in academia and wider society) to shift the focus away from women being the main contraceptive users, and to bring men into the 'reproductive imaginary, as a reproductive partners, progenitors, fathers, nurturers, and decision-makers' (2009, 3). I would extend this further. Firstly, it is important to consider contraceptive use more holistically as everyday practices related to preventing unwanted pregnancies, STIs *or* an intertwined combination of the two. Secondly, it is vital to broaden the understanding and conversation around contraceptive use for pregnancy prevention to include not only heterosexual cisgender (or in short, cis) women but nonbinary people and transgender (or, in short trans) men as well as bisexual, pansexual, and other queer identifying people that may be concerned with pregnancy prevention. To do so, it is necessary to distinguish sexual and gender identities from sexual practices (something I expand on in chapter 3). Thirdly, it

is important that scholars (and healthcare professionals, policymakers, educators, and advocates) work to better understand how contracepting is experienced and is differently im/possible and stratified depending on, but not limited to, gender, age, and sexuality.

Finally, I believe it is valuable to conceptualise contraceptive experiences and practices through the lens of work: as an ongoing activity that requires a range of efforts, energies, knowledges, and capacities. For those not responsible for contraception, a significant benefit is provided, not only health-wise and financially, but in terms of time and energy saved. Wider societal and academic framings and understandings of contracepting is heavily dominated by medical discourses and institutions that often ignore or minimise many concerns and experiences that young people looking for pregnancy or STI prevention have. While certain aspects of contracepting have been explored in social scientific (and to some extent, medical) studies, generally studies do not sufficiently highlight the full range of experiences and practices that can be involved in the work of contracepting, especially as a young person.

Research aims and research questions

The aim of this research project is to make visible young people's practices and experiences with pregnancy and STI prevention: contracepting endeavours that have been largely invisible, obscured and neglected, historically speaking, in Sweden and beyond.

To achieve this aim, within this thesis I use in-depth qualitative interviews to explore young people's stories of learning about and using different contraceptive strategies, and to describe what pregnancy or STI prevention can involve for young people living in Sweden. Importantly, I analyse their experiences and practices of contracepting by conceptualising these as different forms of work. Utilising concepts of work can help better understand what efforts, resources, skills, and knowledges often go into trying to prevent unwanted pregnancies or STIs. In so doing, I also highlight important challenges related to young people's sexual lives that needs addressing and tackling in Sweden – findings I hope can also find relevance in other settings.

The research questions that have guided me throughout the study and that I will ultimately answer throughout this thesis, are:

1. What are some of the everyday practices and experiences of contracepting as a young person in Sweden?

2. What do these everyday practices and experiences involve?

3. How do young people in Sweden navigate this complex work of contracepting?

4. What can the conceptual lens of work reveal about the everyday practices and experiences of contracepting as a young person in Sweden?

My reasons for focusing on exploring *young people's* contraceptive experiences and practices are largely two-fold. First, adolescence and early adulthood are formative years for developing and affecting one's identity, sense of self, and wellbeing. Sexuality, as already mentioned, plays a particularly significant role within these processes. Adolescence is often a time when individuals make their first sexual debuts[16] and start exploring their sexuality. Second, as researcher I believe that participants are ultimately experts on their own lives (Rickardson 2020). I understand people involved in my research as knowing 'more about their lives than I do, and I embrace the partial, yet rich and detailed, insight gleaned from such work' (Rickardson 2020, 61). Thus, while young people are often spoken about in research and public discourse, they are often not taken seriously as experts on important issues within their own lives, like matters concerning sexual and reproductive health and contraceptives. Considering the concern with young people's sexual lives, I think it of utmost relevance for more research to depart from their own shared stories and experiences with contraceptives.

Regarding the relevance and choice of exploring young people's contraceptive experiences and practices in *Sweden*, my reasoning and motivations is as follows. First, as a nation, Sweden has a uniquely widespread, influential, and strong public image and self-image of progressiveness, gender equality, and welfare: 'an image described by many as 'Swedish exceptionalism'' (Martinsson et al. 2016, 1). In fact, Sweden is often singled out as a 'role model for other countries to follow, the one that has found the way to the future' (Martinsson 2021, 84). One element of this image has been the notion of Sweden's progressive, tolerant, and liberal sexual politics (Zimmerman 2015). However, as Lena Martinsson et al.

[16] I explicitly write sexual debuts in plural, as I understand sex as something that can involve a variety of sexual practices and experiences, including but not limited to: masturbation, petting, genital rubbing or dry humping, fingering, oral sex, and different forms of penetrative sex. What people understand as sex varies a great deal and is ultimately subjective.

argue in their work on challenging the myth of gender equality in Sweden, this is not only an oversimplification but a notion of problematic implication, including the assumption that the gender-equality norm is built on, namely, the idea that societal change such as gender equality is 'gradually achievable as a natural linear processes of evolvement undertaken by Swedes' (Martinsson et al. 2016, 4). Second, Sweden was the first nation to make sexual education compulsory in school (Zimmerman 2015, 4), and since its introduction it has continued to evolve. However, despite decades of relatively progressive sexual education programmes and the introduction of Youth Centres, young people continue to report feeling dissatisfied with their sexual education and the way they are resourced in ensuring good sexual health (Bolander 2015; Folkhälsomyndigheten 2017; Kramsjö 2020). There are clearly then still challenges to address that we need to better understand as a society.

The relevance and significance of this research

The specific fields of interest that I see my research as relevant to, and that I both am informed by and wish to contribute towards, are feminist technoscience, critical studies of health and medicine, sociology of sexuality and intimacies, as well as feminist theories of work. Contraception as a phenomenon is one that crosscuts these fields and enters people's lives discursively and materially in different ways. It brings in societal and scholarly discussion and debate around the possibilities, potentials, and implications of scientific and technological developments. It engages with the patient-provider relationship and limitations within healthcare systems when it comes to young people's sexual and reproductive health. It explores the complex role and function that contraceptives play in different sexual practices and different forms of interpersonal relationships. It also contributes by revealing the multifaceted but oft-neglected work that goes into navigating contraceptives and contraceptive strategies. Scholars and researchers with an interest in any of these matters are likely to find resonance and relevance in this thesis.

Additionally, I see this research as being relevant for a range of other actors and interests: practitioners, educators, policymakers, and activists interested in understanding, shaping and improving sexual and reproductive rights and health and contraceptive justice in Sweden and beyond. I also hope that the work feels relevant for young people themselves, as a way to reflect on their own experiences,

feelings, and ideas around contracepting and provide different tools and a language to talk about what contracepting involves for them with others – whether it be partners, friends, peers, family, teachers, healthcare practitioners, or themselves.

There is still much to explore when it comes to contraception as a social phenomenon and young people's experiences and practices with pregnancy and STI prevention. With this study, I hope to provide a deeper understanding of the phenomenon of contracepting as work that is done by young people in various settings and contexts. Contraceptives and contracepting as a social phenomenon, of relevance and relevant concern for investigation by social scientists, is still underexplored – especially studies like mine that centre on young people's subjective experiences, sense-making, interests, and concerns. Explorative and qualitative research approaches to contraception is furthermore relevant and useful for generating further questions and areas of future investigation and concern.

The significance of having positive early sexual experiences cannot be understated. However, to consider how young people's contraceptive journeys and experiences can be improved to become more satisfactory, comfortable, enjoyable, and empowering, the scholarly understanding of what contracepting as a young person entail needs to continue growing and improving. Echoing Julie Brownlie and Simon Anderson (2017), it is not only relevant but significant to start asking questions about how different societal actors can create the conditions for better, more satisfactory, comfortable, enjoyable, and empowering work of contracepting experiences.

An important start is by first listening and taking seriously young people's own accounts and desires. The wider significance of my work is, therefore, to contribute conceptually to efforts of making contraceptive counselling and sexual education in Sweden more relevant and useful to those that need it. It is also to encourage and facilitate different conversations among sexual partners, friends, family, and other close relationships when it comes to the work of contracepting and how to best support young people, each other, and others in doing this work.

Structure of the thesis

This thesis is made up of nine chapters followed by appendices and references. This first chapter has introduced the reader to the topic of contraceptives and set the wider scene for the study. In chapter two I review and discuss previous academic studies on young people's contracepting as well as research around

contraceptives done in or on the Swedish context. I highlight the more sociological and critical research on contracepting, teasing out what I see as the most important contributions to investigating contracepting experiences and practices. The third chapter presents the theoretical framework of the thesis and the main conceptual tools employed in the analysis. It introduces and defines the central concept of work, as well as specific work-based concepts that are particularly useful for analysing contraceptive experiences and practices. It also outlines the wider relational approach I take in studying contraceptive experiences and practices. In the fourth chapter, I describe how I went about designing and doing this piece of research, describing its methodology and accounting for the different methodological departures, processes, and choices I have made or gone through.

The four following chapters, chapters five to eight, make up the core part of the thesis, that is, its empirical chapters. These four chapters represent the main findings and analytical contributions of this study. The topics of these four chapters represent the central dynamics, concerns, and matters participants navigated in their experiences and practices with contraceptives. They cover three broad central relational contexts: friends and friendship, longer term sexual and romantic relationships, and healthcare.

In chapter five, I explore the importance of *friends* and the nuanced and unacknowledged role that friends play in doing the work of contracepting as a young person, which quickly emerged as one of the strongest themes and findings of the research. In chapter six, I describe the main practices and experiences of *sharing the work* of contracepting in longer term sexual relationships shared by the research participants – discussing aspects that can and cannot be shared, and the implications of this. In chapter seven, I explore the experiences and practices involved in *becoming informed* about contraceptives as a young person in Sweden, showing the complexity, effort, and uncertainty that this work can involve. In chapter eight, building on chapter seven, I tease out the extensive work involved in *making contracepting choices* as a young person – highlighting the complex negotiations young people do in choosing contraceptive strategies.

In the final and ninth chapter, I conclude by summarising my main findings and contributions, reflect on some limitations and the wider implications of the study, and look ahead with suggestions for future research endeavours. After the conclusion, there are several appendices. In Appendix A you can find a list of contraceptive methods in alphabetical order, including their names in English and

Swedish, along with a small illustrative image or photo. Appendix B to F provide supplementary documents and texts relevant to chapter three on methodology – texts used as part of carrying out the research.

Chapter 2. Reviewing and identifying trends and tendencies in previous literature on contraception

In 1994 at the Cairo International Conference on Population Development, the first international agreement was created that recognised the right to sexual and reproductive health (Kanem 2018). Ever since, issues concerning sexual and reproductive health and rights (SRHR) – including family planning and contraception – have steadily garnered more attention on the global arena. At both the international and national level, SRHR has slowly become a central concern in achieving, for example, the Sustainable Development Goals, as well as gender equity. This has resulted in a growing body of literature concerned with understanding, mapping, and explaining sexual and reproductive concerns, behaviours, and trends.

In this chapter, I look at existing research around contracepting and the extent to and ways in which, it can help us understand young people's contracepting experiences and practices in Sweden. I aim to give the reader an overview of the existing knowledge production around contraceptives and contracepting. To do so, I first outline the most crucial trends and tendencies I see in previous research on contraception: reviewing the types of investigations, questions, answers, and assumptions that have informed or shaped these studies. In the second part of the chapter, I look at more specific sociological and critical contributions to the study of contraceptive experience and practice, highlighting what I see as the most crucial take-aways and findings from previous research and scholars. Finally, I identify gaps in the literature that I will contribute towards addressing through my own project.

1. How has contraception been researched previously?

In this first part of the chapter, I will summarise and describe how contraception has been researched previously, both internationally and in the Swedish context. I will present the main types of investigations and populations that have been studied, the kinds of questions that have been asked, the answers and solutions that have been given to said questions, and, finally, the assumptions or starting points that have informed these studies.

Types of investigations and populations studied

Most contraceptive research is carried out by academics, particularly ones in medicine and public health, though governmental and non-governmental organisations also play important albeit smaller roles. The fact that the main epistemic actors stem from medicine and public health has strongly influenced the types of investigations into contracepting. As such, many studies focus on healthcare providers or medical professionals and patients. In Sweden, contraceptive research is even more centralised to the medical sphere.

The main groups or populations that have been at the centre of contraceptive research continue to be cis women (as they are understood as the primary contraceptive users) as well as groups constructed as particularly *risky*. The degree of emphasis and concern with risk – risk factors, risk negotiations, high-risk individuals, and risky populations – is staggering. While there has been a move away from using stigmatising language such as risky groups or risky individuals, the discourse of identifying certain groups of people as riskier than others remains. As a relatively recent example, Benjamin S. Smith et al. published an article with a title ending in 'safe sex negotiation among risky men' (Smith et al. 2018), referring to men who have sex with men. The focus on cis women and risky groups is similarly found in the Swedish literature. In fact, studies looking at men who have sex with men account for a large portion of Swedish literature on contracepting (Blaxhult et al. 2014; Strömdahl et al. 2015, 2017; Petersson et al. 2016; Persson et al. 2018; Herder et al. 2020; Kinnman et al. 2022; Nyman and Jellesma 2022, 2022). Moreover, considering the relatively limited literature on contracepting in Sweden overall, there is a notable emphasis on migrants and racialised groups (Larsson et al. 2016; Kolak et al. 2017; Svensson et al. 2017; Arousell et al. 2019, 2019; Iwarsson et al. 2019, 2019; Baroudi et al. 2020, 2020).

The types of relationalities explored in previous research has predominately been relationships in the clinical encounter, between patients and providers. There has been a particular focus on the relationship between young people, risky groups, and healthcare providers, in addition to the relationships between women and healthcare providers. While most of these studies consider these relationships uncritically, some more critical studies highlight the nuanced role coercion, racism, and power dynamics can play within encounters between women and contraceptive counsellors (Yee and Simon 2011; Fisher et al. 2018; Sacks 2018; Stevens 2018; Carvajal and Zambrana 2020; Berndt and Bell 2021; Meier et al. 2021; Caddy et al. 2022). When it comes to young people and contraceptives, the types of relationalities that have been investigated follow some similar patterns. Several look at the provider or healthcare relationship (e.g. Kavanaugh et al. 2013) or provider attitudes towards adolescents' use of LARCs (Morgan et al. 2019). There are also some studies investigating partner dynamics, partner communication (Schmid et al. 2015; Katz and LaRose 2019) or safer sex negotiations (Soler et al. 2000). In the Swedish context, the main relationality considered is by far that of provider and patient. However, the Swedish context also gives particular weight to another relational dynamic: between state, extensions of the state and citizens (Darroch et al. 2016; Engstrand and Kopp Kallner 2018).

Overall, there is still limited research looking at contraception outside of the medical or healthcare sphere. There are limited studies on men's contracepting unless it is men who have sex with men; on women who have sex with women with some notable exceptions (Logie et al. 2015; Everett et al. 2018; Higgins et al. 2019); and even fewer studies on trans and non-binary people (Lindroth et al. 2017).

What kinds of questions have been asked?

In reviewing previous literature on contracepting, interesting patterns emerge regarding the types of questions that are being asked, and the types of answers or conclusions drawn.

The first common question and foundational concern encountered in the literature is *why people do not use contraceptives*. Researchers and policymakers often ask why non-use, abortions levels, non-effective methods like withdrawal,

STI levels continue to be "high"[17] despite the existence of modern highly effective methods. Common research aims involve seeking 'to determine factors associated with nonuse of contraception by women at risk of unintended pregnancy' (Mosher et al. 2015, 181). In Sweden, there is widespread interest in trying to understand women's contraceptive attitudes, use or non-use (Envall et al. 2022) usually as related to concerns with Sweden's high abortion levels despite easy access to contraceptives. In fact, Helena Kopp Kallner et al. lament that 'unwanted pregnancies have stayed at a constant high level with the number of abortions per 1000 women hovering at around 20' during the past decades (Kopp Kallner et al. 2015, 2).

The second kind of common questions revolve around wanting to *map, explain,* or *predict contraceptive behaviours*: use, non-use, risk-taking and STI testing. This can mean asking what methods are being used and to what degree. In other instances researchers ask the degree to which contraceptive use relates to specific factors like attitudes towards gender equity (Nguyen and Jacobsohn 2023), the experience of a pregnancy scare (Gatny et al. 2018), or early timing of first sex (Kågesten and Blum 2015). It can revolve around finding patterns of use at a population level (Craig et al. 2014; Lindh et al. 2016, 2017) or explaining variability of teenage pregnancy in, for example, the EU (Part et al. 2013).

In several Swedish studies, it has meant investigating specific trends on a national level, such as the prevalence of STIs across the wider population (Hansen et al. 2020), the HIV-risk of foreign-born men who have sex with men living in Sweden (Strömdahl et al. 2017), or risk-taking behaviours among Swedish men who have sex with men (Qvarnström and Oscarsson 2015; Dennermalm et al. 2016, 2019; Persson et al. 2018). In other instances it has meant mapping the factors associated with self-reported adverse mood symptoms induced by hormonal contraceptives (Lundin et al. 2021), continuation rates of oral hormonal contraceptives among first-time users (Josefsson et al. 2013), or Scandinavian women's condom use during sexual intercourse with a new partner (Tatla et al. 2020). The umbrella of mapping or explaining contraceptive behaviour also includes studies looking at contraceptive discontinuation or failure rates of contraceptive use, including who is most likely to experience them (Simmons et al. 2019; Sundell et al. 2019).

[17] I put "high" in quotations marks since the notion of high levels of X is ultimately a normative statement.

A third closely connected strand of questioning that emerges in the literatures revolves around exploring a group's (for example young people's) *knowledge, awareness, or attitudes towards contracepting*. Often such studies focus on investigating attitudes towards specific methods, such as LARCs (Bracken and Graham 2014; Svahn et al. 2021; Wemrell and Gunnarsson 2022) or emerging male contraceptive methods (Solomon et al. 2007; Eberhardt et al. 2009). In this type of study, questions around attitudes towards risk among different groups (individuals with STIs, young people, men, or men who have sex with men) are common.

A fourth strand of questioning in the existing literature concerns individuals' *contraceptive decision-making*, preferences, or priorities. Such questions are often shaped by a rational choice perspective in which humans rationally calculate risks and benefits of contraceptive methods or sexual or reproductive behaviours. Researchers here are often interested in what influences a person's decision, choice, and ultimate use of contraceptives or doing family planning. An illustrative example of this type of study is Cassondra Marshall et al. (2016), who investigate young women's contraceptive decision-making and ask whether preferences for contraceptive attributes align with choice of method. In investigating women's pregnancy prevention behaviours scholars have additionally often focused on women's perceptions of, or reasons for, choosing a particular contraceptive method (Egarter et al. 2013), such as permanent contraception (Ehn et al. 2020) or non-medical methods (Nilsson et al. 2018).

The fifth type of commonly asked questions concern contraceptive counselling and healthcare provision. These included looking at the *experiences and perceptions of specific services*, such as abortion care (Purcell 2016) or contraceptive counselling (Kilander et al. 2017; Reyes-Martí et al. 2021). Other studies in this area evaluated how good, effective, or youth-friendly specific contraceptive health care provision, counselling, or information was (Aiken et al. 2018; Mazur et al. 2018).

A sixth type of questions that I want to highlight are studies interested in *efficacy of interventions* for reducing sexual risk behaviours, whether related to unplanned pregnancies or STIs or efficacy of different contraceptive methods, including more recently, digital fertility awareness methods (Berglund Scherwitzl et al. 2016). These can involve evaluating the efficacy of certain types of counselling like motivational interviewing (Tomlin et al. 2017), incentivising HIV testing through a lottery program (Björkman Nyqvist et al. 2018), or social media awareness raising and sexual health promotion (Gabarron and Wynn 2016). In

the Swedish context, the model of structured contraceptive counselling[18] (Envall et al. 2021; Iwarsson et al. 2021, 2022) and the use of reproductive life plan counselling (Stern et al. 2015; Tydén et al. 2016; Skogsdal 2021) are clear examples of this type of questions.

The seventh type of questions focus on exploring *barriers to contracepting* of different kinds. For example, some researchers explored barriers to STI or HIV testing (Persson et al. 2016; Fisher et al. 2018) such as: stigma (Talley 2020), feminine honour endorsement (Foster et al. 2022), masculinity norms (Canabarro and Salazar 2022), male partner contraceptive interference (Katz and LaRose 2019) and domestic violence (Ojha and Babbar 2022, 2023).

The eighth type of question I have identified in previous research are ones concerned with how to *improve sexual health*, identify best practices in contraceptive counselling (Dehlendorf et al. 2014) or solve sexual health issues of specific groups and meet unmet needs for family planning. Several scholars have been concerned with how to improve adolescent sexual health at group level or adolescent contraceptive behaviours (Finer and Philbin 2013; Gottschalk and Ortayli 2014; Chandra-Mouli et al. 2015), while others have focused on how to include men in family planning: men's role in contraceptive decision-making or willingness to use contraceptives (Grady et al. 1996; Raine et al. 2010; Casey et al. 2016; Ajayi et al. 2018; Lalas et al. 2020). Common questions in this category have included what the access and perceptions of sexual and reproductive health care, abortion care, or contraceptive counselling looks like: for the general population as well as more specific populations (such as migrants, minorities, or young people) (Makenzius et al. 2013; Kilander et al. 2019).

And finally, certain questions were more unique to the Swedish context. The first related to *midwifery praxis* and the perceptions, views, attitudes, practices, and experiences of these contraceptive providers (Ekelund et al. 2014; Kilander et al. 2017). Some of these studies looked at midwives' experiences and attitudes towards contraceptive counselling or abortion care among particular groups of people, such as women with intellectual disabilities (Höglund and Larsson 2019a, 2019b), immigrant women (Larsson et al. 2016; Kolak et al. 2017), or young migrants (Tirado et al. 2022).

[18] Structured contraceptive counselling as a method has particularly been considered in evaluating and improving the uptake of LARCs more specifically.

The second more unique question asked in Swedish literature on contracepting, stresses *contraception as a concern for the state*. In international literature, questions of cost and financial burden arose mainly in terms of the cost of contracepting for the individual or the couple. In the Swedish context, however, studies by prominent Swedish contraception scholars have approached it more from a perspective of the cost that contraceptive inefficiencies present to the Swedish state. Nathaniel Henry et al. (2015) analysed the cost-effectiveness of a low-dose contraceptive levonorgestrel intrauterine system in Sweden, arguing that a 'shift in contraceptive use from oral contraception to long-acting reversible contraception methods could result in fewer unintended pregnancies, quality-adjusted life-year gains, as well as cost savings' (Henry et al. 2015, 884). Similarly focused on the financial benefits of IUDs, Sara Engstrand and Helena Kopp Kallner investigated the cost of unintended pregnancy in Sweden, proposing increased LARC usage as a financial solution (Engstrand and Kopp Kallner 2018). The pair concluded that unplanned pregnancies are costly for 'society and women' and a 'switch in 5% of women using non-LARCs could prevent more than 3500 UPs [unplanned pregnancies] yearly, generating savings of more than SEK 70 million (€7.7 million) or of 2.4% of costs for UPs' (Engstrand and Kopp Kallner 2018, 445). Following a similar logic of concern is the type of studies concerned with explaining Sweden's supposedly high abortion rates (Larsson et al. 2002; Ekstrand et al. 2005; Hognert et al. 2017) despite, as scholars argue, access to effective, modern contraceptives.

Finally, I want to point out a couple of puzzling conceptual slippages found in the questions asked by some Swedish studies. Both relate to instances where researchers discussing what they see as problematic so-called repeat behaviours. Regarding abortions, there is a tendency of lumping together unintended or unwanted pregnancy with abortion, which presumes that reducing abortions is the ultimate goal (Kallner et al. 2015, 11). In fact, there is a persistent concern with abortion levels in Sweden. As such, it is not surprising that several studies have looked at women's experiences of contraceptive counselling in the context of having an abortion, ultimately, in order to better prevent future abortions, or what Helena Kilander et al. (2016) refer to as 'repeat abortion'. In a similar vein, regarding STIs, Anna Nielsen et al. (2017) have constructed 'repeat testing' as problematic because they found high rates of chlamydia among 'repeat testers'. In doing so they suggested that testing for STIs might be a 'safe approach' to 'unsafe

sex', and thus end up constructing the act of testing itself as somehow an indicator of risky sexual behaviours.

Across several studies there is also a linguistic tension in the highly stigmatising language used in speaking of high-risk individuals versus potentially vulnerable groups. Efforts to identify folks deemed at risk, can further be found in the case of the evidence-informed toolkit SEXIT (SEXual health Identification Tool) whose aim is to explore how to best identify 'young people exposed to or at risk of sexual ill health, at Swedish Youth Centres and to investigate SEXIT's potential to identify young people in need of special care and monitoring' (Hammarström et al. 2019, 45). While many studies refrain from labelling individuals as high risk and instead opt for high-risk or risky behaviours, there is a conceptual slippage in practice: a slippage that is especially problematic when the groups or individuals researched have historically and currently been especially marginalised by these same systems, like queer men, HIV positive men, migrants, or refugees.

What answers and solutions have been given?

As I have outlined in the previous section, various research questions have been posed around the topic of contraception. The answers and solutions given to these questions, on the other hand, are less varied. The most common answer or solution provided is by far the importance of *knowledge and information*. It is widely maintained that with increased information, risky behaviours would be reduced. Frederik Tilmann Von Rosen et al., for example, conclude that their results show that 'despite their particular risk to contract an STI, adolescents suffer from suboptimal levels of knowledge on STIs beyond HIV' and, therefore, urgent efforts are 'needed to improve adolescent STI knowledge in order to improve the uptake of primary and secondary prevention' (Von Rosen et al. 2018, 1). Other examples of knowledge being given as the answer to research questions posed include Juliet Richters et al. (2016), who argued that it is necessary for people to know how to use contraceptives properly.

Similar trends exist in Sweden. Increasing awareness, sex education and ensuring that people know what their options are repeatedly argued as the answer in the Swedish literature, whether it be in order to improve migrant or refugee youths' access to sexual and reproductive healthcare (Baroudi et al. 2020, 2023; Nordström and Agardh 2021) or to reduce risks associated with oral sex and STIs (Fridlund et al. 2014). Increased or improved sexual education

and proper contraceptive counselling has also been raised, which often meant addressing 'misperceptions', 'misinformation' and 'myths' about modern contraceptive methods (Russo et al. 2013; Hindin et al. 2014; Stevens 2018) and tackling young people's knowledge deficits, especially when it came to LARC use (Pritt et al. 2017).

The second, closely connected, type of answer and solution to contraceptive concerns identified by researchers involved enabling, encouraging, or simply making sure that people make *informed choices* about contraception and sexual health. This is a particularly common story when it comes to women's pregnancy prevention. For example, Bodil Ehn et al. (2020) and Cecilia Caetano et al. maintain that contraceptive counsellors must discuss all contraceptive options with women 'so that she can make an informed choice on what best suits them' (Caetano et al. 2019, 35). In a similar fashion, Janelle Rodriquez et al. argue for the necessity of personalized contraceptive counselling and helping 'women make the right choice' (2016, 89). The notion of uninformed or misinformed contraceptive users needing to be given improved knowledge or awareness have seemingly become a catch-all solution to perceived contraceptive issues.

The third type builds on notions of needing to know and have enough information in order to make (the right) contraception decisions: adding the need for individuals to be *empowered and have autonomy* in utilising their knowledge. Anthony Ajayi et al. (2018), for example, explain that the female students in their study, despite having the required knowledge for prevention, still practised risky sexual behaviours. As such, to produce change in this population interventions are required that 'target sociocultural norms and empowerment of women to develop skills in negotiating safe sex' (Ajayi et al. 2018).

Similar to the type of questions asked around people's (including young people's) contracepting, many of the answers given focus on individuals, and individual behavioural change. However, there were some concerned with change among providers or contraceptive counselling as a praxis, stressing the need for *unbiased, patient-centred contraceptive care* (Solo and Festin 2019) as well as youth-friendly, non-judgemental and low-barrier services and information (Begun et al. 2019). Some scholars also reference cultural sensitivity (Svensson et al. 2017; Baroudi et al. 2020, 2023) and reproductive justice in healthcare (Barcelos 2018; Ely et al. 2020) as well as the need for anti-discrimination when it comes to racial and ethnic minorities and LGBTQ people (Sacks 2018; Higgins et al. 2019; Yan et al. 2019; Agénor et al. 2020; Mann et al. 2022). For Mazen Baroudi et al.

(2020; 2023) it involved improving the cultural acceptability and responsiveness of services, especially Youth Centres. Baroudi (2023) further argues that this includes challenging internalised and cultural racism.

Macro-level answers and solutions more focused on structural conditions are rarer to encounter in contraceptive research in general. Some researchers maintain the need to increase the availability of contraceptives (Ross and Stover 2013), to find structural solutions related to infrastructure for chlamydia prevention (Deogan et al. 2013), or challenge the *role of stigma* connected to emergency contraceptives (Card and Williams 2014; Cantarero Arevalo and Merchant 2020) and being diagnosed with HIV or other STIs (Eaton et al. 2018; Yan et al. 2019).

Finally, a type of answer that was more prevalent in the Swedish context was the necessity of providers to nudge individuals towards "correct" contraceptive solutions. While coercion is never explicitly mentioned as a strategy, discussions pointing to aligning women's reproductive intentions with their contraceptive outcomes is raised (Skogsdal et al. 2018) as well as counselling needing improving to achieve contraceptive *adherence* (Obern et al. 2023). Matilda Ekelund et al. (2014) argue that education is needed about the benefits of intrauterine contraception, especially to young and nulliparous[19] women to counter reluctance and ultimately increase the numbers of healthcare providers offering these long-acting methods.

What assumptions or starting points have they been informed by?

Certain foundational, underlying assumptions emerge from the problems and solutions presented in existing literature. In addition to contracepting being largely constructed as an individual issue, rather than a societal and structural problems, *pregnancy prevention and STI prevention tend to be firmly treated as separate concerns*. The one exception are studies looking at multipurpose prevention technologies, such as Martha Brady and Judy Manning, (2013) and Trinette Fernandes et al. (2020).

The second assumption or starting point informing these contraceptive studies is the *aim and ideal of planning*. The unquestioned aim of most studies on contraception is to work towards or promoting reproductive and sexual planning: highlighting continued rationalistic, neoliberal ideals. In this context unintended

[19] Nulliparous is a medical term meaning never given birth.

pregnancies are per definition something problematic and emerges as 'significant public health issue problems' (Williams and Fortenberry 2013, S29) alongside STIs, especially among adolescents (Williams and Fortenberry 2013, S29). Connected to this emphasis and ideal of planning is essentialist or uncritical views on the meaning and nature of risk. Just as planning is taken-for-granted as something to aim for and as positive, so is the understanding of the supposed objectivity of risk.

This builds into a third assumption of *contraceptive use and removal of risk behaviours as an ultimate goal*. This is most evident in studies around contraceptive counselling in connection to having an abortion and in many studies on young people's contracepting or lack thereof. The underlying starting points and aims are usually instrumental in nature, attempting to find the best pathways towards increased contraceptive use. In Virginia Ramseyer Winter and Lindsay Rae Ruhr's (2017) study one can see how this instrumentalist logic is expressed through the explored relationship between positive body image and contraceptive use. They found that body appreciation was significantly related to use of condoms and hormonal contraceptives, which they found 'promising as dual contraceptive use is the best way to prevent unintended pregnancy and sexually transmitted infections (STIs)' (Winter and Ruhr 2017, 168). This reflects an instrumentalization of issues like body image, highlighting their usefulness for prevention of pregnancy and STIs while staying completely divorced from their impact on individual wellbeing in general. Such an instrumentalization can discount people's negative experiences of contracepting, such as harmful side effects.

The fourth assumption that I want to highlight from the literature is the concern with and construction of *some individuals or groups as more problematic than others* when it comes to contracepting. I have already noted the trends of singling out certain populations for investigation and studying these populations primarily through lenses of risk. In Sweden, this is expressed through the common concern with identifying risk-factors to better intervene and prevent unwanted pregnancies or STIs. In such research, factors such as having foreign-born parentage (Sundbeck et al. 2016), low socioeconomic status and religiousness (discussed and problematised in Arousell et al., 2019) and early age of sexual intercourse (Guleria et al. 2017) have been identified as risk-factors for contraceptive non-use. The logic of being able to identify risk groups or individuals with particular risky behaviours for intervention is a stigmatising practice, and is particularly troubling considering Sweden's long history of

eugenic practices and contraceptive coercion (Broberg and Roll-Hansen 1996; Hyatt 1998; Byrman 2001).

The final type of assumption I want to raise returns to the aforementioned predilection in the Swedish literature for *constructing the contraceptive problem from the perspective of state* or wider society. This can be best exemplified in the persisting construction of abortion levels in Sweden as problem that simply needs to be reduced and unmet need for contraception being equated with a woman experiencing an unintended pregnancy (Hellström et al. 2019; Envall et al. 2022). A study might declare that it is trying to improve contraceptive decision-making, yet in analysing what the problem is actually represented to be (Bacchi 2009) it is abortion levels being too high that emerges as the implicit issue. As such, terms are reworked and conflated to fit that problem formulation: an abortion equals unmet need for contraception and more LARCs equals less abortions. Yet, someone might experience an unintended pregnancy, carry on the pregnancy, or have an abortion without it implying that either is a problem for them or that their contraceptive needs were unmet.

Summary of types of questions, answers, and underlying assumptions in existing literature on contracepting

Questions & concerns	Answers & solutions	Underlying assumptions
? Understanding why individuals or groups do not use contraception ? Mapping, explaining, predicting contraceptive behaviours: use, non-use, and STI testing ? Knowledge, awareness, attitudes towards contracepting ? Contraceptive choice- & decision-making, calculations & preferences ? Experiences, quality & best practices of contraceptive counselling ? Efficacy of interventions or contraceptive methods ? Barriers to contraceptive use, STI testing etc. ? How to improve sexual or reproductive health	⇨ Increasing knowledge & information ⇨ With the right or enough knowledge, risky behaviours are reduced, contraceptive methods are used properly. ⇨ Myth & misconception-busting ⇨ Sexual education ⇨ Making informed choices ⇨ Being empowered ⇨ Unbiased, patient-centred care & cultural sensivitiy ⇨ Structural conditions like reducing stigma & increasing availability	✶ Pregnancy & STI prevention are separate things ✶ The aim & ideal in sexuality, reproduction & contracepting is *planning* ✶ Risks are objective things & must be avoided ✶ The end game is use of contraceptive technologies ✶ LARCs are the most effective methods & should be promoted ✶ Some people are more problematic (risky) than others
More unique to the Swedish context		
? Midwifery praxis & perspectives ? The cost for the state of unplanned pregnancies * Risky/vulnerable slippage	⇨ Nudging and adherence	✶ Problem constructed from perspective of state or wider society

2. Sociological contributions to studying contraception

In the second half of this chapter, I will discuss the main types of sociological investigations around contracepting that have been done and tease out their main contributions to studying contracepting as a social phenomenon. These include: contracepting as feminised work and as something that is more than a physical issue, studies focusing on pleasure and sexual acceptability of contraceptives, critical interrogations of medicine and health including different ways of knowing, challenging perspectives of the rational individual and idealised responsible sexual citizen, and critiques of the neoliberal view of contraceptive choice-making.

Contracepting as feminised work and an unfair gendered burden

The first contributions I want to highlight are sociological studies who have investigated and contributed towards conceptualising contracepting as feminised work and, ultimately, an unfair gendered burden (Littlejohn 2021) . It has been shown time and time again that there are clear gendered dimensions for the meaning-making, valuing, and distribution of the work of pregnancy prevention in particular, both at the societal and the interpersonal level. On the interpersonal level, this is especially evident in heterosexual relationships in domestic situations, where, as John Dixon and Margaret Wetherell illustrate, women 'continue to bear more responsibility than their male partners for routine domestic tasks (…) which have been variously described as 'mundane', 'repetitive', 'unrelenting' and 'non-discretionary'' (Dixon and Wetherell, 2004, 167-168).

Picking up and building on domestic work analyses, scholars interested in contracepting for pregnancy prevention suggest that similar dynamics are found and explain divisions of contraceptive labor. Andrea M. Bertotti notes that '[d]omestic labor researchers have examined a multitude of duties disproportionately initiated and performed by women, yet the labor and responsibility associated with navigating a couple's fertility—fertility work—has been largely overlooked' (2013, 13). This type of work, Bertotti continues, mimics the organisation of other forms of domestic labor in which 'the time, attention, stress, and physical burden associated with avoiding pregnancy lies primarily on the shoulders of women' (2013, 13). Julie Fennell further explains this dynamic, arguing that the reason this responsibility typically falls to women is because of 'a combination of biotechnological constraints and social

expectations' (2011, 499). Moreover, especially 'hormonal contraceptives require occasional doctor's visits, infrequent pharmacy purchases, and some sort of contraceptive regimental maintenance (daily, weekly, monthly, or sometimes much less)' (Fennell 2011, 499-500). As such, one can see how contracepting related to pregnancy prevention becomes socially produced as women's work and responsibility, resulting in an unfair gendered burden and a gendered inequality.

One fascinating way that the gendered inequality related to contracepting have been theorised is from feminist science and technology studies scholars like Nelly Oudshoorn (1999, 2003, 2004) who has shown the role that technologies play in 'stabilizing or destabilizing such conventions creating new or reinforcing existing performances of gender' (2004, 352) including that of contraceptive technologies. Oudshoorn suggests that before the introduction of new contraceptives for women in 1960s 'no stabilized, gendered conventions for the use of contraceptives existed' (2004, 352). At that time, they continue, neither men nor women had many contraception options beyond condoms, spermicides, diaphragms, and sterilisation, but that situation 'changed drastically when new contraceptives for women became available' (2004, 352).

At the time of writing in the early 2000s, Oudshoorn (2004, 352) noted that there had been 13 new contraceptive technologies introduced since the Second World War, including, of course, the contraceptive pill. Today that number is far greater. This 'predominance of modern contraceptive drugs for women has disciplined men and women to delegate responsibilities for contraception largely to women' (2004, 352). Oudshoorn and other feminist scholars highlight how contraceptives have thus become 'disciplinary technologies', part of socialising and disciplining our reproductive behaviours in a series of ways (2004, 352-353).

In analysing and making sense of women's and men's work it is important, however, to remember that these are not homogenous groups. As intersectional scholars have argued and shown repeatedly, gendered inequalities are not experienced or structured in equally. This is something Bertotti recognises, arguing that, as 'with other forms of domestic labor, fertility work is not equally distributed among women' and that 'racial and socioeconomic factors affect the gendered division of labor, with some women more likely to have partners who share it' (2013, 14). However, in studies around contraception – including in Sweden – this is often not adequately acknowledged.

Reacting to these identified gendered patterns and dynamics, there has been efforts from social researchers to highlight men's reproductive bodies and

contraceptive behaviours: bringing them into the 'reproductive imaginary' (Almeling and Waggoner 2013). Cristen Dalessandro et al. (2019) did so by analysing college men's accounts of contraceptive decision-making in the US, and introduced the concept of 'strategic silence' to make sense of their behaviours, echoing Catherine Ashcraft's (2000) concept of 'domestic dodging'. What Dalessandro et al. argue is that the men interviewed, deployed strategic silence in various situations including before sex, which 'opened up the possibility of sex without condoms unless women specifically asked for condoms' (2019, 14). Moreover, their accounts illustrated 'while men know they should use condoms, they still deploy strategic silence, which serves as a powerful mechanism of maintaining inequality by privileging men's desires and tasking women with more work' (2019, 19).

Another contribution that has further nuanced these gendered dimensions comes from Ann M. Fefferman and Ushma D. Upadhyay's (2018) work on 'hybrid masculinity' and young men's contraceptive management, specifically around hormonal contraception and the copper IUD. Through interviewing young men and women of colour in the US, they identified 'two emergent discourses in participants' depictions of men's place in contraceptive management relative to women's bodies: one being a feminist paradigm of respect and support, while the other a patriarchal model reifying women's primacy in domestic life' (2018, 378). Besides these emergent discourses, Fefferman and Upadhyay found that some men could 'mobilize a feminist discourse and enact a more egalitarian masculinity, insofar as they help partners with mutual reproductive goals and support women's control over their own bodies' (2018, 372). As Fefferman and Upadhyay emphasise, men 'can engage in contraceptive management without detracting from women's efforts toward reproductive goals' (2018, 388). However, as Britta Wiggington et al. (2016) note, increasing men's involvement in contracepting can have detrimental consequences. Specifically, they note an ambivalence within these discussions and calls for men to take more responsibility for the contraceptive burden, between the unfair gendered burden and the desire to maintain one's bodily and reproductive control and autonomy (Wigginton et al., 2016, 738).

With that said, highlighting the possibilities that do exist for different gendered dynamics in the work of contracepting is crucial: whether it be done through exploring how men can support their partners or in the development of new male contraceptives (Oudshoorn 1999, 2003, 2004; Solomon et al. 2007; Eberhardt, Wersch, et al. 2009; Campo-Engelstein 2012; Dismore et al. 2014). Something

which might contribute towards challenging the feminisation of contraception in which women have been made responsible not only for preventing unwanted pregnancies but for enabling men's sexuality and pleasure. As Wiggington et al. argue, 'unlike condoms, female contraception does not interrupt sex, does not threaten the ''naturalness'' of sex and most importantly it does not compromise men's pleasure – in line with the ''male sex drive'' discourse. In this way, the use of female contraception facilitates the construction and experience of ''real sex''' (Wigginton et al., 2015, 181). John L. Oliffe et al. call this pattern of 'looking after the man's libido (and then health)' "emphasised femininity" (2013, 6). However, they also identify alternative femininities in exploring 'how women interpret and respond to heterosexual men's sexual health practices' (2013, 1) especially around STI testing. Through their analysis they highlight how femininities can both be 'complicit in sustaining, as well as being critical of and disrupting masculine discourses that affirm sexual pleasure and resistance to health help-seeking as men's patriarchal privileges' (2013, 1).

Contracepting as more than a physical burden

The second contribution to sociologically analysing contraception is found in works by scholars that have argued for the importance of understanding contracepting as more than only a physical or physiological burden. While contraceptive use is an embodied experience it is 'enmeshed in immediate material and relational contexts' (Wigginton et al., 2016, 729).

Certain scholars have been especially vital in challenging the primacy of the physical in discourse around contraceptives. Bertotti (2013), mentioned above, has highlighted the time and stress aspects of contracepting. Katrina Kimport (2017) highlights the attention, time, and stress involved in the regular work of pregnancy prevention and using contraceptives. She specifically notes, through her participant's storied experiences, that the stress mentioned was twofold: first, 'the stress of denied self-knowledge' and the inability to be "natural"' and second, 'the emotional stress of commencing contraception, including fear of the physical aspects of a method such as side effects and method-associated pain' (2017, 1099). Fennell (2011) has similarly highlighted the emotional and mental aspects of the pregnancy prevention, especially in the notion of planning. They suggest that '"planning" in general is a feminized characteristic in many relationships, and family planning becomes another aspect of this general planning behaviour. As such, it is

difficult to discern to what degree planning versus family planning is the gendered labor' (Fennell 2011, 516). Yet, regardless of whether this gendered dynamic comes from planning in general or family planning in particular, it remains gendered labour. Other scholars have highlighted the emotion work involved in accessing and acquiring emergency contraceptives in particular, and the management of shame that this can involve (Cantarero Arevalo and Merchant 2020).

Another recent, and highly relevant, contribution that highlights the non-physical work of contracepting is that of Swedish scholars Lena Gunnarsson and Maria Wemrell (2022) who investigate the epistemic work involved in contracepting. They investigate online knowledge production related to the copper IUD and find 'rather than uncritically adopting any kind of information on the copper IUD, many participants described having engaged in a time-consuming labour of identifying, assessing and drawing conclusions from various sources including scientific ones' (Gunnarsson and Wemrell 2022, 180). Through their analysis of Swedish women's claims about systemic side effects of the copper intrauterine device they offer the notion of 'collective labour of scientific patchworking' (2022, 182) to make sense of the epistemic practices the women engaged in.

Another way in which previous social researchers have contributed towards understanding and analysing contracepting as something more than a mere physical endeavour is by discussing the relational work involved in negotiating meanings, norms, and risks around safe sex. As Debbie Fallon (2013) notes, this can mean negotiating competing risks that are highly gendered. In their 2013 paper Fallon discusses a particular conflict experienced by a 'group of young females who accessed emergency contraception (EC) following either contraceptive failure or unprotected sex' (2013, 318). This conflict appeared due to unequal gendered meanings and judgements of 'being prepared' to have sex as a young woman versus 'not being prepared' and facing moral judgement for failed contracepting.

Other examples which highlight the negotiations of conflicting norms related to contracepting are given by Laurie James-Hawkins et al. (2019) and Pam Lowe (2005): specifically when it comes to navigating meanings around equitable coupledom in heterosexual relationships. The latter highlights that women's contraceptive negotiations are complex and 'feature conflicting ideas about embodied risks, notions of equality within their own heterosexual relationships and wider societal expectations' (Lowe 2005, 83). What they mean here, is that while

women might feel responsible in one way for contracepting, it simultaneously clashes with ideas and ideals of gender equality norms within couples (Lowe 2005, 83).

While less explored, needing to negotiate conflicting norms related to contracepting is something men can experience as well. James-Hawkins et al. (2019) show how university men in the US navigated what they felt as competing norms around sexual health decision-making and women's bodily autonomy. In their study, James-Hawkins et al. highlight that the consequences of these conflicting norms included constraints on men's participation as 'they were afraid of impeding women's bodily autonomy' (2019, 11), and thus, women still ended up being mainly responsible for contraceptive use and communication.

Towards inclusions of pleasure and sexual acceptability

A third contribution from more sociologically leaning research lies in studying people's (especially young people's) sexual lives and contracepting experiences from perspectives around pleasure and sexual acceptability. As Jenny A. Higgins et al. (2020) argue, researchers and practitioners need to go beyond merely discussing safety and efficacy to consider people's sexual priorities. This includes countering the erasure of pleasure in sexual science research, and the overemphasis on 'risk, disease, and dysfunction' as well as the reinforcement of heteronormativity (Jones 2019, 644).

In research around contraceptive technologies and contraceptive use, pleasure has played a very minor role. In fact, ever since the introduction of the contraceptive pill and the choice to promote it as a way to 'postpone menstruation, safely and surely' (Watkins 2012, 1465), contraception has been largely desexualised (Hanbury and Eastham 2016, 256) and de-eroticised (Cassar 2019) especially in the context of youth sexuality and sex education. As Ali Hanbury and Rachael Eastham explain, often youth sexuality is assumed to be 'deviant, risky or inherently troublesome' (2016, 262). Like Hanbury and Eastham, I suggest it can be otherwise. Instead young people's sexuality and sexual pleasure can be approached as 'exciting and stimulating process with outcomes that extend beyond typical ideas of being disease or risk-free and instead focus on being empowering, exciting and joyous' (2016, 262). Some researchers have starting looking at people's experiences of contracepting and the importance of the sexual acceptability of a method or strategy (Fennell 2014). As Jenny A. Higgins and

Jennifer S. Hirsch put it, '[p]leasure, then, seems to matter. However, how it matters is complex, as are the meanings and shades of pleasure itself' (2008, 1820).

In this regard, researchers and policymakers are still catching up, so to speak, because young people themselves are of course already aware of the role that pleasure and eroticism play in negotiating and navigating contraception. In Joanne Cassar's brilliant ethnographic study utilising digital photos of toilet graffiti in Malta among girls, erotic discourse plays a central role. In it Cassar found that the young graffiti writers 'employed an erotic discourse to assert their entitlement to sexual pleasure and to "orgasm"' in negotiating sex and contraceptive use (2019, 1083). As Cassar demonstrates, there are several discourses surrounding safe sex, more accurately understood as a continuum. Moreover, by 'debating safe sex students could move across this continuum; not necessarily in a linear way but backwards and forwards according to culturally prescribed dictates on safe sex' (2019, 1072).

Another important development in more sociological research that produces more nuanced accounts and analysis of contracepting practices and experiences, are more nuanced and critical studies around men who have sex with men, 'barebacking'[20] (Adam 2005), and PrEP. I especially want to mention Clay Davis (2020) who critically analyses 'PrEP clinical trials, dissecting the novel techniques researchers use to demonstrate efficacy' (2020, 860). In so doing, Davis effectively argues that through an 'interplay between adherence to a prophylactic regimen and risk for HIV, biomedical HIV prevention research has revealed a new subject of biopolitics, Homo adhaerens' (2020, 860). Davis shows how 'Homo adhaerens becomes the privileged biological citizen and research subject because of their self-disciplining ability' and 'manifests itself as an expectation of adherence that incites patients to play an active role in managing their own risk' (2020, 870). While Davis examines the 'Homo adhaerens' in the context of PrEP research, 'adherence has been a primary concern of social scientists and medical researchers for half a century' (2020, 864). In discussing the researcher's process of producing the ideal subjects in which risk is bound to adherence, Davis found that '[a]fter identifying high-risk populations and carving them into salient identity groups, investigators must directly account for noncompliance. To do this, they again employ

[20] Barebacking describes having penetrative sex without condoms and is a term that 'became widespread in the LGBT+ community in the 1990s, when HIV-positive queer men began openly discussing having sex with other HIV-positive people without using a condom' (Wakefield 2021)

subgroup analysis – this time creating a synthetic cohort of perfectly adherent participants' (2020, 868).

Interrogating the primacy of and power dynamics within medicine and health

Closely connected to the previous theme, another area of sociological study of contraception highly relevant to my own work is studies interrogating the primacy of and power dynamics within medicine and health. One aspect of this is interrogations of power dynamics within healthcare and medical encounters and contraceptive counselling. Several studies have explored interpersonal dynamics that impact encounters within contraceptive counselling, including more coercive contraceptive practices (Yee and Simon 2011; Ledger et al. 2016; Brandi et al. 2018; Höglund and Larsson 2019a; Senderowicz 2019). It is not unusual for young people to experience (implicit) pressure within contraceptive counselling, especially young people who experience multiple marginalisation like the young Black and Latina women interviewed by Anu Manchikanti Gomez and Mikaela Wapman (2017).

Another approach within this type of research has been to purposely investigate the way biases influence and shape contraceptive practitioners (Stevens 2018; Manzer and Bell 2021; Mann et al. 2022). In Emily S. Mann et al.'s study, they showed that '[b]ias informed by structural inequalities and power relations influences how clinicians perceive their patients and approach counselling them about contraception' (2022, 66), specifically structural inequalities related to race/ethnicity, socioeconomic status, and age. For example, they found that clinicians would interpret patient's 'concerns or refusal to use effective contraceptive methods as a problem with patients themselves' (2022, 66). Ultimately, Mann et al. argue that there is much work to be done to redress 'structural inequalities and power relations that inform provider bias in the context of contraceptive counselling' (2022, 66).

Other studies similarly investigating the unequal relationship and encounters between contraceptive patients and providers, have looked at how providers themselves make sense of their role. Manzer and Bell found that, rather 'than acknowledge their individually held biases, providers evoked data or used safe biases to disregard and/or justify their own assumptions about pregnancy that influenced many of their prescribing and counselling decisions' (2021, 131). This kind of benevolent bias notion, was also found by Lindsay M. Stevens (2018)

through their interviews with clinicians and their attitudes about the legitimacy of patient concerns and dissatisfaction with contraception. Stevens found that clinician attitudes can delegitimize concerns and dissatisfaction with contraception and side effects that patients experience, by framing these concerns as 'myths' or 'nocebo' (2018, 146) that ultimately need to be 'busted'. One example of this in Stevens' study was the instance of a clinician minimizing 'continuous bleeding as acceptable, because it is "expected" and because she has already communicated to patients that she will prioritize the IUD's efficacy in preventing pregnancy "no matter what happens."' (2018, 149). This is a troubling dynamic to say the least, that echoes historical power inequalities between medical professionals and lay people.

The second aspect of interrogating the primacy of and power dynamics within healthcare and medicine when it comes to contracepting, is about particularly the power of medical knowledge and knowledge-production. There are several fascinating works looking at and unpacking key discourses, meanings and assumptions in medical or gynaecological knowledge (see Bertotti and Miner 2019; Beynon-Jones 2013; Carson 2018; Davis 2020; Mann et al. 2022; Temkina 2015). For example, it has been argued that a particular epistemic dynamic in medical discourse is the production of embodied experiences or situations as fixable problems and needing medical intervention in particular (Mann et al. 2022). Another example is Siân M. Beynon-Jones whose analysis of 'health professionals' accounts illustrates the socio-material work that is necessary in order for abortion to be enacted as evidence of a 'fixable' problem with contraception' (Beynon-Jones 2013, 105).

The power and authority of medical knowledge is well-known, including in constructing what is seen as rational or not in contracepting, something Kristin Luker critiqued back in the late 1970s in her study on abortion and the decision not to contracept. In it, Luker writes that from 'the medical and institutional viewpoint' women's contraceptive decision-making is understood as 'simple in the extreme: women should know that intercourse leads to pregnancy, so that any woman who is unwilling to pay what they view as minor costs of contraception, when faced with the major costs of an abortion, is both self-destructive and irrational' (Luker 1978, 140). As Beynon-Jones suggest of Luker's study, 'the central aim was to destabilise these assumptions by illustrating that, when contraception is situated within the lived context of its use, its non-use becomes an entirely rational act' (Beynon-Jones 2013, 106).

Yet, today this rationalistic understanding strongly prevails in discussions of abortions or non-use of contraception. Medical and public health constructions of 'risk' and 'non-risk' continue to dominate when it comes to contraceptive technologies. As Alina Geampana points out, despite their primacy in women users' experiences, worries around sexual function and pleasure are seldom considered in medical literature aimed at evaluating risks of hormonal contraception (2016, 15). As they note, 'loss of desire or nausea and headaches can have severe consequences on women's daily functioning' (2016, 15), yet this is rarely treated as such. In fact, 'safety' is more often 'defined as the relative absence of the threat of death which is a limited perspective when taking into consideration the concerns of women users' (Geampana 2016, 15)

Risk and safety, therefore, continues to be constructed primarily from the point of view and interests of medical and healthcare sectors, in which users' experiences of what they deem risky side effects is not taken seriously enough (Kammen and Oudshoorn 2002; Littlejohn 2013). This is of course seldomly explicitly acknowledged but naturalised in talk. Through their article on *Gender and risk assessment in contraceptive technologies*, Jessika van Kammen and Nelly Oudshoorn (2002) show the double-standard and tendencies that exists and has existed in taking contraceptive side effects seriously. They argue that when it has concerned women's contraceptives, 'researchers and policymakers have represented side effects as mild and transient, whereas women's health advocates have described them as profoundly affecting women's lives and daily well being' (Kammen and Oudshoorn 2002, 454). Yet, when it comes to risk assessments and lay perspectives in relation to men's contraceptive technologies, there is s shared sentiment in taking lay concerns seriously.

The tension and blurring of interests are perhaps most evidently shown and argued by Beynon-Jones, who highlight the conflicting interests of healthcare policy and ideal healthcare practice. As they suggest, 'the target of healthcare *practice* is very different to that of healthcare *policy*: the latter is concerned with overall 'rates' of contraception/abortion usage whereas the former is concerned with individuals' usage of contraception/abortion' (Beynon-Jones 2013, 108 [*emphasis added*]). Moreover, in representing abortions as 'automatic evidence of 'contraceptive failure'' as these healthcare providers in Beynon-Jones' study often did, 'contraceptive control over fertility is positioned as a natural (i.e. normal) female bodily state, which has broken down and can be restored by health

professionals rather than a state which women may, or may not, decide to try to achieve using technological assistance' (2013, 108).

Considering different forms of knowing beyond the medical

Building on the previous section, I now want to consider some research contributions that have gone beyond the medical sphere and towards the acknowledgement of different forms of knowledge as well as what this entails. Following commonly held discussions in STS literature more widely around meanings of knowledge and the relationship between lay and expert knowing, there are an increasing emphasis on exploring epistemic processes beyond the medical space. In doing so, scholars have started emphasising the importance and immense value placed on embodied knowing when it comes to contraception (Gunnarsson and Wemrell 2022), including in contraceptive consultations (Lowe 2005b).

Moreover, by paying attention to and taking seriously lay people's embodied knowledge researchers are better able to understand and identify conflicting views on safety, risk and the un/acceptability of contraceptive technologies (Hardon 1992; Solomon et al. 2007). For example, while fears of hormones in medical settings and discourse often is minimised or dismissed, more nuanced research perspectives such as that of Mireille Le Guen et al. (2021) acknowledge that this fear is rather complex and multifactorial and worthy of further consideration.

Another scholar who have approached lay assessments of risks without assuming these to be erroneous, as medical perspectives often would have it, is Geampana (2019). They highlight how 'user concerns reflect a different positionality' (2019, 1521) which raises the question of who can decide what counts as an accurate risk or not. In interviewing women about their negative experiences of the 'controversial drugs Yaz and Yasmin' in Canada, they illustrate differences in views or assessment of the risks of hormonal contraception between patients and providers. Historically, the side effects of the pill and hormonal contraceptives have been commonly used and justified by weighing them against the risks of pregnancy (Oudshoorn 1999). Yet, as Geampana found in their interviews, in many instances patients or users, challenge and reject this comparison, with one woman stating that comparing oral contraceptive risks 'with pregnancy risks is like looking at "apples and oranges."' (2019, 1524).

Another tension, that Geampana highlights, is one that 'emerged between risks in large populations/epidemiological data and risk as a personal experience. According to some interviewees, the medical at-risk profile served as false reassurance that they will not experience severe side effects. If they did not fit this profile, yet suffered health issues, the perceived gravity of the situation and the drugs' risks were amplified' (2019, 1525). Moreover, many of the women interviewed understandably and repeatedly expressed a desire that their personal experiences be taken more seriously, wishing 'to be seen as more than a statistic, given the numerous ways in which illness has affected their lives' (2019, 1525).

Medicine, healthcare, and public health institutions and actors regularly want to construct scientific facts and knowledge as the only proper, rational, legitimate knowledge out there regarding contracepting, STI and pregnancy prevention. However, as is repeatedly shown, this is not the case. As Sara Planting-Bergloo et al. show in their study of Swedish upper secondary sex education, while 'scientific facts about human reproduction are important for the students' ability to navigate between the advantages and disadvantages of various contraceptive methods' it can 'not only be a matter of scientific facts' but 'how natural science, historical, political, cultural, and market oriented intertwining's affect students' notions of contraception' (2022, 541).

In such a context then, it is unsurprising that users may feel unsupported, dismissed or coerced in contraceptive counselling situation and perceive professionals as overly 'pharma-optimistic' (Bertotti and Miner 2019) or overly optimistic about the IUD (Stern et al. 2022). Ultimately, as these scholars have highlighted, this often results in frustration, alienation, and dissatisfaction with contraceptive care, the contraceptive care encounter, and medical and healthcare institutions.

Challenging perspectives of the rational individual and the idealised responsible sexual citizen

Two last contribution that I want to shine a light on strongly echo my own desire to study contraceptive experiences and practices relationally and structurally. The first is efforts to go beyond discourse centred of the rational individual and individual responsibility and a take a more structural look at contracepting systems.

One such more structural analytical contribution comes from Julie Pulerwitz et al. (2019) in proposing a new conceptual framework to address specifically social norms that influence adolescent sexual and reproductive health. They

demonstrate their framework through a visual representation (*see figure 1*) and illustrate the multitude of factors that affect adolescent sexual and reproductive health decision-making. As they note, for example, 'a young person may concurrently be influenced by peer group norms supporting use of contraception and prohibitions on such use put forth by faith leaders' (2019, S9).

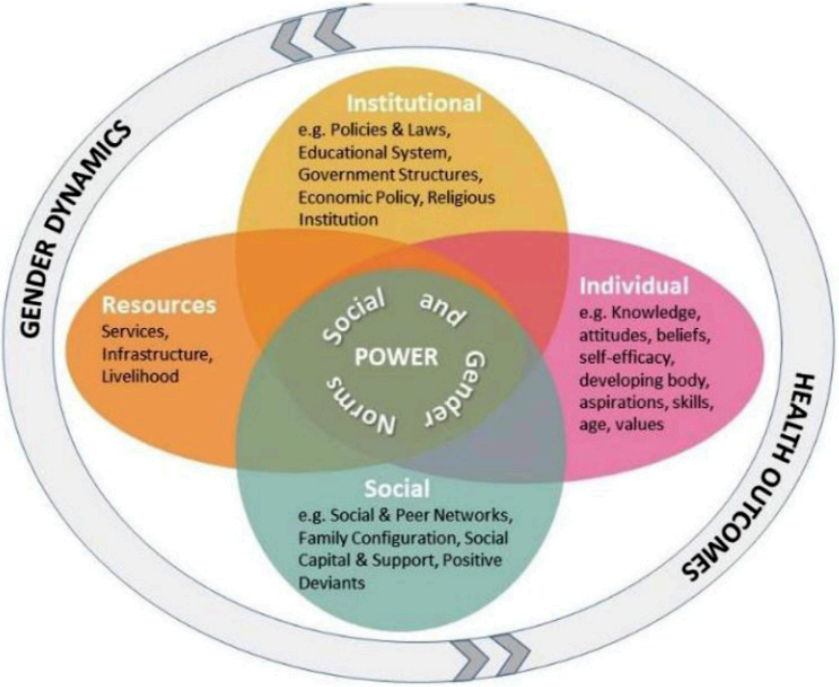


Figure 1. Conceptual framework highlighting centrality of social and gender norms, and power for ASRH (Adolescent Sexual and Reproductive Health), in Pulerwitz et al. (2019, S8)

One particular perspective that has produced excellent analysis of contracepting from a structural perspectives, and beyond individualising and individual responsibility frameworks, is that of reproductive justice (Gomez et al. 2018; Kaitz et al. 2019; Meier et al. 2019; Levey and McCreary 2022). Taking a reproductive justice perspective means contextualising, historicising matters of reproductive and sexuality, like contraceptives and consider that the meaning of, for example, reproductive freedom varies (Gomez et al. 2018).

Anu Manchikanti Gomez and colleagues (Gomez 2014; Gomez et al. 2014, 2020) have produced some great work in this regard, emphasising the need to remember histories of reproductive coercion in contraceptive praxis and promotion, particularly when it comes to LARC methods such as the IUD. As Gomez et al. explain, much 'current research around promoting LARC uptake assumes a logical model of decision-making and implicitly privileges planned pregnancies, and therefore LARC methods, as the best methods through which to achieve such pregnancies' (2020, 1368). However, 'promoting long-acting reversible contraceptives without a critical examination of their history in regulating the reproduction of racialized women' (Barcelos 2018, 259) is a recipe for a history of violence and coercion to continue and repeat itself. Gomez et al. (2020, 1375), Jenny A. Higgins (2014), and Stephanie Meier et al. (2019) have shown that these histories of coercion, reproductive oppressions, and medical mistreatments continue to shape experiences and perceptions of contraception, and LARCs today among marginalized women as well as their general trust in the healthcare system.

I share Gomez et al.'s belief that barriers to LARC methods should be reduced across the board for those individuals who desire them, as well as their concern in that an 'unchecked enthusiasm for them can lead to the adoption of programs that, paradoxically, undermine women's reproductive autonomy' (2014, 171) – an 'enthusiasm can quickly become coercion' (Brian et al. 2020, 313). Indeed there is evidence suggesting 'that providers recommend IUDs and implants more to poor women of color than to poor White women and more to poor White women than middle-class women' (Higgins et al. 2016, 1932). In order to avoid this, a shift is necessary: in which work to promote LARC methods puts 'the priorities, needs and preferences of individual women—not the promotion of specific technologies—first' (Gomez et al. 2014, 171).

In this context, one helpful concept introduced by Leigh Senderowicz is contraceptive coercion as a spectrum (2019). They highlight how coercion is not a binary outcome but rather exists on a spectrum, ranging from subtler to more overt forms and experiences. The subtler forms Senderowicz explains can include having very limited methods available, biased or directive counselling or false medical information while the more overt ones can include refusing to remove a LARC at a woman's request or inserting methods without a woman's knowledge or consent (2019, 6). They place practices such as threats to deny future care, using scare tactics, and insisting until the woman accepts as somewhere at the

middle of the spectrum (2019, 6). They also show how structures can promote coercion, such as an organisation having a certain quota of LARCs that they intend to reach (Senderowicz 2019), which is the case in the Swedish context (see SFOG-FARG 2019).

A type of contraceptive coercion that some feminist and intersectional scholars have problematised relates to patterns of LARC promotion on a larger scale, specifically, and how this in turn becomes 'a manifestation of reproductive governance' (Brian et al. 2020, 313). As Jenny Dyck Brian et al. have shown, LARC promotion from health campaigns and corporate advertising is very much 'ideologically productive' (2020, 313), in that they 'foreground the kind of woman who chooses an IUD or an implant' on that makes 'good choices for their health and their future children' (Brian et al. 2020, 316). LARCs are typically presented as common-sense tools for pregnancy prevention, in which, some 'young women are identified as especially in need of LARC because they cannot be trusted to manage their fertility in accordance with the normative model of sexual citizenship' (Brian et al. 2020, 316). In fact, LARC promotion discourse has taken for granted that 'all young women should and will be empowered to choose LARC to prevent pregnancy' (2020, 316) which, in turn, makes targeted LARC promotion justified and only rational.

Differentiating reproductive populations has a long biopolitical history (Yuval-Davis 1997; Collins 1998), including in the Swedish and Nordic context (Broberg and Roll-Hansen 1996; Hyatt 1998). In defining particular populations and bodies as risky, biomedical intervention is produced as rational and justified. Through 'a system of stratified biomedicalization, the IUD in particular has developed as a technological solution to a biopolitical desire to manage and control particular populations' (Levey and McCreary 2022, 5). As Madeline Levey and Tyler McCreary illustrate and argue, the 'history of the IUD involves a complex interweaving of initiatives to extend women's reproductive autonomy, control undesired reproduction within the population, and project forms of masculine medical authority over women's bodies' (2022, 6). Moreover, the role the IUD plays in gynaecological practice has 'shifted over time as the device has become entrenched in the processes of disciplining bodies' (2022, 14). This, as Levey and McCreary note, is a particularly unique step in the 'reproductive disciplining of bodies', as it is 'a contraceptive technology that has the capacity to transform those deemed irresponsible into non-reproductive bodies through insertion' (2022, 16).

Others have highlighted the role contraceptive technologies play in producing idealised sexual and reproductive citizens. Kristina Saunders, for example, demonstrates how 'neoliberal, postfeminist, and middle-class norms which intersect to classify reproduction as imperative for some women, while for 'others' it is classified as inappropriate and in need of regulation' (Saunders, 2021, 75). As Chikako Takeshita (2012) and others show, LARC promotion and use of IUDs have come to signify a certain type of ideal sexual citizenship. Brian et al. explain that sexual citizenship involves 'normative configurations of personhood that are linked to national goals or ideals' (2020, 315). However, in contrast to state-sanctioned sterilisation policies of the twentieth century which several states including Sweden implemented, 'much of the contemporary discourse on sexual citizenship is neoliberal and emphasises individuals' roles in assuming responsibility for adherence to a normative model of sexual citizenship in order to prevent socially undesirable outcomes' (Grzanka and Mann 2020, 315).

Through this lens, young people and sexual education, can be understood as sexual citizenship in the making (Elliott 2014). As Sinikka Elliott found through their ethnographic study of sexual educators in high schools, 'sex educators rely on and reproduce gender, race, class, and sexual inequalities in their lessons in personal responsibility that put forth a version of the good sexual citizen as self-sufficient, self-regulating, and consequence-bearing, what I call the responsible sexual agent' (Elliott, 2014, 221). As neoliberal logics dictate, Elliott argues, 'the responsible sexual agent is a self-regulating body. In addition, the responsible sexual agent knows that if she makes bad choices, it will be her fault and she will bear the brunt of the consequences (2014, 221). In this governmentality, health and sexual health in particular, is becoming increasingly individualised and a central moral concern: denoting what Elliott denotes as 'healthism' (2014, 314).

Critiques of the neoliberal view of contraceptive choice-making

The final contribution from sociological literature and scholars that I want to draw out, is one of particular importance to my own theorising and analysis of contracepting. Namely, those providing critiques of these neoliberal views and constructions of contraceptive choice-making and decision-making. Kara Granzow notes that as 'citizens of the Western world, we are living in an 'era of choice'' (2007, 44), which is built on two important components. One, that 'we see ourselves and others as autonomous beings with 'selves'' and, two, 'that we are

responsible for ourselves' (2007, 44). Granzow continues, arguing that 'this modern abstracted individual is a product of liberalist and neo-liberalist paradigms that presume agency, free will, responsibility and rational intellect (2007, 44). This has meant that much dominant feminist discourse has been that of liberal feminist discourse, which sees women's emancipation as a 'struggle towards women's inclusion as rational actors in the social and public sphere' (2007, 46).

There have recently been calls to provide more nuanced models of contraceptive or reproductive decision-making that, for example, unravels 'the illusion of a binary model of planned/unplanned parenthood' (Taragin-Zeller 2019, 370) and problematises simplistic discourses around risk and barebacking (Adam 2005). As Barry D. Adam outlines, the 'neoliberal view constructs human actors as rational, adult, contract-making individuals in a free market of options' (2005, 344). However, this is a view that cannot consider the 'much more complex motivators and vulnerabilities that characterize real human interaction and it denies the vulnerabilities, emotions, and tough dilemmas faced by people in their everyday lives' (Adam 2005, 344). While the neoliberal, responsibilizing discourse and rhetoric dominant in industrial societies (like Sweden) is 'available for making sense of, and formulating choice-making projects in everyday life, nevertheless it does not capture the totality of these projects, whether for groups of people or even for single individuals' (Adam 2005, 345).

There have been studies investigating the material conditions under which people choice-make, including troubling the meanings of choice itself. Nayantara Sheoran Appleton, for example, highlights the 'everyday material conditions under which women create narrative around choice and agency' regarding emergency contraceptive pills (2020, 1). Appleton asserts, that the women of the study 'were neither victims that needed rescuing, nor agents that needed glorification for fighting some monolithic power structure; rather they are women who draw from experiences, histories, and modalities of an evolving moment to negotiate their own individual forms of choice and agency' (2020, 15). Other important contributions to troubling meanings of choice include Geampana who notes that debates on weighing the risks and benefits of different contraceptive technologies, is also a 'discourse of individual choice, where consumers are assumed to benefit from having more options, regardless of what these options actually entail' (2019b, 1132).

Raising the question of what counts as meaningful choice and interrogating the limitations of existing contraceptive options that individuals are meant to choose

from responsibly and rationally, is vital. Stefanie Clarke et al. have conceptualised this choice in this regard more like a 'pseudo-choice' (Clarke et al. 2020, 983) while Wigginton et al. have proposed that contraceptive use 'could be understood as a constrained choice (...) as something women 'must' use (and choose) or something they feel 'forced' to be in charge of, because of their current priority to avoid pregnancy' (2016, 735-736). However, as Appleton rightly points out, agency is not only limited to actions of choosing this or that but can also mean refusal: choosing not to use contraceptive technologies or contracept. Yet, this is seldomly seen as the case. Moreover, as Higgins writes, 'effectiveness' is not the only characteristic influencing people's contraceptive choices: '[i]ndividual preferences will lead some women to choose non-LARC methods even when fully informed of their options' (Higgins 2017, 149).

Emily S. Mann and Patrick R. Grzanka (2018) have gone a step further, arguing instead that contracepting dynamics are more accurately a case of agency without choice. Investigating discourse of LARC promotion they find that the IUD or implant is communicated as the self-evident, commonsense choice for 'the young female citizen-consumer' (2018, 349) despite the various, complex reasons why someone may not want or decide to use LARCs. As such, LARCs become produced, even when seen with a more generous gaze, as not just the right tool, but the only tool for the job of pregnancy prevention (2018, 336). Furthermore, in tracing the lack of LARC alternatives, it is communicated that 'choosing a different contraceptive method, or choosing not to contracept at all, would be a bad—and implicitly irresponsible—choice, we see how the visual discourse across three sites comes to turn one specific "choice" into an imperative' (Grzanka and Mann 2018, 350)

Contained in this imperative is also the ideal and imperative of planning, which Granzow (2007) notes and Lealle Ruhl (2002) analyses. Ruhl argues that what is unique in contemporary discussions and 'debates about birth control and fertility control' is 'their emphasis on *self-control* (…) not the *wish* to plan one's births, to intervene in an inherently ungovernable process, but rather the *obligation* to do' (Ruhl 2002, 643-644). Ruhl asks, how then 'is it guaranteed that liberal subjects will assume the responsibility of self-regulation?' (2002, 645). In response, she suggests that this is where 'habits' enter: the production of self-control through 'good habits' (2002, 645). Yet, as Ruhl ultimately point out, the notion of family planning is somewhat oxymoronic, because 'pregnancy is occasionally planned, occasionally unplanned; if unplanned, it does not necessarily reflect deep personal

irresponsibility on the woman who finds herself unexpectedly "caught." It may, on the contrary, represent a failure of contraception' (2002, 650-651).

The notion of '[p]lanned reproduction is idealized as the manifestation of women's ultimate freedom (from the body) and the unplanned pregnancy confronts women with their failure to control (their bodies), their lack of choice in pregnancy and consequently their lack of freedom' (2007, 49). In using the pill, the 'responsibility for control extends beyond contraception in an immediate sex situation to become a part of a daily routine. Responsibility for self-regulating reproduction becomes an obligation even when not having sex' (Granzow 2007, 50). Yet, as Granzow maintains, choice 'is not some abstract universal property of life. (…) Choice in itself is gendered, classed, aged, cultured, and available only in accordance to ability and access' (2007, 52).

Instead it is more accurate or relevant to speak of contraceptive choice-making and decision-making as a complex process (Melo et al. 2015; Downey et al. 2017). Margaret Mary Downey et al. argue that, rather than a destination, contraceptive decision making is a journey: a journey that is iterative, relational and reflective (2017, 541-542). Juliana Melo et al, similarly, map out what they see as the process of adolescent and young adult women's contraceptive decision-making (2015). In doing so they create a conceptual framework to represent this process and its four stages: (1) contemplation, (2) preparation, (3) action, and (4) maintenance (2015, 226). While I agree with both Downey et al. and Melo et al. in their conceptualisations of contraceptive decision or choice-making as a journey and process, I still find myself wanting to move beyond conversations that centre the contraceptive choice- or decision-making. In the next chapter I will return to this and argue why I feel that there is a need for new conceptual developments, and specifically, that of *the work of contracepting*.

Conclusion

In this chapter I have reviewed the ways in which contraception has been researched previously, identifying central trends and tendencies in the literature as well as the most crucial sociological contributions to studying contraception. Overall, studies around contracepting continue to mainly be concerned with women (who can get pregnant) as a group – except for men who have sex with men. As such, trans people, non-binary people, women who have sex with

women, and men who have sex with women are largely erased as contraceptive users. Moreover, when more or multiply marginalised groups or populations are included and researched, dominant discourses around risk and pathology are overwhelming. Regarding young people's contracepting and sexual-reproductive lives and capabilities, the dominance of risk is similarly persistent. Overall, issues around pleasure, joy, and sexual acceptability are side-lined.

In both wider and sociological research there are persisting, stubborn concerns with exploring contracepting through the singular lens of informed decision-making and choice-making. The assumption that contraception is ultimately a matter of not knowing enough or needing to know better continues to be evident. And, even when it is acknowledged that unintended pregnancies or STIs occur even when correctly using contraceptive methods and knowing prevention perfectly well, the response and solution remains: more information, education, or choice-making. This consistent bottleneck in solutions implies that there is something more complex and messier going on than not knowing or informed choice. In fact, to me it signals continued formulation of solutions and responses based on limited and flawed views of the underlying issue or problem.

As Beynon-Jones (2013, 111) note in the context of their Scottish study on abortion (though it echoes wider contraceptive patterns): research in the area of contracepting has most notably been based on extremely limited empirical materials, namely the accounts of healthcare and medical professionals. And while there is value in such accounts, 'interviews with this single group of actors clearly provide very restricted insights into the socio-material complexities of healthcare practice' (Beynon-Jones 2013, 111). As they continue to suggest, which I strongly echo, it is even more crucial however, to look at the everyday realities, practices, and experiences that people engage in beyond the medicalized space of clinics.

The empirical gaps are even more pronounced in the Swedish context, as there are extremely few studies that explore contracepting beyond the medical space, through more critical approaches, and as a social phenomenon that is engaged in by more than solely a limited group of women. The sociological contributions I draw on, moreover, have mainly emerged from research on the US context which also highlights the need for more social and critical research in other national contexts, such as Sweden. After having reviewed the existing literature on contraception, I will now move onto to present the design of this particular study; its theoretical framework and conceptual tools, followed by its methodology and study design.

Chapter 3. Theoretical framework and conceptual tools

Theory and concepts are some of the key tools we have at our disposal as scholars and researchers. We think with and through the language, imagery, and imagination of theory and theoretical concepts. What makes a theory or concept relevant is the extent to which they can help us do something: whether it is explain, highlight, compare, critique, suppress, obscure, illuminate, show, produce, break down, construct, or deconstruct something. As Dorothy E. Smith notes, a research puzzle or problematic may be developed from the researcher's own everyday experiences of a particular phenomenon (Smith 2005, 207). However, as she argues, the 'actualities of the everyday world doesn't tell you what to observe and record' but rather 'needs theoretical specification to guide the direction' (Smith 2005, 209) of the researcher's gaze.

Theory and concepts are crucial tools of our trade (to echo Howard S. Becker (1998)) and are embodied and subjective. Depending on their format, structure, or organisation, one can do, see, dissect, or highlight different things: that is, some realities are more encouraged or supported than others, depending on the specific theory or concept one employs. Smith calls this theoretical specification an ontology to emphasise the realness of what is being discovered and justify the possibility of discovery (Smith 2005, 209). Theory or theoretical concepts only come into meaningful existence by social context which structures, if not governs, our interaction or entanglement with it. How you choose to use a theory or concept is subjective and shaped by socio-cultural forces. In that sense, theory or concept often are multifaceted in meaning and in their deployment.

In this chapter I will present the theoretical framework and main conceptual tools of this study. I will first present the central concept of work as well as explain how I understand and will utilise this concept. Second, I will present and outline specific work-based theoretical concepts useful for studying contracepting

experiences and practices which I employ within my analysis. Finally, before concluding, I will present the critical relational approach I have taken to investigating contracepting experiences and practices.

1. The central concept of work

In this section, I will outline the central concept of work as the foundational concept of this thesis' theoretical framework. I start by discussing the choice to focus on contraceptive activities or practices as *work* rather than the more commonly utilised *use*. Second, I further outline what is contained in, and draw the conceptual boundaries of, the concept of *work* within this research project.

Defining work

The concept of work has various histories and cultural connotations depending on language and academic tradition. In modern industrialised societies, work is sometimes referred to as a folk concept, something most of us have a common sense notion of what is (Daniels 1987, 403). Typically, as Arlene Kaplan Davis suggests, work is understood as 'something that, whatever its status, is hard (it can be arduous, boring, taxing, challenging, stressful), yet we have to do it' (1987, 403). Davis argues that the folk conception of work is shaped by three elements: '(1) the differences between public and private activity; (2) the importance of financial recompense; and (3) the effects of gender on judgments about the legitimacy of calling an activity work-or if it is recognized as work, giving it a high value' (1987, 403). I share Davis' view that these commonsense understandings are highly restrictive and makes invisible many types of work that do not conform to these three ideas.

Within this project, the concept of work is used along the lines of Marxist feminist thinkers such as Dorothy E. Smith. She argues that in institutional ethnography '"work" is used in a generous sense to extend to anything done by people that takes time and effort that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about' (Smith 2005, 151-152). Crucially, Smith also underlines that work is something 'intentional: it is done in some actual place under definite conditions and with definite resources, and it takes time' (2005, 154). Like Smith, I

understand the concept of work as an important guide which orients the researcher 'to what people are doing and to the forms of coordinating people's doings that make up that complex of work organization' (2005, 161).

This kind of critical understanding of work is particularly central when looking at contraceptives and is foundational to my understanding and analysis of the work of contracepting. What I find so impressive in Smith's articulation of work is how it provides the space for agency of those doing work whilst still recognising the structures that organise, shape and impact how they are able to understand and go about doing this work. I also appreciate the focus on people's experiences of doing work as this opens up to exploring more than the activities and results themselves. Because, as Smith argues, 'when people are speaking of what they do as work, they can also include how they think about it, how they plan, and how they feel' (Smith 2005, 155). Smith manages to include the individual experiences and challenges of doing work whilst not losing sight of wider dynamics, power relationships and oppressive structures. As such, framing contraceptive use as work has been particularly important as it encourages both me and participants to broaden our thinking of what this use can involve.

Studies around young people and contraception, in Sweden and beyond, has tended to be interested in mapping, measuring, and explaining their *use* of contraceptive methods. They have been particularly interested in examining contraceptive decision-making, contraceptive choices, as well as reviewing contraceptive counselling. Some scholars have begun to more critically examine the idea of free and meaningful contraceptive choice and decision-making (Granzow 2007; Downey et al. 2017; Mann and Grzanka 2018; Littlejohn 2021), but there is still much to unpack and explore. As I argued in the previous chapter, across many previous studies and their underlying problem-formulations, there has been a taken-for-granted focus on contraceptive use. Especially consistent use of the most effective methods (often LARCs) which uncritically becomes constructed and understood as the end goal, only real outcome, and aim. As I showed in this chapter, the studies are often underpinned by a normative assumption that contraceptive use unequivocally is, and always should be, the wider (societal) goal. It is an assumption that sets up the problem in rather simplistic terms, contrasting contraceptive use and contraceptive non-use in binary ways. It produces the notion of a linear contraceptive journey ending in use of the right and appropriate contraceptive method. However, as I argue

throughout within this thesis and as many know through lived experience, the story is usually not quite as simple or as linear as that.

By focusing on *use* of contraceptives the question and experience of physical use and non-use is centralised and we limit what we can ask and what kind of dialogues we can have with young people as researchers, healthcare practitioners, educators and publish health professionals. It is crucial to understand and unpack meanings of contraceptive non-use as something complex. Rather, we must approach contraceptive practices, including choices of non-use, with respect and as understandable and not irrational choices. Talking about contraceptive use and non-use in binary and simplistic normative terms (where use is deemed good, and non-use bad) limits our imaginations and capacity for conversation in various ways. It limits the imagination of who is and can be involved in the different efforts and activities of contracepting, and what those efforts and activities involve beyond the physical usage of contraceptive methods.

So, while it is hopefully clear why a singular focus on investigating and being concerned with young sexual and reproductive actors' contraceptive use is problematic, what is gained and what are the benefits of conceptually focusing on contracepting as *work* rather than contraceptive *use*? Looking at contraceptive activities, including use and non-use, as work enables a shift in perspective that opens up for seeing, telling, and hearing a more nuanced and complicated story. A story of what deliberations, thoughts, feelings, relationalities, and practicalities are involved in young people's contraceptive choices, practices, and experiences.

The concept of work allows for an inclusion of contraceptive-related activities that are not just about the physical or practical usage of a method – like taking a contraceptive pill every morning, wearing a condom, or getting an IUD inserted. The concept of work can help us better acknowledge and understand that these activities are not one-off achievements but require and are dependent on all sorts of resources and efforts. One can ask what efforts and resources are needed for doing these 'lines of work' (see Corbin and Strauss 1985 for discussion on resourcing illness work), and where resources are understood as time, emotional or physical energy, money, knowledge, and social, practical, and emotional support. The work of contracepting requires and is contingent on a range of resources, resources that can be various degrees of adequate or inadequate, available, or unavailable, and in competition with other needs, wishes and desires. By moving from focusing on young people's contraceptive *use* to their *work* of contracepting we can then move towards talking about young people's

resourcefulness, emphasising agency, keeping in mind the structural restrains and benefits afforded by their social and societal positioning in terms of power, privilege, and oppression.

Work as contextual

An early question I got when outlining my employment of the concept of work within this thesis was that 'it sounds like everything can be work all the time, so when is it not work?' Based on the various conceptual examples of work, it might be fair to wonder what the boundaries of the various work-concepts are. Because surely there are activities and events that cannot be considered or labelled work?

One of my supervisors in discussing this gave as an example, the activity of sleeping as an instance that, on the one hand, could be construed as non-work: where going or falling asleep is simply an activity that is done by some without any particular planning, efforts or concerns. On the other hand, as they also pointed out, for others, the activity of sleeping can entail enormous amounts of management, effort, energy, and concern. One might need to make particular arrangements (physically, socially or temporally), take sleeping medication, or practice routines for relaxation – all activities that could reasonably and clearly be considered work. As such, the question of whether something is or is not – could or could not – be considered work is not a question of the discrete *type* of activity but a question of circumstances. As Susan Leigh Star and Anselm Strauss (1999, 14) similarly argue, what counts 'as work does not depend *a priori* on any set of indicators, but rather on the definition of the situation'. An activity can be or require more or less work depending on the wider social context and the relationship between the person or persons doing the work, the nature of the work and the wider context in which the work is carried out. As such, 'the nature of work changes over time and in various contexts' (Daniels 1987, 411).

Another entry point to this discussion could be to consider what the opposite to work would be. The first term that comes to mind for me, and that has been suggested to me by several other scholars, is play: engaging in some activity purely for enjoyment and recreation rather than a serious or practical purpose. Yet, I find this suggested opposition troubling for similar reasons as I would find hobbies as a suggested antonym to work insufficient. Playful activities or activities of play can and often do require planning, efforts, and consideration: for both child and adult play. Ultimately, work can involve play just as play can involve work. To

reiterate, the question of whether something is or is not – could or could not – be considered play (or work) is not a question of the discrete *type* of activity but a question of circumstances and meaning-making.

In 2005 Julian Kücklich published an article titled *Precarious Playbour: Modders and the Digital Games Industry* introducing the concept of "playbour", combining play and labour. In doing so he aimed to 'gain insight into the changing relationship between work and play in the creative industries, and the ideological ramifications of this change' (Kücklich 2005, n.k.). Moreover, in order to clarify to conceptual slipperiness between play, or leisure, and work, or labour, Kücklich argues that it 'seems necessary to differentiate forms of "productive leisure" from unproductive leisure' (Kücklich 2005, n.k.). This discussion, however, is clearly based in the situated specific sense-making of work of 'modding' (computer game modification) and this particular form of unpaid labour. As such, when Kücklich writes and speaks of play, labour, and playbour, the meaning of play is mainly that of game play. Having said that, it does raise an important point about the fluidity and messiness of the meanings of play and work, leisure and labour. Finally, it also underlines the importance of considering processes of work and play contextually.

When it comes to pregnancy or STI prevention, I find it more useful to think of it in such terms: of more or less work depending on the context and circumstances. Some circumstances where it might be relevant to speak of pregnancy or STI prevention as being little to no, or at least far less, work include: when a pregnancy or STI is not unwanted or of great concern; when you do not think or feel that you are so to speak at risk of unwanted pregnancy or STIs; when you do not think or feel that pregnancy or STI prevention work is work you are normatively supposed to or required to do; or, when the work is outsourced to someone else or being done for you. Moreover, when it comes to the work of contracepting, it can be more or less work for different people at different times for different reasons. Perhaps, you do not see or feel the need to prevent a potential pregnancy or STIs through contraceptive strategies, or you are using contraceptive methods or strategies that – for you – does not require too much effort, energy, time, or resources. Then the experience of doing the work of contracepting might not be a particularly laborious one.

Ultimately, the personal experience of doing the work of contracepting is what is key and what should be our concern as researchers, policymakers, educators, and healthcare professionals. There is no objective way to determine an activity as

more or less work. Depending on circumstances, social location, and structural positioning in society in terms of intersecting privilege and oppression, one contraceptive activity might be a non-issue for someone while it is laborious, difficult, or tiring for another. If one uses the example of getting contraceptive counselling, determining when it is more or less work and what circumstances would make it easier or more difficult work depends on a range of factors. These can include knowing where to go, how to get there, what the appointment involves, how to logistically arrange the appointment, what kind of questions one should ask to the midwife/doctor/nurse, getting time off school or work, being able to physically go to the appointment, having the financial means to pay for a potential fee or other costs, having someone who could accompany you if needed, feeling comfortable within the medical and healthcare system, and having wider social or emotional support. This is not an exhaustive list, but only some examples of what can be involved in the work of contracepting at first glance.

Joining feminist efforts to reconceptualise and broaden the meaning of work

In feminist traditions work has often been employed to reconceptualise a social phenomenon and critique the dichotomy of public/private that defines some activities as work and others as not. Feminist scholars and activists have contributed to challenging what is understood as work and critiqued how as a society we value and make sense of different forms of work, calling 'attention to the issue of just what is work by insisting on the importance of all the activities where women predominate' (Daniels 1987, 405). The meanings around both work (and labour, as these have sometimes been used interchangeably) have strongly revolved around and been related to paid work or employment: where work or labour meant activities done in the public sphere, whereas activities in the private sphere where not conceptualised in the same way. This is something that feminist thinkers started challenging as early as the turn of the last century (Gilman 1903) and, later on, especially second wave feminists (Oakley 1974; Federici 2012 [1975]).

There have been, broadly speaking, two concerns in the reconceptualisation efforts of different feminised activities by previous feminist thinkers and theoreticians. The first have been concerns regarding the concept of work in economic terms, critiquing historical and gendered distinctions between unpaid

and paid work (Oakley 1974) and exploring the hidden economic values of domestic and reproductive work (Federici, 2012 [1975]). Other feminist debates around work have not necessarily been about highlighting the economic value (or value in terms of market-output in economic terms) but more about the quality of the activity: about the work-ness quality of the activity. This concern has centred on recognising some activities as requiring skill and effort in the same way as conventionally recognised forms of work. These are activities that are not usually framed as laborious and taking effort and sometimes very particular skills.

The categorisation of previous feminist research interested in reconceptualising work is meant to represent tendencies and serve as useful heuristic descriptors to make sense of how work has been utilised in previous scholarship. Perhaps it is more useful to think of these two categorisations of previous feminist endeavours around work as a spectrum that involves instances of overlap between these framings. Moreover, the types of conceptualisation efforts can also be seen as reiterative of each other: where the work-ness quality comes from the everyday understanding of work as paid employment and the prestige and recognition it brings.

An important element of the feminist efforts mentioned thus far, is to use the concept of work to reframe and recognise activities that have otherwise been unseen. The way that I try to study contraceptive activities through the lens of contracepting as work similarly provides a different conceptual lens or way of seeing something familiar: a shift in perspective that can better capture young people's contraceptive experiences and efforts.

In different undertakings interested in producing social change – whether it is research, grassroots organising, advocacy, or policy-making – the need to make a particular issue or problem more visible is often stressed. The logic behind it being that we can only fix the issue or start combatting the problem when wider society or central societal actors can perceive it. So, research needs to produce knowledge about and shine a light on a phenomenon either to raise awareness of the issue with the awareness-raising *in itself* as the goal or to better advocate for particular changes necessary to start improving and solving the issue. Sometimes, however, it is not enough to shine a light or point to something with our current lenses or glasses, that is, the conventional ways of looking, hearing and listening to something in society. Rather than simply moving our gaze, one must reconfigure it. It becomes necessary to shift the perspective and look at the empirical world with different tools and lenses for an experience or issue to become speak-about-able and visible.

The point and necessity of making something visible through research is closely connected to issues around recognition. As Arlene Kaplan Daniels notes, the significance of work as a concept 'lies deeper than its importance as an indicator of status' (1987, 407). In modern industrialised societies, work 'provides a clue to a person's worth in society-how others judge and regard' them (Daniels 1987, 404) and any 'recognition of an activity as work gives it a moral force and dignity' (Daniels 1987, 404). For an issue or experience to be recognised, that is, not just seen but acknowledged by others, it must be visible. Yet recognition cannot be assumed to follow visibility implicitly and automatically. I want to note, however, that visibility may not always be desired. Susan Leigh Star and Anselm Strauss (1999, 9) note, 'visibility can mean legitimacy, rescue from obscurity or other aspects of exploitation'. Visibility can also 'create reification of work, opportunities for surveillance, or come to increase group communication and process burdens' (1999, 10). Processes of making activities visible can reduce their complexity and risk flattening and homogenising experience. As Star and Strauss argue, 'it is impossible to define anything inherently as visible or invisible; similarly, it is impossible *a priori* to say that either are absolutely good or bad, desirable or undesirable' (1999, 23).

2. Work-based concepts useful for studying contracepting experiences and practices

There have been several inspiring and generative work-based concepts developed by feminist and other critical scholars over the last few decades. I will now go on to introduce the readers to specific theoretical work-based concepts that will be used or referenced and that have helped me in analysing my participants experiences and practices with contraceptives. While I present these work concepts separately, it is important to remember that they are often deeply intertwined and sometimes even influenced by each other.

Invisible work

The first work-based concept I want to introduce has already been raised: *invisible work*. It was coined by Arlene Kaplan Daniels in 1987 to describe women's unpaid

work (especially household work and volunteer work) which have been culturally and economically devalued. Following Daniels' analysis, Erin Hatton sketches out how scholars have 'extended the concept of invisible work to characterize various types of feminized reproductive labour' (2017, 336) as well as a 'broad array of non-reproductive labour' (2017, 337). Hatton notes that while the concept has no clear official definition, the extensive literature on the subject 'suggests that invisible work may involve being physically out of sight (…), ignored or overlooked (…), socially marginalized (…), economically and/or culturally devalued (…), legally unprotected and unregulated (…) or some combination thereof' (2017, 337). However, as they go on to argue, these indicators raise more questions than they answer.

In response to this, Hatton presents a definition of invisible work as 'labour that is economically devalued through three intersecting sociological mechanisms – here identified as cultural, legal and spatial mechanisms of invisibility – which operate in different ways and to different degrees' (2017, 337). These mechanisms of invisibility that Hatton develops offer a pedagogical framework and language for better understanding and analysing different forms of work that is typically made invisible. The sociocultural mechanisms refers to work that is obscured or devalued through 'hegemonic cultural ideologies', such as gender, race, class, age, sexuality, or ability (Hatton 2017, 339). These mechanisms 'operate on at least two levels: (1) on workers' bodies through the requirement of hidden bodily labour; and (2) on workers' skills by naturalizing and devaluing them' (Hatton 2017, 338-339). The second kind of mechanism is work that is 'made invisible through sociolegal mechanisms: work that is legally deemed to be noneconomic, illegal or otherwise unregulated' (2017, 341). The third type is the sociospatial mechanisms which 'are in effect when work is economically devalued because it is physically segregated from the socially constructed 'workplace'' such as the domestic sphere or non-traditional worksites (2017, 343).

An important point that Hatton makes, which is worth bearing in mind in my coming analysis of the work of contracepting, is how invisible work compounds and can be ''multiply invisible' in the tradition of intersectionality theorists who analyse the intersecting axes of inequality and disadvantage' (Hatton 2017, 345). Hatton exemplifies how some types of sociolegally invisible work tends to be further obscured or devalued by sociocultural mechanisms. She argues that such 'is the case for volunteer work, care work and sex work, in which hegemonic gender ideologies obscure the fact that labour is being performed and lend

legitimacy to their exclusion from legal definitions of 'employment'' (Hatton 2017, 342). These mechanisms are further helpful in making sense of the other work-based concepts presented below.

A conundrum one faces in studying invisible work, such as household work or in Marjorie DeVault's case feeding work, is that it is sometimes 'literally invisible' since much of the time, this cannot be seen, it 'is largely mental work, spread over time and mixed in with other activities' (DeVault 1994, 56). In instances such as these, where 'the repetitiveness of the work can be deceiving, so that even those who do the work barely recognize how much they do' (DeVault 1994, 38) research projects can serve some purpose to shed light and acknowledge the work that is ongoing. In a similar vein, I wish to make it possible for readers to see the work of contracepting that often has remained invisible.

Household work and care work

As I have already raised, the meanings around work have historically revolved around and been related to paid work or employment: where work or labour are activities done in the public sphere, whereas activities in the private sphere have not been afforded the same status. This is something that early feminist thinkers started challenging around the turn of the last century. One such thinker was Charlotte Perkins Gilman (1903) who wrote about household work and the situation for domestic workers.

Gilman discusses the very concrete and tangible effects of not understanding this type of work as work, arguing that, '[f]or physical troubles, as we have before indicated, the home is no relief… There is no law to improve the sanitary condition of the kitchen, to compel the admission of oxygen to the bedroom. In the home every law of health may be disregarded with impunity' (Gilman 1903, 77). She emphasised that by not calling the work done in the private sphere, in homes, work – the people doing said work struggle to argue for better working conditions and cannot come together as a workforce to advocate for their rights. Moreover, Gilman points out the gendered meanings of different forms of work, arguing that '[w]e consider the work of the woman in the house as essentially feminine, and fail to see that, as work, it is exactly like any other kind of human activity, having the same limitations and the same possibilities' (1903, 98).

House- or domestic work thus becomes conceptualised and constructed as the activities that women do and not men, who are 'too busy doing other things, too

blinded by their scorn for "women's work."' (1903, 116). Gilman goes on to sustain that woman was actually 'the first worker… [because] she is a mother… Motherhood means giving. There is no limit to this urgency. The mother gives all she has to the young, including life' (1903, 86). Here I think she strays from her otherwise strong argument on the gendered conceptualisation of work, towards naturalising motherhood and biological essentialism in order to make the case that 'the care of children become at last what it should be -- the noblest and most valuable profession' (1903, 122). Whilst I understand where this claim is coming from, especially in a context where all activities associated with women are misrecognised and demonised, it is still a problematic one.

Jumping forward in time to the mid-1970s and the second wave of feminist thinking, we find a similar debate in the work of Silvia Fedirici. Like Gilman, Fedirici discusses in her essay *Wages against Housework*, the desperate need to re-conceptualise how and what we understand as work. Very concretely, Fedirici argued for wages for housework, and she understood this as "political perspective" and not a thinking which can 'detach the end result of our struggle from the struggle itself and… miss its significance in demystifying and subverting the role to which women have been confined in capitalist society' (Federici 2012, 27). In contrast to Gilman, Fedirici does not see housework and reproductive work as something noble. She powerfully maintains, '[t]hey say it is love. We say it is unwaged work. They call it frigidity. We call it absenteeism. Every miscarriage is a work accident' (2012, 27). Moreover, Fedirici is clear that she, or rather they as she writes as part of a collective and a movement, is 'not struggling for a more equal redistribution of the same work… [but] to put an end to this work and the first step is to put a price tag on it' (Federici 2012, 49). For Fedirici the struggle is as much against patriarchal as much as capitalist modes of production (Federici 2012, 50), something I think is key in understanding, unpacking and challenging the structural organisation of gendered work/labour relations.

Beyond challenging the thinking of what we think of as work at all, and extending it to household work, Fedirici also has powerful analysis of how we can understand and explain this dynamic, and the meanings attached to it. When Fedirici talks of recognising housework as work, she argues it is not 'a job like other jobs, but we are speaking of the most pervasive manipulation, and the subtlest violence that capitalism has ever perpetrated against any section of the working class' (2012, 28). However, what I find to be her strongest argument in her analysis of housework is the impact of the historical construction of woman's

"natural" proneness for this particular type of work, exemplifying what Hatton later come to call sociocultural mechanism of invisible work enacted through naturalised skills. Fedirici writes that housework 'has been transformed into a natural attribute' of women and 'the unwaged condition of housework has been the most powerful weapon in reinforcing the common assumption that housework is not work' (2012, 28).

In making this case, Fedirici points to something fundamental: that it is not enough to only argue for wages for housework, as this will not succeed as long as the ontological status of housework as *work* is changed. Because, if 'it is natural to do certain things, then all women are expected to do them and even like doing them' (2012, 30). Thus, the struggle for wages that Fedirici and others propose is about something much more than wages for work. To demand wages for housework, she argues, 'is to make it visible that our minds, our bodies and emotions have all been distorted for a specific function, in a specific function, and then have been thrown back at us as a model to which we should all conform if we want to be accepted as women in this society' (2012, 30-31). Finally, what I think Fedirici manages to illustrate and argue so well, is the deep complexity underpinning the social organisation of work in society, and how we much both unpack what we understand as work on many levels to argue for the recognition of something, like housework or contracepting, as work.

A concept which is closely related to household or domestic work, that I want to connect here, is care work. The meaning of caring can be, much like that of work, wide-ranging and ambiguous. I appreciate Berenice Fisher and Joan Tronto's suggestion that caring can be viewed as a '*species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible*' (Fisher and Tronto 1990, 40). By world they include 'our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web' (1990, 40). Fisher and Tronto further explain caring as a process with 'four intertwining phases: *caring about, taking care of, caregiving, and care-receiving*' (1990, 40). Additionally, they suggest that caring as a practice also involve 'certain *ability factors,* specific preconditions of caring activity. The most important of these factors are *time, material resources, knowledge,* and *skill*' (1990, 41).

Emily K. Abel and Margaret K. Nelson suggest that 'caregiving is an activity encompassing both instrumental tasks and affective relations' (1990, 4) and argue for the importance of the social and historical context within care occurs. They

underscore that it is difficult to detangle caregiving from personal service due to ingrained societal inequalities such as class, race, and gender (1990, 7). Echoing these arguments, Fisher and Tronto note that we 'know that human "needs" change with the historical, cultural, class, and other contexts. We also know that such contexts involve power relations that affect the content, definition, distribution, and boundaries of caring activities' (1990, 40). As such, much like the work of contracepting, caregiving or care work must be examined within their specific settings and contexts in order to gain any meaningful understanding of what this entails in people's lives.

Epistemic work and emotion work

An element of both household and care work that I want to raise is the mental efforts and epistemic work they require. As Marjorie DeVault puts it in analysing the work of feeding the family, planning a meal is 'rarely recognized as the kind of intellectual problem it actually is… like solving a puzzle' (DeVault 1994, 47). When it comes to experiences and practices of contracepting, epistemic work is a crucial concept to bear in mind.

Epistemic work, as defined by Scott D.N. Cook and John Seely Brown, refers to 'the work people must do to acquire, confirm, deploy, or modify what needs to be known in order for them to do what they do' (Cook and Brown 1999, 399). Epistemic comes from the Greek word episteme, which can be translated to knowledge or understanding. Rejjo Savolainen argues that 'epistemic work includes both the explicit and tacit knowledge possessed by the individual, as well as knowing inherent in the actions he or she carries out' (Savolainen 2009, 6). Thus, epistemic work is something that is done by all individuals in their everyday lives. The work of knowledge and knowing, as explained by Cook and Brown, is 'done as part of action or practice, like that done in the actual riding of a bicycle or the actual making of a medical diagnosis. Knowing is dynamic, concrete, and relational' (Cook and Brown 1999, 387). I will return to and expand on this important topic of relationality in the final section of this chapter.

In Smith's (2005) articulation of work as a concept, the emphasis lies in people's experiences of doing the work including how they think and feel about it. I suspect that one of the reasons that Smith includes how people feel about their work and doing work is Arlie Hochschild's extensive contributions (Hochschild 1979a, 1979b, 1997, 2003; Hochschild and Machung 2012) on

theorising emotions and her conceptualisation of emotion work as a specific type of work. This is another feminist scholar that has shaped my choice to focus on the concept of work. Hochschild is primarily interested in the role emotions play in different social contexts, especially professional ones; not just how we actually feel or appear to feel in different situations, but how we try to feel according to what she terms emotional regimes. It is something that 'can be done by the self upon the self, by the self upon others, and by others upon oneself' (Hochschild 1979a, 562). Moreover, by the term emotion work she refers, 'to the act of trying to change in degree or quality an emotion or feeling. To "work on" an emotion or feeling is, for our purposes, the same as "to manage" an emotion or to do "deep acting." Note that "emotion work" refers to the effort – the act of trying – and not the outcomes, which may or may not be successful' (Hochschild 1979a, 561).

In Hochschild's understanding of emotion work, consciousness and intention are treated as key and is a very active process, something I appreciate and agree with. Whilst I think that these aspects are important to emphasise, I question whether consciousness and intention is so straightforward: like, either you are conscious and intentional in your emotion, or you are not. I see emotions as something more complicated. Often one may not be completely conscious of the emotion work one does or clear about what one is intending to feel. Having said that, I find Hochschild's concepts and writing incredibly useful, including her differentiation between 'two broad types of emotion work: *evocation,* in which the cognitive focus is on a desired feeling which is initially absent, and *suppression*, in which the cognitive focus is on an undesired feeling which is initially present' (Hochschild 1979a, 561). Finally, in contrast to many other scholars using the concepts of work and labour, Hochschild makes it rather clear that she understands emotion work and emotional labor as distinct things. She uses, 'the term *emotional labor* to mean the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has *exchange value*' whilst she uses 'the synonymous terms *emotion work* or *emotion management* to refer to these same acts done in a private context where they have *use value*' (1979b, 7).

I chose to present epistemic work and emotion work under the same heading because of their unique relationship and interconnection. Like several previous scholars of emotions have shown and argued extensively, the dichotomy of emotion/reason, and feeling/knowing is problematic and misleading, and the terms are in reality intimately intertwined (Jaggar 1989; Barbalet 2001; Bloch

2009). Like Sara Ahmed, I see emotions as relational, in that 'they involve (re)actions or relations of 'towardness' or 'awayness'' to particular objects. (Ahmed 2014, 8). In other words, '[e]motions are intentional in the sense that they are 'about' something: they involve a direction or orientation towards an object (…) The 'aboutness' of emotions means they involve a stance on the world, or a way of apprehending the world' (Ahmed 2014, 7). Determining a feeling involves 'thought and evaluation' while it is deeply felt by the body. The way I understand Ahmed's reasoning here, is that emotions and feeling always includes sense-making and knowledge production: emotional sense-making and negotiations that are ongoing and relational to materials, structures, ideology, self, and others. Knowing always involves feeling, and feeling informs and shapes our knowing.

A slightly different way of bringing together knowledge and emotion, is through what Sylvia Terpe discusses as 'epistemic feelings' (2016). She describes how, in the philosophy of emotion, 'a class of affective phenomena called epistemic feelings (e.g. certainty, doubt, or surprise)' (2016, 5). She argues that epistemic feelings are typified by two interconnected elements, namely: the quality of one's knowledge and the quality of one's emotions,

> For instance, feelings of certainty and evidence often refer to (explicit and implicit) taken-for-granted knowledge. In contrast, doubt and uncertainty indicate that existing knowledge and beliefs are getting shaky, while surprise, wonder, and having a hunch may announce new, but not yet clearly articulated knowledge and beliefs. Furthermore, I suggest that epistemic feelings not only address the quality of one's knowledge and beliefs, but also the quality of one's emotions. For instance, one person may be very certain about his/her feelings of guilt, while another may have doubts about whether his/her guilt is justified or whether it is guilt at all, and not shame, anger or some other emotion that he/she is feeling. (Terpe 2016, 6)

In discussing and making sense of how epistemic feelings have been theorised previously, Terpe proposes and outlines a 'typology of three ideal-types of dynamic mechanisms' (2016, 8): moral elaboration, moral relativization, and moral closure (2016, 8-9). The first dynamic of moral elaboration, briefly put, 'arise out of the experience of gap… either moral certainties are shaken by moments of doubt and surprise, or the sense of a hunch… in processes of moral elaboration people try to re-phrase their (previous) moral commitments with the "vocabulary available in a given culture"' (2016, 8). The second dynamic, moral relativization, she continues, 'is dominated by epistemic feelings of doubt and

uncertainty… In moral relativization, the perception of moral plurality is coupled with an absence of epistemic evidence with regard to moral matters' (2016, 8-9). Finally, the third dynamic, moral closure, 'is characterized by strong epistemic feelings of certainty and evidence… Although moral closure can be regarded as the opposite of moral relativization, both dynamics are similar in their assumption that 'real morality' has to be unequivocal, only allowing one valid position' (2016, 9). In my analysis of young people's work of contracepting, I will return to these concepts of epistemic work, emotion work and epistemic feelings.

Patient work and articulation work

The final couple of work-based concepts I want to familiarise the reader with come from a slightly different scholarly space. Feminist scholars are, of course, not the only types of researchers who have been concerned with reconsidering and making sense of different activities through the lens of work. In the area of medical sociology, this has also been a concern in the form of *patient work* (Strauss et al. 1982; Corbin and Strauss 1985) – a concept with important connections to and inspirations for the conceptualisation of the work of contracepting. In 1982, Ansel Strauss and colleagues coined the concept of patient work (as a result of a two-year long observational study at wards across six hospitals in the Bay Area of California) as way to speak of 'patient's participation in their own care' (Strauss et al. 1982, 977). The authors were particularly interested in treating the patient in more agential terms, and ultimately critiquing the classic image and medical models of patients, chronic illness and the 'sick role' as 'temporarily passive and acquiescent, being treated by an active physician and helped by equally vigorous caretakers' (Strauss et al. 1982, 978).

In tracing the peculiarities of how patients both manage and shape 'work done on their illnesses' (Strauss et al. 1982, 977), they spoke of patient work as sometimes being: explicit and implicit (1982, 978), body work (1982, 979), visible or invisible, legitimate or illegitimate as well as something that often included psychological and identity work (Strauss et al. 1982, 980). They break down the type of work they found patients to be doing in the different wards they observed into seven types of work (*see table 2*). They further suggest that 'different modes of patient immersion in a ward's division of labor' could be traced from observing 'patients-at-work' and the relationship between patients and staff: expecting, demanding, inviting, negotiating, and teaching (Strauss et al. 1982, 983).

Table 2. Seven types of work of hospitalized patients introduced by Strauss et al.*

Type of work	Examples
Mirror image of staff's work	Giving urine, which staff takes to the lab for testing.
Supplementary to staff's work	Maintaining composure in the face of procedural tasks.
Substitute for staff's work	Activity staff were meant to do, or patients believe staff were supposed to do.
Work patients deem *necessary*	Activity patients deem necessary but not staff, like monitoring for potential error or incompetence.
Work to *rectify* staff errors	Directly rectifying themselves, or reporting/complaining to responsible authorities.
Work staff *cannot possibly do*	Identity work or giving information about allergies to certain drugs.
Work that is *outside the range* of what staff may conceive of as their work	Coping with highly personalised, deep identity problems precipitated by the illness.

*Table created by author based on article and conceptualisation of patient work by Strauss et al. (1982, 981).

The most obvious mode, according to Strauss et al., is instances where 'staff expect patients to work (whether staff calls it work or not)' (1982, 983). Others involve staff demanding to bear certain responsibilities or inviting patients 'into the division of labor' (1982, 983) because of, for example, a nurse being temporarily busy. By negotiating, Strauss et al. refer to instances involving some sort of trade-off between patient and staff, be it explicit or implicit. Finally, '"teaching the patient"' is translatable into getting the patient either to work or to work more effectively on [their] own behalf' (Strauss et al. 1982, 983). Ultimately, their argument was that, '[c]lear recognition of patients' work as part of the total division and organization of labor could result in a decrease of tension and conflict between patients and staff members, contributing towards more effective medical and nursing care, as well as more effective teaching of the patients themselves' (Strauss et al. 1982, 977)

Three years after this study was published and patient work was coined, Strauss, now collaborating with Juliet Corbin, continued these theoretical discussions: now based on a study of 'the work done by *the chronically ill and their spouses* in managing both the illnesses and their lives' (Corbin and Strauss 1985, 225). Here the concept of work was introduced slightly differently, instead moving away from the hospital to explain the management of chronic illness at home. In doing so

they break down chronic illness management into 'three lines of work' and their interplay: illness work, everyday life work, and biographical work (Corbin and Strauss 1985, 224). Conceptually, there is a lot one can draw on from their discussions, including to those interested in making sense of the management of sexual and/or reproductive health. Firstly, they usefully emphasise the variation and constantly varying nature of the work (of managing chronic illness), as it is sometimes routinely done and other times one-off. It can also vary a tremendously in amount, the time it takes and how often the work needs to be done. As such 'there is a great deal of variation, not only in the total types of work to be done for each line of work but also in the properties of that work' (Corbin and Strauss 1985, 226).

The second contribution I want to draw from this work is their application of 'articulation work' (Strauss et al., 1997 [1985]), 'to denote the planning and coordination necessary to operationalize any associated set of tasks' (Corbin and Strauss 1985, 242). Corbin and Strauss summarise the articulation as taking place at three levels,

> The first is the task. Each type of work is made up of bundles of tasks that occur sequentially or simultaneously… The second level of articulation is between lines of work. Both must be planned for and coordinated around each other, if gaps or omissions are to be avoided in either or both… The third level of articulation is that of resources. They must all be planned for and coordinated among tasks and lines of work. (1985, 242-243)

This kind of understanding of the everyday experiences involved in managing chronic illness crucially shines a light on and takes seriously the practical, mental, and relational forms of work that occurs outside of the medical venues (hospitals and clinics). With this in mind, my interest arose in developing the work of contracepting in analytic terms that acknowledges the work related to managing the sexual and reproductive body outside of the contraceptive counselling offices and healthcare clinics. Corbin and Strauss highlight this as well, noting the importance of understanding the 'problems which are entailed in carrying out their lives in the face of illness… in analytic terms' (Corbin and Strauss 1985, 246) especially considering how little support is given to people with chronic illnesses outside of the official medical spaces. Therefore, they argue, 'the ill are thrown back on whatever resources they can generate and maintain' (Corbin and

Strauss 1985, 246) especially in trying to manage and cope in these systems of medical and healthcare.

In this overall section on work-based concepts useful for studying contracepting experiences and practices, I have presented seven sub-categories of work that will be employed within the analysis (to different extents). This does not mean that another study on contracepting might need or choose to depart from different theories of work. With that said, for this study at this time, these were the concepts I have utilised.

3. Taking a critical relational approach to contracepting

As I have emphasised throughout this chapter, it is necessary to understand and analyse experiences and practices of work contextually. Any work of contracepting depends on the wider social context and the relationship between the person or persons doing the work, the nature of the work and the wider context in which the work is carried out. This understanding has steered me towards investigating and analysing the work of contracepting both relationally and critically. In the final section of this chapter, I will explain what taking a critical relational approach has entailed in this study.

The meaning of relationality and a relational approach

The relational thinking which informs my work comes from a few different strands of scholarly work, but mainly relational sociology (Emirbayer 1997; Crossley 2013; Powell and Dépelteau 2013) and material feminist thinkers (Thayer-Bacon 2010; Roseneil and Ketokivi 2016; Mauthner 2021). As Barbara Thayer-Bacon notes, relation signifies a great range of things from 'existential connections of things' (2010, 17) to interpersonal relationships (such as professor and student or sexual partners). Additionally, she also notes how the term relational is used in 'a general manner, as with social relationships between a citizen and their country, or the relationship of men to women' (Thayer-Bacon 2010, 17). Despite the various ways the term relation and relational are used, Thayer-Bacon argues that a common thread can be identified, namely in the theme of 'connection' to others (2010, 17).

For me, to take a relational approach is to put this notion of social relations as interconnectedness at the centre of the analysis and understand people as relational beings. I understand relationships as different contexts in which the work of contracepting is done. By relationships I include interpersonal relationships but also relationships to and between institutions, discourse, ideas, knowledge, non-human actors, things, and matter. Moreover, I share Thayer-Bacon's assertion that 'relations are transactional in that we affect each other, dynamically and functionally, and each is changed as a result' (2010, 17). That is, regardless of the type of relation we speak of, whether abstract or concrete, interpersonal or generalised, there is a mutuality and process of affecting and being affected through the connection. Following this reasoning, I believe that social reality is best understood in 'dynamic, continuous, and processual terms' (Emirbayer 1997, 281) where social phenomena are treated as 'processes, constituted by flows of action or interaction, which operate immanently to the life of individuals rather than on a separate order of reality' (Powell and Dépelteau 2013, 2). In this understanding, individuals are understood as 'always-already enmeshed in relations of interdependency with others and cannot be understood, even theoretically, apart from their relational contexts' (Powell and Dépelteau 2013, 2).

This relational perspective resonates with Dorothy E. Smith's notion of writing a sociology which 'starts from where we are in our everyday lives' and 'explores social relations and organization in which our everyday doings participate' (Smith 2005, 1). Like me, Smith sees discourse (ideas, knowledge, and more immaterial entities) as something that is 'among people's doings' and 'organizes relations among people; and while it speaks of and from and in people's activities, it does not exhaust them' (2005, 25). Smith focuses on the 'actualities' of people's lives and what the experience of these doings are for an actual person or group of people. In doing so, she manages to connect the micro (doings, activities, practices) to the macro (social structures, power structures). I share Smith's desire to analyse in this way and to have a relational approach in which '[t]hought, concepts, beliefs, ideology, et cetera, et cetera, are not allowed to escape into a metaphysical space set up for them in people's heads and outside their doings' (2005, 209).

I find this collapsing or bridging of micro and macro processes are best exemplified in Smith's conceptualisation of 'the problematic'; a term used 'to locate the discursive organization of a field of investigation that is larger than a

specific question or problem' (Smith 2005, 38). Smith stresses that, the problematic is not 'discursively constructed from what is particular to an individual; it may well start in an individual's experience, but as it moves to explore the *social relations in which that experience is embedded*, it necessarily brings under scrutiny relations that aren't peculiar to that individual (Smith 2005, 42 [*emphasis added*). This is crucial for understanding and being able to talk about how different, unique, situated, individual experiences relate to each other (without being the same) through a wider social system or structure.

Echoing such sentiments, Sasha Roseneil and Kaisa Ketokivi even propose the term 'relational person' to maintain the notion of an individual person within relational theorising. They suggest that defining a person explicitly as relational takes refocusing the attention to how our 'sense of self' is produced in relation to others and other things (Roseneil and Ketokivi 2016, 145). I share their desire to maintain the concept of the individual, albeit as seen through a relational lens. Ultimately, I find it fruitful and generative to understand individual beings as 'inter-actors: actors-in-relation' (Crossley 2013, 125) and people as being part of, what Natasha S. Mauthner (2021, 36) calls, relational webs.

Doing critical inquiry and the function of power

In addition to taking a relational approach, my approach to investigating the work of contracepting is a critical one. Critical inquiry usually entails, in some way, 'criticizing, rejecting, and/or trying to fix social problems that emerge in situations of social injustice' (Collins and Bilge 2020, 70). Or differently put, it involves examining or critiquing existing power dynamics in society that creates inequalities and injustices. Discussions around power often centre on either what power is, who or what has power, or how power functions. The latter is the more important one to me and my research. Overall, I understand power as a multifaceted concept and phenomenon: as something that functions at different levels, both micro and macro, discursive and material, interpersonally and collectively.

There are several reasons why a critical perspective is necessary in my relational approach to contracepting. One reason for why I explicitly talk of power and power structures is to contrast and challenge individualised, rationalised accounts and views of agency which dominate much scholarly work around sexuality, reproduction, and contraceptives. In my work I draw on a

view of power which 'highlights the ways in which broad historical, political, economic, cultural, and social forces enable some individuals to exercise power over others, or inculcate certain abilities and dispositions in some actors but not in others' (Allen 2016, 2). I am also guided by a 'constitutive conception of power' which 'focuses on the fundamentally transindividual and relational ways in which individuals and the social worlds they inhabit are themselves constituted by power relations' (Allen 2016, 2).

As likely evident by now, my conceptualisation of work and relationality is greatly influenced by the work of Dorothy E. Smith, and like Smith, my understanding of power is shaped by various scholars including Michel Foucault. In addition to conceptualisations around power/knowledge (Foucault 1980, 1995), I especially relate to Foucault's critical work on the history of sexuality and biopower (1978). Foucault argued that the way in which power or mechanisms of power functioned in the West has undergone 'profound transformation'. He maintained that this shift was 'a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them' (Foucault 1978, 136). He writes of this as a shift in a power focusing on administrating and controlling death to power of 'the social body to ensure, maintain, or develop its life' (1978, 136).

Foucault argues, commencing in the 17th century, 'this power over life evolved in two basic forms' with the first one being 'centred on the body as a machine' and the second being centred on 'the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes' (1978, 139). The prior was mainly concerned with matters of discipline and optimization: 'procedures of power that characterized the *disciplines*: an *anatomo-politics of the human body*' (1978, 139). The latter, on the other hand, was supervised and 'effected through an entire series of interventions and *regulatory controls: a biopolitics of the population*' (1978, 139). This power directed us 'toward the performances of the body' (Foucault 1978, 139). Both forms of power are relevant for developments of contraceptive dynamics in the Swedish context: in the disciplining power of the body of the individual human, and the regulatory power of the wider population and body of the nation.

Foucault further argues that there was an 'explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of "biopower."' (Foucault 1978). In the 19th century in the West, one of the most important and influential techniques or

technologies of power, he argued, was the 'deployment of sexuality' (1978, 140). In the intersection between body and population 'sex became a crucial target of a power organized around the management of life rather than the menace of death' (1978, 147). As such, the experience of doing, and context in which people do, the work of contracepting is shaped by these wider power dynamics that have produced and continue to shape the current sexual and reproductive landscape.

One element missing from Foucault's accounts on power that I believe is crucial to consider in investigating contraceptive experiences is the notion of agency. While I see different power structures, institutions, and discourses as strongly shaping, enabling, making difficult or restricting contraceptive practices and experiences in society, I still understand people has having agency in navigating and negotiating these structures or systems. With that in mind, I return to Smith who captures agency by insisting on focusing her inquiry on what actual people do. For me it is important to acknowledge and highlight the agency of young people in doing the work of contracepting at the same time as recognising and highlighting the power dynamics involved, and the injustices and challenges they can pose.

A norm-critical relational approach to contracepting, gender and sexuality

An important aspect of critical theory and inquiry, as noted by Chris Beasley (2005, 16), is to problematise and critique the mainstream, that which is taken-for-granted, and 'the norm'. As Beasley argues, critical theorising and thinking 'operates not as a mere description or analysis of 'what is' as given, but from the point of view of scepticism' (2005, 16). Being norm-critical often revolves around challenging taken-for-granted dualistic and binary thinking that continues to permeate Western societies. This can include dualisms such as nature/culture, rationality/emotionality, body/mind, and subjectivity/objectivity (Alaimo and Hekman 2008). This project has in many ways started from such a perspective, questioning why the contraceptive landscape looks the way it does, problematising what so called normal contraceptive use entails and troubling dichotomous reasoning. It has meant taking a norm-critical approach to contracepting, but also to gender and sexuality – two foundational analytical tools in analysing the work of contracepting.

Broadly speaking, I take a relational and postmodern approach to gender and sexuality, which moves away from seeing gender and sexuality as fixed, coherent,

and stable, towards seeing gender and sexuality as plural, provisional, and situated (Butler 1990, 1993). As Beasley summarises, in starting from such a perspective, '[g]ender and sexuality are conceived as the product of endless citation and reiteration of certain normative categories (such as man or heterosexual), rather than as formed out of an already existent biological basis' (Beasley 2005, 254). Thus, I see both gender and sexuality as socially constructed categories, albeit with real material effects.

Academic theories of gender and sexuality are abundant, rich and complex, and relate to everyday understandings and terminologies people use to best describe and make sense of their own gender, sexual identities and experiences. The academic and everyday understandings and usages of gender and sexuality-related terms have developed in relation to each other and continue to overlap, interact, and sometimes differ. As such, I want to clarify how different gender and sexuality terms and concepts are understood and used within this thesis.

I understand gender as an organising principle and relational process with historically and culturally specific meanings: 'a shifting and contextual phenomenon, gender does not denote a substantive being, but a relative point of convergence among culturally and historically specific set of relations' (Butler 1990, 14). Gender is something that is done in relation to other human and non-human actors. Judith Butler conceptualises gender as 'an ongoing discursive practice (…) the repeated stylization of the body, a set of repeated acts within a highly regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being' (Butler 1990, 45). Gender, while often naturalised and essentialised, is a relational doing and a practice creating the appearance of a fixed essence or being: the notion of man and woman, masculine and feminine, as something one *is*.

In less abstract terms, I use the concept of gender to highlight the socially produced nature of gender and gendered meanings attached to behaviours, practices, objects, knowledge, emotions, and other social phenomena. The way gender further functions in society, is by hierarchically categorising not only people but attributes and actions as 'male' or 'female', masculine or feminine in which that associated with the latter (male, man, masculine) is usually regarded as both the norm and as more valued. Thus, to speak of something as *gendered* is a way of describing it and express action (Pilcher and Whelehan 2004, 60). Much like I do by using *contracepting*, 'gender as a verb ('to gender', 'gendered', 'gendering', 'engender') is a reflection of changed understandings of gender as an

active ongoing process' (Pilcher and Whelehan 2004, 60). Or, as Joan Acker suggests, to say that any analytic unit is 'gendered means that advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine' (Acker 1990, 146).

As Butler notes, however, there are ways gender can be 'troubled' and there is agency 'located within the possibility of a variation' of the repetition of gender acts. This can be seen in a variety of ways and actions of people in society, including the growing vocabulary used to describe yourself. In designing this study and representing my participants, I have taken my cue from LGBTQ+ organisations such as GLAAD, Stonewall (2020) and (in Sweden) RFSL (2023). As such, gender (in addition to the more analytical conception previously discussed) refers to whether an individual categorises themselves as woman or female, man or male, or non-binary. Gender identity relates to a person's internal sense of self and their gender, whether that is man, woman, neither or both and can be described through terms such as: cisgender, transgender, and agender. When gender identity aligns with the sex assigned at birth one can be described as cisgender, whereas transgender refers to having a gender identity that differs from the sex assigned at birth. Agender refers to a person who does not identify as having a gender. Other terms that people might prefer to describe or represent themselves include genderqueer, gender-expansive, gender-fluid, gender-nonconforming, or pangender. This is by no means exhaustive and continues to grow and shift.

When it comes to sexuality, I understand it largely in similar theoretical terms to gender. Stevi Jackson and Sue Scott (2010) provide a useful differentiation and useful distinction between sexuality and sexualities. A distinction that I understand as one of theory versus empirics. Sexuality, when used in its singular tense, they argue, is meant to 'denote a sphere of social life interconnected with all other aspects of the social' whereas sexualities in plural, is meant to capture 'the variety and flexibility of sexual desires, practices and lifestyles' (2010, 163) as well as 'highlighting their diversity' (2010, 2). In doing so, they want to reaffirm their 'commitment to treating sexuality as a sphere of human, social activity and a field of sociological inquiry' (2010, 2). Much like gender, human sexuality is not 'fixed, but it is both reproduced *and* transformed as an ongoing accomplishment of everyday practices within wider social relations' (Jackson and Scott 2010, 151).

Like with gender, terminology and ways to speak about sexuality is rich and diverse. Sexual identity or sexual orientation can be understood to describe a person's sexual attraction to other people (or lack thereof), such as straight, heterosexual, homosexual, gay, lesbian, bisexual, pansexual, and asexual. Sexual identity is an important shaping factor in the work of contracepting. In my analysis however, more emphasis is placed on exploring and talking about different sexual practices between different bodies and the role that different contraceptives play based on these. As such, I do no refer to the notion of sex (as in biological sex or sex assigned at birth) but rather specify particular bodily capacities when relevant. For example, I may speak of a person with a vagina or penis, that can get pregnant, or that menstruates. I find that this is far more inclusive, useful and analytically relevant.

Conclusion

In this chapter, I have presented the wider theoretical framework and conceptual tools used within this thesis. I explained my approach to investigating contracepting as ongoing doings and practices, that can include both pregnancy and STI prevention. I outlined the rationale for the central concept of work and what this might help us reveal about contraceptive experiences and practices. I laid out why I focus on contracepting as *work* rather than contraceptive *use* and how this provides a useful shift in perspective. I argued that the notion of *the work of contracepting* is a different way to enter the conversation around sexual and reproductive health that relies on a different, more open-ended understanding of the underlying problem.

In the second section of the chapter, I presented work-based concepts useful for studying contracepting experiences and practices and that will be used in the analysis, namely: invisible work, household and care work, epistemic and emotion work, and patient and articulation work. Finally, in the third section, I argued for the importance of understanding work contextually and relationally and through a critical lens that considers the role and function of power in the work of contracepting. In the following section, I will present and explain the reasoning for the study and its design, specifically outlining and accounting for methodological departures, processes, choices, and outcomes.

Chapter 4. Accounting for methodological departures, processes, and choices

This study is based on empirical material generated from 27 individual in-depth qualitative interviews with 13 women, men, and non-binary people aged 18 to 29 of different sexual identities. All but one participant had experience of (or had considered that they might need) contracepting for both STI and pregnancy prevention, with the remaining participant only having considered their own contracepting needs in relation to STIs. Participants were mainly white cis women or non-binary people who could get pregnant that were or had been practising penetrative vaginal-penile sex but who did not identify as heterosexual. The interviews were carried out over the course of a year, from 2019 to 2020, mainly in person but also online or over the phone (due to the impact of Covid-19). In this chapter, I will describe, explain, and account for the resulting material and how I conducted my research, particularly how and why I ended up designing the project the way I did.

I will first describe the more overarching methodological approach I have taken, specifically in drawing from feminist and critical methodologies. Second, I will account for how I went about designing my research project investigating contracepting experiences and practices through qualitative in-depth interviews. I will also present the recruitment process and introduce the interview participants. Third, I will provide some methodological reflections from the research design and process, including negotiating some ethical tensions and reflect on the wider recruitment process. Finally, I will describe the analytical process and approach, outlining how I generated empirical material, identified analytical leads, and went about analysing stories of contracepting influenced by narrative inquiry and critical optimism.

1. Feminist and critical methodological departures

In this section, I will briefly outline and explain the overarching methodological approach of my research, which has informed the overall design of the project: general feminist principles that I stand by and the limits of feminist methodologies. The specific research practices and design choices following these principles will be illuminated in the following sections.

Facet methodology, reflexivity and investigating the social

In my research, I explore and investigate wider social dynamics, relations, and phenomena through everyday experiences and practices. Like Dorothy E. Smith, who describes her inquiry as map-making (2005, 29), I believe that inquiry and analysis of the social in the local (or micro) can be explicated or mapped 'beyond the local of the everyday' (2005, 11). Thus, I believe that the scope of what can be investigated or become visible from the specificity of someone's everyday experiences and practices extends to wider social dynamics. At least, one can contribute towards the 'mapping the relations that connect one local site to others' (Smith 2005, 29).

Beyond Smith, I find Jennifer Mason's (2011) facet methodology as particularly generative for guiding, explaining, and understanding my own research inquiry. Through the use of light and gemstone metaphors, the aim of a facet methodological approach 'is to create a strategically illuminating set of facets in relation to specific research concerns and questions: not a random set, or an eclectic set, or a representative set, or a total set' (Mason 2011, 77). Light-based metaphors are common in the social sciences and everyday language. In facet methodology, however, Mason suggests, 'it is better to express our dominant metaphors as "casting light" and "refraction", not least because these suggest an always partial, angled, illumination, but one that can nonetheless be very vivid' (2011, 80). I find this metaphor useful because it acknowledges the inevitability of making choices – explicitly and implicitly – when illuminating something or casting light on the gemstone of inquiry. One cannot cast light on all facets within research, rather, it is inescapable that the process of casting light on some phenomenon or experiences casts a shadow on others.

I also appreciate that Mason's facet methodology refuses to break any bond that the researcher has to worlds they move in and through. Facets, in Mason's terms,

'are always simultaneously methodological and substantive, and are directed towards puzzles about the entwinement, contingencies, and multi-dimensionality of the world' (2011, 83). This means that as researchers,

> (…) we are unlikely to enter any research engagement with data and the world without having crafted some facets to guide us. But facets will also be shaped and changed throughout the process, as new insights develop, new theories and concepts take shape, and new lines of investigation start to emerge' (Mason 2011, 83).

Accounting for these facets, and the process of insight and change, is a central task of the researcher. It requires what is sometimes spoken of as reflexivity, or actively considering the role of the researcher in the research process, which facet methodology as an approach and practice encourages us to do. I understand reflexivity as a thoroughly relational capacity and practice (Archer 2013, 145) which involves 'the regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their social contexts and vice versa' (Archer 2007, 4). As Margaret Archer emphasises, reflexivity is a capacity that all actors-in-relation can and do engage in, not only researchers.

In research practice, I find Natasha S. Mauthner and Andrea Doucet's (2003) suggestion to think of reflexivity as a spectrum useful, because regardless of how much we might want to be or consider ourselves to be aware and reflexive as researchers, we can never completely account for ourselves: our emotions, mind, and selves. Therefore, it may be more helpful to consider reflexivity in terms of 'degrees of reflexivity', 'with some influences being easier to identify and articulate at the time of our work while others may take time, distance and detachment from the research (…) through emotional and intellectual distance from our projects' (Mauthner and Doucet 2003, 425). With that said, just because we can never fully account for our intersubjective involvement with the world does not mean we should not try our best to 'improve our research skills and to enhance researcher transparency, (…) [and] continue to be reflexive; to throw as much light as possible onto our research practices and processes' (Bishop and Shepherd 2011, 1290). Ultimately, it is an important task of being a researcher to engage in practices of and engagement with reflexivity, of interrogating your own assumptions, intersecting privileges and oppressions, histories, and power, and how these shape the research process.

Feminist ethical practices and limits of feminist methodologies

A vital aspect of my relational and critical methodological approach is considering questions of ethics and feminist ethical research practices. As Donna Haraway puts it, making an 'ethical judgment is not a quantitative calculation at root but an acknowledgement of responsibility for a relationship' (2000, 147). Building on the previous discussion on reflexivity, I understand ethics as ongoing and inevitably bound up with all phases of research, that comes with being attentive to the different membership roles one embodies during the research process (Cooper and Rogers 2015, 4.6.).

As a researcher I am guided by feminist ethical practices: of researcher accountability, responsibility, advocacy, reflexivity (Rice 2009, 250) and embodied engagement (Rice 2009, 259). Drawing on some of Carla Rice's reflections around feminist strategies for embodied engagement, my research approach and analysis includes trying to emphasise 'contradiction, complexity and theoretical plurality (…), privileging of participants' experiential knowledges, agency and creativity; and (…) attending to experiences of difference throughout interviewing and theorizing' (Rice 2009, 248). I see my embodied engagement as related to a feminist ethic of care (Sevenhuijsen 1998; Mauthner and Edwards 2002). As Selma Sevenhuijsen suggests, an 'ethics of care involves different moral concepts: responsibilities and relationships rather than rules and rights' (1998, 107). A feminist ethics of care does not start or end with the process of seeking and getting approval from an ethics review board. Rather, it begins much earlier and never formally ends. It runs throughout the research, into analysis, writing, and dissemination.

With that said, the methodological implications of a feminist ethics of care can be more complicated and difficult in practice, especially considering the wider institutional setting in which we exist. As a feminist and critical scholar and researcher I argue against extractive and oppressive modes of knowledge production that have historically coloured academic institutions. Yet, it is difficult to entirely move away from the historical processes that have shaped the space within which I work. Kelly Limes-Taylor Henderson and Jennifer Esposito argue that the best real option is 'using others in the nicest way possible' (2019, 876). As they aptly note, 'it may be hard for us to reconcile the idea that much of our work requires taking advantage of others' socioeconomic positions, as well as their experiences in those positions' (Limes-Taylor Henderson and Esposito 2019, 886). They provide some suggestions for how researchers can think about

themselves as we do our work: '1. We don't know it all. In fact, we don't know much. (…) 2. We will get some of it right, but most of it wrong (…) [and] 3. We probably need our subjects/participants more than they need us' (Limes-Taylor Henderson and Esposito 2019, 886-887) I similarly understand that a necessary path forward as researchers is to acknowledge the messy context in which we work, resist oppression where it is found, and endeavour to be 'humble learners' (2019, 888) in our pursuit of knowledge.

Thus, while I am interested in challenging individualistic, neoliberal discourses around contracepting and cast light on contraceptive experiences that have been kept in the dark, I also do this research for my own research learning, pursuing a PhD, desiring a job and an income, and for my own sense of intellectual and creative development. But this is not a zero-sum game: there can be a multitude of benefits and interests without antagonistic competition. However, as Limes-Taylor Henderson and Esposito underscore, the danger lies in trying to make it appear as if our research projects can be fault-free. Openness to being wrong, to not getting it right, taking on feedback and critique, and (to paraphrase Samuel Beckett) trying again and trying better, and then maybe failing again but failing better.

Additionally, as colleagues have highlighted[21], participants are also agential and reflexive actors in the research process. Especially in research that relies on opt-in recruitment and participation (like mine) this becomes particularly evident. People may have all sorts of reasons for choosing to take part, including seeing the interview as a strategic opportunity for themselves to advocate for a particular issue or concern, or try to influence the researcher directly (Copes et al. 2013; Jacobsson and Åkerström 2013). They might also do so out of their personal activism or for a desire to have their stories heard. As such, the notions of benefit and harm, using and being used are complex ones.

[21] I am particularly grateful for the input from and conversations I have had with Mary Holmes and Oriana Quaglietta Bernal for these insights.

2. Research design: interviews and recruitment

After having given an overview of my methodological principles, I will now discuss the more specific research design and methodological choices of my thesis including relying on interviews as research methods and participant recruitment.

The choice of qualitative interviews

My research is, broadly speaking, concerned with contracepting as a social phenomenon and how it plays out for young people in their everyday lives. As I noted while reviewing previous literature on contracepting, research to date has often centred on the medical sphere, especially in Sweden. Another methodological tendency has been to rely on survey research or ethnographic research (such as qualitative interviews) with healthcare providers. Based on this, I have seen a need for more qualitative studies which instead centre on young people and that give them a space to share their stories of contracepting. I specifically chose to employ qualitative in-depth semi-structured interviews with the aim of better understanding their everyday experiences, interactions, practices, views, feelings, knowledge processes and sense-making around contracepting and contraceptives.

The reason I believe these types of interviews were best suited was because I wanted to explore young people's accounts of doing the work of contracepting in Sweden with more depth and nuance. As Mason explains, qualitative interviewing can be used when you depart from an ontological position in which 'people's knowledge, views, understandings, interpretations, experiences, and interactions are meaningful properties of the social reality which your research questions are designed to explore' (2002, 63).

Qualitative in-depth interviews are useful for giving 'participants the opportunity to describe experiences in detail and to give their perspectives and interpretations of these experiences' (Taylor 2005, 40) and for exploring 'research participants' statements about their experience, how they portray this experience, and what it means to them, as they indicate during the interview' (Charmaz 2014, 58). I find that a great strength of qualitative interviewing 'is that it can combine depth of understanding with purposeful, systematic, analytic research design to answer theoretically motivated questions' (Lamont and Swidler 2014, 159). Moreover, they can, 'reveal emotional dimensions of social experience that are not

often evident in behavior' as well as 'the imagined meanings of their activities, their self-concepts, their fantasies about themselves (and about others)' (Lamont and Swidler 2014, 159). These dimensions are difficult to access without talking to people.

Another important facet of why I have chosen to use qualitative interviewing is for pragmatic reasons. In the case of sexual experiences and practices including contracepting, making observations (for example) would be difficult or even impossible (Mason 2002; Lamont and Swidler 2014). As Mason further suggests, there are pragmatic reasoning for qualitative interviews, namely, because '*the data you want may not feasibly be available in any other form*, so that asking people for their accounts, talking and listening to them, and so on, is the only way to generate the kind of data you want' (Mason 2002, 66). Like with much hidden or invisible types of work in society, there are everyday experiences and practices that are taken-for-granted and not actively thought of. Much of the everyday, of memories, of studying the unspoken or invisible practices, or of studying unmarked identities, requires being asked, and often time to reflect and respond. It was with this methodological challenge in mind that I ended up deciding to do not one but two in-depth interviews with each participant, giving participants some time and space to reflect only to later reconnect and continue our conversation.

Doing two interviews and interviewing tools

I developed separate interview guides for the two interviews. The first (*see appendix B1*) was based around themes, usually starting with more open questions about the participant, asking what drew them to take part and to tell me a little about themselves. From there, the interview was loosely organized to first talk about the past: early experiences of contracepting, sexual education, how they learned about contraceptives and sex, and so on. After this, we often organically moved onto the present, talking about what their current relationship and situation around contracepting looked like and who and what this involved. After some trial and error, I found that starting off the interview by asking participants about their experiences of sexual education and learning about contraceptives for the first time was a fruitful starting point for the conversation.

Towards the end of the first interview, I would usually look ahead and ask what the young person thinks their future contraceptive situation might look like and

what they would wish it to be. I would always conclude the first interview by asking questions the covered the following: one, if there is anything else they wanted to tell me about; two, what they felt about the interview; three, how it felt to talk about these different issues and experiences, and fourth, if they would still be interested and happy to take part in the second, follow-up interview. I always ensured to finish transcribing the first interview, as well as taking detailed notes and noting down questions, before going into the second one.

The follow-up interview affirmed my belief in the value of reconnecting with interview participants a second time. This stems from my project's approach of casting light on wider social phenomena and dynamics by looking at everyday phenomena. I choose to do this because, as Ladd Wheeler and Harry T. Reis suggest, it is arguably 'the recurrent "little experiences" of everyday life that fill most of our waking time and occupy the vast majority of our conscious attention' (1991, 340). When it comes to studies on contraceptives, I believe this is particularly apt. However, going about studying the 'little experiences of everyday life' is not straightforward as participants, per definition, may not think of them as interesting or relevant to mention, or actively recall and remember them in the initial interview stage. Thus, to attempt to bridge this experiential gap, I asked participants back for another interview after they have had the time to mull over and further reflect on what was brought up in the first interview. I have found in the past, and in this project, that often memories or stories that did not come up immediately in the first interview session might very likely do so after some time. Thus, the need for a follow-up interview. For these interviews I also created a small reflection tool (*see figure 2*) that I introduced to participants at the end of the first interview, allowing the participant to engage by writing their own comments or making connections by drawing arrows between things.

When researching everyday experiences and practices (such as contracepting) that are seen as unimportant or something we do not necessarily reflect on actively, having a reflection tool that will trigger new ideas and perspectives can be helpful. I asked participants to continue these reflections at home, suggested that they can keep a diary if they wish or take the reflection tool sheet with them as well. I was careful to underscore that this was not a requirement, and that it was completely up to them how they wanted to engage with.

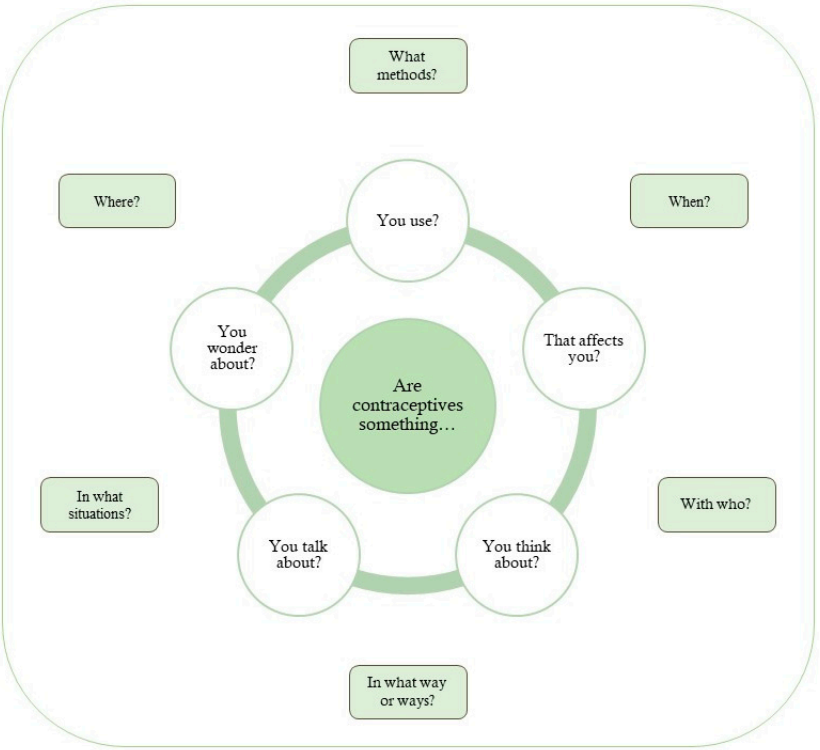


Figure 2. Reflection Tool

In the second interview we returned to what reflections and/or notes the participants had made and explored these further. Several, though not all, participants spent at least some time reflecting around the tool, either by themselves or with friends or a partner. Some participants forgot about it, whilst others got quite enthused by drawing or making notes on the figure. This was probably to be expected, considering how differently people remember, process, and reflect on everyday experiences, practices, thoughts, and feelings. As such, I believe its inclusion in the project was successful.

The second interview was differently organised than the first, and the interview guide (*see appendix B2*) varied more depending on the individual. After the first interview, I transcribed the interview and added and developed the interview guide based on stories or experiences that piqued my interest and that I was curious to hear more about, some aspects that were notably untold, follow-up

questions I missed in the first interview, and so on. The second interview was loosely organised around first talking through any of their reflections, thoughts or feelings that had come up since we met last (in relation to the reflection tool, if used). I would also ask any specific questions that had emerged for me from the first interview and transcribing process. After this, the conversation would turn a bit more future-oriented and speculative, talking about what they think a "good" respectively "bad" contraceptive method might be or involved, and about the roles and responsibilities societally speaking, when it comes to contraceptives. I would conclude in similar ways to the first interview, by asking how it had felt and how it feels to round off this brief interviewing relationship.

Another important reason why I wanted to do a second interview was ethics. Only doing one interview with someone, especially when the topic is deeply personal and intimate, always felt to me as abrupt and odd. In addition to giving participants time to reflect over a longer period, it also allowed for a more organic check-in, a continuing of the relationship and trust-building. This choice allowed me to engage in a more relaxed and calm interviewing style. It gave me confidence and made me feel comfortable to put the interview guide to the side. If there was something I realised I wanted to ask that I forgot to bring up in the first interview, I always had a second chance. This ease and comfort enabled me to be more present and engaged in the moment, to focus my energies on listening, paying attention to the interview participant, bringing in relevant stories and examples, and managing my own emotions. Or put differently, it enabled me to focus on creating a generative space for conversation and all that it entails. As Mason (2002) argues, in trying to evaluate whether one's interview practice and style is ethical, it can be useful to ask, answer, and reflect on: 'what you ask', 'how you ask it', and '[w]hat you 'let' your interviewees tell you' (2002, 79-80). By having two interviews, I was better able to think and reflect on my interview practice and style in the moment of interviewing, and to reflect and develop it between interviews.

Recruitment strategies: determining *who* and *how* to recruit

When I first started designing what eventually became this piece of doctoral research, I was keen to focus on interviewing individual young people, which I ultimately defined as the ages 18 to 29. My reasoning then for wanting to focus on young people of different sexual identities and gender identities – and individuals rather than couples – was because most studies concerned with

contracepting, or contraceptive use tend to centre on (often slightly older) people in monogamous hetero-relationships. That is, those constructed as "responsible" users (Giddens 1992). Now in hindsight, I realise that perhaps a more accurate motivation – that I could not quite put my finger on some years ago – was a frustration with the adult-centric, risk-centric, and public health-centric focus of previous research, veered towards pathologising young people's sexual activities. I was driven by a desire to speak with young people about contracepting not from the perspective of a sexual educator or healthcare practitioner (of which I am neither) but as someone who sees contracepting as something messy and complicated, that goes well beyond questions of contraceptive use or non-use and being concerned about getting young people to use more or better contraceptive methods.

When designing and planning the recruitment of participants in my first year, I was guided by an understanding of the work of contracepting as something that included more than the physical usage of, for example, the pill, IUD, or condoms. The way I articulated it at the time was that the work of contracepting also meant planning, negotiating, and considerations of choosing to use or not use contraception. As such, I argued, participants were not required to have tried a contraceptive method physically, only to have engaged in some aspect or another of doing the work of contracepting. My conceptualisation of the work of contracepting has developed since then and become more succinct. Yet, thanks to this initial design, I managed to keep focus on contracepting as something beyond use or non-use.

Thus, when I planned for recruitment in the early phases of the study, I decided that I wanted to focus on young cis, trans, and nonbinary people over the age of 18, with some sort of experience of either pregnancy and/or STI prevention. Additionally, for practical reasons I chose to recruit only individuals residing in the region of Skåne, in which I lived and worked. That is, I needed to be able to affordably travel for in-person interviews. I was interested in people of various sexual identities and with experiences of difference sexual practices to counter the heteronormativity of general contraceptive research. As Ben K. Beitin explains, '[q]uantitative researchers are in search of large, random samples that are representative of a larger population and can be generalized' while '[q]ualitative researchers are more interested in a small number of participants who represent the phenomena of interest' (Beitin 2012, 248). My recruitment strategy was

aimed at heterogeneity of experience and practice, to the extent that a small qualitative study can achieve.

My recruitment plan for gaining varied experiences and stories of young people's contracepting was therefore to use selective and strategic snowball sampling (Biernacki and Waldorf 1981). This combined generalised online and offline recruitment with specifically using my own personal, organisational, and professional networks and contacts within, primarily, sexual and reproductive rights activist circles. A particularly impactful source of recruitment was the membership-based sexual and reproductive rights organisation RFSU, who work specifically with young people, and often young LGBTQ+ people. I was already active in the local branch of RFSU before I started my PhD project, which gave me greater insight into the sexual and reproductive landscape in the region and across Sweden. Through it I got to know several individuals and actors that deepened my understanding of contracepting, sexual health, and sexual and reproductive rights issues in Sweden. It also meant I worked (in an activist capacity) alongside a range of central actors working in important online/offline spaces for young people's sexual and/or reproductive health and rights. Overall, this recruitment approach relied on the support of various gatekeepers or mediators who could help share my call for participants and information material.

The role of gatekeepers or mediators (Kristensen and Ravn 2015) can be particularly important when wanting to reach out to and access groups that you do not have immediate connections to, who experience marginalisation in society, or who have little or low trust in the institutions you are part of as a researcher (in my case, academia). In such instances, gatekeepers can not only inform and communicate with potential participants more effectively than an "outsider", but also serve as a mechanism for holding the researcher accountable. Sometimes, this can include being a literal gatekeeper: and stopping a researcher from recruiting at a time or place that they deem inappropriate or problematic.

Through selective/strategic snowball sampling, I strategically chose which networks and contacts to approach in order to access the participants that I was interested in accessing. Namely, cis, trans, and nonbinary people between the ages of 18 and 29, of various sexual identities. In order to counteract the normative pressure in contraceptive research to focus on heterosexual cis women, I particularly focused my recruitment towards reaching LGBTQ+ young people.

The two phases of recruiting interview participants

After getting the go-ahead for fieldwork (see case number 2019–01071 for my ethical approval), I decided to recruit a few participants for pilot interviews to see if my general interview approach and structure seemed to work. I did two pilot interviews (including follow-up interviews) during the summer of 2019 with: Anna[22], a single person in their early 20s who identified as pansexual and somewhere between cis woman and non-binary, and Nova, cis woman who in their mid-20s identified as pansexual who was in a long-term cohabitating relationship with a cis man. I recruited these participants through social media groups for RFSU members, of which I was already a member. I felt that this was a good starting point as I was already known figure in this space, and because the group included many young LGBTQ+ people. These were successful interviews and garnered rich and interesting stories around the work of contracepting, to the extent that I decided to include them in my general pool of empirical material.

After these interviews, I grappled with how to go about recruiting participants in a way that meant I was able to include more diverse experiences and storytelling at the same time as being aware of the study being more in-depth, and thus limited in number of participants. I therefore decided to carry out my recruitment more gradually and carefully and continuously re-evaluate my recruitment strategies. After the recruitment for the pilot interviewees, which were done via Facebook through my own personal networks and that of RFSU, I continued recruitment efforts over the course of a few months in the fall of 2019. I call this phase one of recruitment and interviews. I created recruitment materials (*see appendix D1*) and contacted different youth organisations (especially aimed at LGBTQ+ young people) and individuals in the region of Skåne that were active in the general area of sexual/reproductive education or politics (and that I knew had large social media followings to reach a broader audience) asking them to share my call for participants. I also posted my call in various local/regional social media pages and groups. I additionally contacted Youth Centres hoping to advertise my study in their venues, which they ultimately declined.

During this phase, I recruited another five young people. These participants all came through either local SRHR organisations or previous participants. I conducted interviews in person, either at cafés or in spaces at the university based

[22] This is a pseudonym and all names referring to participants are henceforth pseudonyms to ensure participants' anonymity.

on participant preference. In one instance I did a follow-up interview at a participants' workplace, and another at a participant's home. After conducting both interviews with these five young people, I paused recruitment and took time to reflect on the empirical material I was starting to generate and the makeup up of the participants I had recruited.

At the end of my full recruitment, I asked all participants to provide some further demographic information around identifications and background (*see appendix F*). All but one participant did so, and with this information I found that several participants that I had wrongly assumed to identify as cis or heterosexual, were in fact non-binary or pansexual. However, at the time, I did not have this information, which is what informed my choice to carry out the more targeted second phase of recruitment in early 2020. This prompted me to specifically call for participants who identified as a person of colour, LGBTQ+ person, person with a disability and/or working-class background (*see appendix D2*), dimensions that play particularly central roles in shaping experiences of and access to contraceptives and sexual and reproductive healthcare and support (Taylor 2010; Volscho 2011; Takeshita 2012; Ledger et al. 2016; Ela and Budnick 2017; Bahner 2018; Agénor et al. 2020; Wickström et al. 2020; Espejord and Sandset 2022). I got as far as starting to create new recruitment materials before the Covid-19 pandemic hit, which put this new recruitment phase on pause. It also delayed some follow-up interviews I had yet to complete, which ended up being carried out online instead of in-person.

In the early summer of 2020, I decided to continue the second phase of recruitment. With the summer and warmer weather approaching, it was now possible to do face-to-face interviews more safely outside, and I and many others had started becoming more accustomed to communication virtually using Zoom, Skype, or other digital communication technologies. Furthermore, time constraints and a worry about the continued pandemic made me feel that I could not postpone data collection further. Because of these time restrictions and my desire to recruit a more diverse group participants, I decided to increase the age range from 18 to 25, to 18 to 29. I also did this to be able to include a more diverse group of prospective participants who had gotten in touch following the new recruitment call, but who were slightly older than the original age range. To me, having a narrower age range felt less important than being more inclusive of more marginalised experiences related to race, ethnicity, class, disability, gender identity and sexual identity. Considering that young people make their different

sexual debuts at various ages, it also felt relevant to allow for participants whose contraceptive-related experiences or reflections may have increased later in their 20s. In the end, it also ended up being interesting and generative to hear stories from individuals broadly speaking in the transition from a young person who is able to go to Youth Centres, to a young person now required to seek healthcare in the adult healthcare system.

I found new social media spaces to share the call (where I asked the administrator of the group or page if I or they could share the post) and reached out to new gatekeepers to share my call for participants. At the time in Sweden, there was very little in terms of general pandemic guidelines and regulations limiting social interactions. However, to ensure the safety of myself, the participants, people either of us encounter, and the wider public, I decided to only give participants the options of doing interviews outdoors at cafés or parks, online (with or without camera), or over the phone.

During this round of recruitment, I interviewed six individuals, twice each. I am less sure of where specifically these participants heard about my research; however, I know that many came from the online spaces I had reached out to in this round of recruitment. One learning from this recruitment process has been that it might be useful to explicitly ask where participants heard of the study in order to better evaluate my recruitment strategies. In the end, my recruitment and interviewing process took place over the course of little more than a year, and was a combination of face-to-face, digital and phone interviews. In total, I conducted 27 interviews with 13 young people, in addition to three interviews with midwives (two currently or very recently working at Youth Centres and one working independently) to gain a better understanding of the healthcare system for young people when it came to sexual and reproductive health in contemporary Sweden.

A general presentation of participants and their backgrounds

I now want to briefly introduce the group of interview participants that ended up taking part in this research and that made this work possible. This information was gathered partly from the interviews and partly from the small demographics questionnaire I sent out at the end of 2020 (*see appendix F*).

Participants were between the ages of 18 and 29. The majority identified as cis men or women, and a few as non-binary, genderfluid, or somewhere between ciswoman and nonbinary. One person identified themselves as someone with

experience of being a trans person. Four individuals identified as pansexual, fiv as bisexual (some of whom explained with a leaning towards men or women), tw as gay, and one as straight. Most participants were in some form of long-ter relationship, but three were not (as far as I know). Several of the pan or bisexual women were in relationships with cis men at the time of the interview or filling out the questionnaire. Most participants were white Swedes, but three had racialised Swedish backgrounds. Three or four came from more working-class background, while the rest were middle-class. See table 3 for a further breakdown of these categories.

These descriptions are based on initial communication, identifications in interviews and responses to the short questionnaire, trying to use the direct words and language used by participants as much as possible. As the reader will see, there is some information missing in regard to two participants, and rather than me trying to infer or guess (which would be ethically and methodologically dubious), I chose to leave it blank.

Table 3. Description of interview participants in terms of age, gender and gender identity, sexuality, relationship status, racialisation, and ethnicity and socio-economic background

Pseudonym	Age	Gender & Gender identity	Sexuality	Relationship status	Racialisation & Ethnicity	Socio-economic background
Anna	Early 20s	Cis woman-Non-binary	Pan, monogamous	Single	White Swedish	Working-class background
Nova	Mid 20s	Cis woman	Pan	Relationship with cis man	White Swedish	Upper middleclass background
Stina	Mid 20s	Cis woman	Bi	Relationship with man	White Swedish	Middleclass background
Pim	Mid 20s	Non-binary, genderfluid with experience of identifing as transperson	Pan, poly	Relationship with man & girlfriend	White Swedish	Working-class background
Hugo	Mid 20s	Cis man	Gay	Relationship with cis man	White Swedish	Middleclass background
William	Early 20s	Cis man	Heterosexual	Relationship with woman	White Swedish	Upper middleclass background
Sally	Late teens	Cis woman	Bi	Boyfriend	White Swedish	Middleclass background
Helena	Early 20s	Cis woman	Bi, preference women	Relationship with cis man	White Swedish	Middleclass background
Miriam	Late 20s	Cis woman	Queer		Racialised Swedish	Working-class background
Mehmed	Late 20s	Cis man	Gay	Boyfriend	White Turkish	Middleclass background
Nicole	Late 20s	Non-binary		Single	Racialised Swedish	
Edith	Late teens	Cis woman	Bi, slight preference men	Boyfriend	White Swedish	Middleclass & working-class background
Gabriella	Late 20s	Cis woman	Bi	Relationship with cis man	Racialised Swedish	Lower middleclass

The descriptions and categorisations used by participants to describe their backgrounds or identifications must be understood as contextual and not fixed. At the time of the research participation, these were the descriptions that best matched the young people's feelings and senses of self. As Carol Smart notes, in critical opposition to historical tendencies in sociology to treat 'people as too material and too rational (….) sociological subjects are selves-in-process, not fixed at the point of interview but part of their own past and the socio-cultural history that has helped shaped them, and of course selves in the process of becoming' (Smart 2009, 4). As all people are relational, fluid beings, I am conscious that these identifications are of a time and place and may have changed since the time of their participation.

3. Methodological reflections from the research design and process

Before moving on to present and explain the analytical process of this thesis, I want to consider a few specific methodological reflections from the research design and process.

Navigating and negotiating initial ethical considerations

I applied for ethical approval for this project with the Swedish Ethical Review Authority at the end of 2018 since it would clearly deal with personal sensitive data related to both health and sexuality. My application was approved in early 2019 (case number: 2019–01071). In the application I carefully outlined how I would abide by research ethical rules and regulations. I also discussed some of the specific aspects that I saw as crucial wider ethical issues and how I would attempt to manage them during the research. These included, firstly, considering the potential vulnerability of participants. I (correctly) expected some of my eventual participants to be people who experiences marginalisation in society. This made issues around informed consent, power dynamics, transparency, and care particularly crucial. I also aimed for participants to feel empowered and like they gained something from participating, countering extractive modes of research where research participants are subjects to be probed for information.

Secondly, conducting research that explores sex and relationships brings out particular ethical issues to consider. Topics related to contraceptives (such as sexuality and sexual relations) can be sensitive to share and talk about, and it can end up being emotionally demanding. As I emphasised in designing the project and in my ethics application, this necessitated taking informed consent seriously, approaching it as an ongoing process (Hutchinson et al., 2002). In practice, this ended up meaning, in different ways and at different times, that I reminded the participants that participation was completely voluntary, that during the interview process they were free to take a break including pausing the recording device, and that they could withdraw from the study completely at any point in the data collection and analysis process, without needing to give me a specific justification.

Thirdly, to minimise the risk of discomfort on the part of the interview participant, I prepared for and remained attentive to physical cues (such as in speech, facial expression, or body language) that could indicate that the interviewee was distressed, in order to steer the interview on to another theme or offer them the possibility of taking a break or stopping the interview if necessary. In practice, this also ended up being about listening to my gut instinct, reading between the lines, and sensing the mood and emotions that emerged. Overall, I tried to give the interviewees as much freedom as possible in deciding what the interview would cover including how it was structured and going where they wanted to conversation to go.

Another important ethical consideration whenever one is talking to people about sex and relationships is the risk of past or current negative experiences, memories or traumas arising in the interview setting for the participant or researcher. To avoid the possibility of retraumatising participants, I decided to avoid posing direct questions relating to sexual violence. However, some participants brought this topic up in the interview quite organically. I therefore managed the interview so as to give them the freedom to choose for how long they wanted to continue the discussion. Researching particularly sensitive topics often ends up requiring a lot of emotion work for the researcher, highlighting the importance of caring for both the participants and yourself. As Virgina Dickson-Swift et al. note, '[r]esearchers working on sensitive topics, although not human service workers, are often exposed in a secondary fashion to the trauma experienced by others' (Dickson-Swift et al. 2009, 73).

Some participants did share stories and experiences of sexual abuse, rape, sexual coercion, and different forms of sexual violence. When they did, I tried to be

particularly conscious of how I listened and responded to their stories, acknowledging and validating these difficult experiences while being attentive to how much and in what ways the participant wanted to share and talk about them. In setting the scene for each interview, I was also communicative with participants throughout that they never had to speak about or share experiences they did not want to share or that they did not feel comfortable sharing. My previous research work, and activist and personal experience has provided me with insight and training into talking about experiences of trauma with others (especially gendered and sexual violence). I have, for example, received some training through volunteering at a women's shelter and being involved in activism around SRHR and sexual violence in the past as well as mental health first aid training.

I also prepared information to be available regarding different help services that the interviewee could turn to on request, if they felt that they would like further professional support or information. During interviews and on request, I also made information available about currently available contraceptive methods and where they can find more information on contraceptives and other issues concerning sex/uality and relationships. These provisions were, however, in the end, not utilised nor something any participant asked for. Sometimes questions around existing contraceptive methods would arise in the interview, and when I felt that I could safely and confidently answer them, I would. Sometimes neither of us knew the answer to a query. In such instances, I tried to investigate it between interviews and or suggest places where the participant could go for further information. However, I always made sure to explain that I was not a contraceptive counsellor or a scientific expert in the physiological, biological, or chemical functioning of different contraceptive technologies.

Reflections from and on the interview encounters

As already mentioned, the interview encounters ended up looking rather different – partly due to the impact of the pandemic and the need for social distancing and partly because of the semi-structured nature of the interviews and their ongoing development. The early interviews always influenced and fed into the latter ones, in terms of types of questions asked, themes or topics to keep in mind, or practical considerations around timing and location of the interview. As such, the interview encounters also involved ongoing reflections

and learnings. For this section, however, I want to mention a few reflections that came out of the interview encounters.

First, I want to reflect on including and interviewing acquaintances or friends within this thesis. Two participants of this study were people that I was either more intimately acquainted with or that I had recently befriended. In both instances, I had never spoken to them about contraception in any in-depth way besides sharing about my research topic. There can be obvious benefits to interviewing people you know, namely, already having some level of established trust and rapport. Yet, informally talking about something as friends or acquaintances is different from that of a formal research interview. This required me to be clear about the purpose and boundaries of the interviews and not use any information I might later learn about their contraceptive experiences after the interviews were conducted (or that I had from before). I have also chosen not to point out which of these participants I know from other settings for confidentiality and anonymity reasons. Ultimately, I believe having some sort of pre-established relationship shapes the interview in comparable ways to sharing other elements or facets of experience with interviewees: providing some commonality and grounds for connection.

A second reflection relates to the challenges of interviewing online compared to in-person. An interview is a conversation with a purpose, and whether a conversation feels comfortable and easy often depends on the quality of the relationship and the ease of having the conversation. Whether online or offline, practical matters such as the space of the interview contribute greatly to the feeling of the interview. And interruptions or distractions – whether a noisy café environment or a lagging internet – matters a lot for the quality of the interview. I am grateful that I was able to do interviews virtually or over the phone during the pandemic and thus able to carry on with my project without too much delay. As Oliffe et al. (2021, 3). have noted, there can be benefits of conducting videoconference interviews such as Zoom, including allowing participants to be interviewed from the comfort, safety, and ease of their home. Other benefits include cost and time efficiency and interviewees more easily being able to withdraw from the interview 'with a click of a button' (Deakin and Wakefield 2014, 613). However, as Hannah Deakin and Kelly Wakefield (2014, 613) found in their research, there can be drawbacks stemming from technological difficulties disrupting the pace and flow of the interview as well as challenges in building rapport. Personally, I experienced it as more challenging and tiring to conduct

interviews in this way as I found that trying to pay attention to tone and emotion was significantly harder while limited to either voice-only or voice- and video-only formats. It is likely that I might have been able to have kept the conversation going for longer if we had met in person. Having said that, doing the interview over the phone or online was what some participants preferred and felt most at ease with. As such, for some an in-person meeting might have been a barrier to their participation altogether. Ultimately, whether in-person or distance, interview studies carry with them varied pros and cons depending on the intersection of method, participant, theme, and researcher.

A third reflection that emerged from the interview encounters is the nuance and complexity of practising ongoing consent and ethical interviewing throughout. A key strategy in this was to sometimes cushion my questions, which involved pre-empting with 'we do not have to talk about this' or 'you do not have to answer if you don't want to'. Knowing when to cushion or preface a question with such sentences is tricky, and most of the time people did not say no directly but rather steered conversations towards things they wanted to or preferred to share or discuss. One notable exception was my interview encounter with Nicole, who explicitly said no to answering a particular question. To be honest, this straightforwardness did throw me off. But in a useful way, making me reflect on the utter importance of repeating, during different stages of the interview process, that it is completely fine to not answer a question, end the interview, or essentially withdraw consent at any time. Nicole may not have felt comfortable to or as comfortable to say 'I do not want to answer that question, and can we talk about something else' if I had not mentioned it in the information material, in our correspondence, and at the beginning of the interview itself.

Another important element of practising ethical interviewing involved trying to normalise and destigmatised certain experiences and trying to show that I would not judge a particular practice or experience, by, for example, referencing that 'some or many other folks have mentioned that…', 'it would be understandable if this felt difficult', and reiterating that it is not always easy or straightforward to go about contracepting. To reaffirm the non-judgmental space, I would also sometimes refer to myself or say that I understand from a personal perspective too in relation to their past or current contracepting or sexual choices, practices, or experiences.

Finally, one of the main takeaways from the interview encounters regarding the research design and decision to do a follow-up interview, was how much this was

both appreciated by participants (and myself) and valuable for generating more in-depth material. Many participants were hesitant about whether they would have enough to say in the second interview. But, reassuring them that I would be happy either way to meet them again, they all agreed and took part in a second interview. Almost all participants were surprised at how much they had to share, discuss, and reflect on in the second encounter. Many appreciated having an opportunity to meet again. At the end of our second interview Sandra said, in response to my question whether it had felt alright this time as well, 'yes, a bit more relaxed this time – we have already met and such'. At the end of my both of my pilot interviews, I asked Anna and Nova more explicitly what they thought about the interview design and having two interviews. Both thought it was 'very good' to have another interview because, as Nova reasons, 'it would have felt a bit empty/hollow to just meet once'. Anna, further reflected that,

> I feel that that it was very nice to come a bit unprepared and then to have two [interviews], another for thoughts that… then I think I would encourage the others to write them down, and to keep them and bring next time. Because it becomes a bit fresher maybe… four to six weeks was a bit too long. Maybe two to three weeks. Then you have time to think. I got really excited [about the research] and then it a lot of time passed… then I think that this thing [the reflection tool], that it is very open and that is good. (Anna)

I agreed with Anna's feedback that have a slightly shorter time between interviews made sense, which shaped how I organised the remaining follow-up interviews. Overall, having a second interview proved to be one of the most crucial elements of my research design choice: for my own comfort and confidence as a researcher, for sitting reflections and thoughts in motions to better capture 'the little moments' and everyday practices that often go unnoticed, and, for the ethical reasons of catching up with participants and rounding off the interview relationship.

Reflecting on the wider recruitment process

I want to conclude this section by reflecting on the wider recruitment process, mainly regarding the benefits and limitations of opt-in recruitment based on having some sort of experience with STI and/or pregnancy prevention practices. The way my recruitment was mostly carried out was by getting the word out and spreading my recruitment materials as much as I could, particularly within

certain online contexts. This was also combined with some snowball sampling of participants sharing the project with their intimate others who then chose to take part.

There are benefits of this type of opt-in recruitment. Ethically, you are less likely to have people taking part even though they might feel uneasy and uncomfortable, rather than potentially having said yes because they were directly asked by someone in authority. As such, as a researcher you can be more confident that those asking to participate do so because they genuinely want to. You are also less likely to have people dropping out last minute. There was only really one participant that I felt hesitant about whether they actually wanted to take part or not, by virtue of them being very slow in communicating with me prior to and in setting up the interviews. This prompted me to reach out to them a few times to underscore that it was completely okay if they were no longer interested, and they did not have to take part. Yet every time they reaffirmed that they very much wanted to, and they ultimately took part in both interviews.

The main limitations or issues with this type of recruitment that I felt, was related to diversity of recruitment. After the first phase of recruitment, there was an overrepresentation of people I had presumed to be white straight cis women which resulted in a second recruitment round asking specifically for people with more marginalised experiences. However, even with more targeted recruitment I still ended up with an overrepresentation of straight white cis women, some of whom explicitly acknowledged that the recruitment was not aimed at them. In fact, I ended up having to politely decline some to have capacity to include participants with more marginalised experiences. This overrepresentation, and my presumptions as a researcher, reflect how societal assumptions of the standard contraceptive user can undermine the scope and criticality of research.

The issue of contraceptives is, regardless of how I framed it in my recruitment materials, largely coded as a women's issue and about pregnancy prevention – a similar dynamic found by other scholars, such as Guro Korsnes Kristensen and Malin Noem Ravn (2015, 728-729) on researching domestic work in Norway which was similarly gendered as women's work. This is a historical pattern, in that women have been more likely to be responsible for the work of contracepting in heterosexual couplings. Combined with the historical narrative of contraceptives being a women's issue (or job) and the resulting societal dynamic of making women responsible when it comes to reproductive and sexual matters, it might also be that those with experience of taking on this work see more relevance to

their own lives and have more of an interest in taking part. Gender, class, and race further affect why some women may feel more entitled to be the subjects of the research than others, as white middleclass cis women have often been assumed to be the norm for family-planning policies.

Additionally, being a white researcher was likely an issue in terms of trust and belief that it would be a safe or useful enough interview space for black people or people of colour. Academic research remains a predominately white space and struggles with a history of racism that permeates to the current day, institutionally and in terms of research practices (Pred 2000; Limes-Taylor Henderson and Esposito 2019). Even more so when it comes to medical research and reproductive matters, which have been a hotbed for racist practice, violence and oppression (Duster 2006; Volscho 2011; Davis 2019; DeJoy 2019; Sudenkaarne and Blell 2022). This, understandably, often results in a lack of trust and belief in the system and those representing it. This was also expressed to me when posting my call for participants in a social media group centred around anti-racist discussion in Sweden. Like comments I got on this post, I acknowledge the need for more diverse research teams for a research project to have a better chance at being successful and inclusive. Unfortunately, as I replied, this was not possible in this case, being a PhD project with no funding to hire extra researchers. Ultimately, this highlights a fundamental issue with academia and academic research: historical power dynamics that continue to shape and influence research practices and institutions today, and the homogeneity among those carrying out said research. The perception that potential participants have of the research, the research institution, and the researcher are factors that shape recruitment, analysis and the resulting knowledge generated.

4. The analytical process

In this final section of this chapter, I will outline and explain the analytical process of this project, including how I went about generating the empirical material and how I went about analysing this material.

Generating the empirical material

I understand my empirical material as something produced or generated, which begins with the process and choices made in recruiting and interviewing, continuing throughout transcribing interviews. I carried out transcription alongside the interviewing process and concluded it all by early 2021. And, just as the generating of material begins before transcribing, so does the analysis. The generation and analysis of empirical materials is an ongoing process 'that is theoretical, selective, interpretive, and representational' (Davidson 2009, 37). By re-listening to interviews and manually transcribing, I ended up spending more time in the interview encounter, familiarising myself with the material. My transcription process developed and improved throughout doing this research. It is well-known that verbatim transcription requires significant 'time, physical and human resources' (Halcomb and Davidson 2006, 40). To use my somewhat limited time and resources more effectively, I chose to selectively transcribe the sections I deemed potentially relevant. This meant that I would briefly summarise rather than transcribe verbatim sections in which we clearly strayed from the topic of contraception. As a result, I combined selective transcription with extended sections of verbatim transcription as well as extensive notetaking after each interview. Sometimes, I went back and re-listened to sections to see if I had missed crucial words or phrases.

In the up-coming analytical chapters, the reader will see that I use a mix of longer verbatim quotes, paraphrased citations, and summaries of stories or accounts. In some instances, I believe longer, fuller verbatim quotes are necessary because, as Carol Smart suggests, they became, 'a way of bringing 'real lives' into the sociological text' (Smart 2009, 5). For shorter quotes, I use single quotation marks ('') whereas block quotes are used for longer ones. Stylistically in transcribing, I have used brackets [] to indicate notes or words that were not present on the recorded and thus added to the transcript for clarification or when specific names are replaced for anonymity reasons. Nonverbal sounds, events, or

communication were recorded in parentheses and italicised ((*laughs*)). Parentheses with three dots ((…)) were used to express an omission I made in presenting a quote. Within presented transcripts I have used both full quotation marks ("") to indicate quoted dialogue recounted within the recording and italics for shorter passages of recounting interior monologue. Sometimes the Swedish words used by participants were tricky to translate. In some instances, I chose to keep the Swedish word or presenting it in its original language with full quotation marks, followed by the closest English translation in square brackets. In other instances, I chose to represent the Swedish word by combining two English translations of said word separated by a forward slash (/).

Transcribing and quoting are both deliberate, subjective practices made by the researcher. I further realise that in choosing quotes, stories, or accounts to exemplify an analytical point or to represent a finding, I tend to cite participants who were more expressive, whose interviews were the longest, as well as those with a stronger interest in SRHR issues. This is a methodological challenge related to interviewing, as it relies on people's abilities or affinity for expressing views, feelings, and experiences through talk. The format of the interview also affected its length and depth, where in-person interviews were longer and more engaged compared to ones conducted over video call or phone. With that said, every single interview has either directly or indirectly informed the analytical process and the ultimate findings.

Another reason for why some participants ended up taking less space in the analysis was due choices I made about which relational contexts and actors I saw as most central across all interviews. Initially, I had planned to write several more analytical chapters – I even drafted and shared a few of these. However, in choosing the analytical and theoretical focus of the thesis, some chapters and themes were removed. Thus, while I made a conscious effort to include and represent all participants as equally as possible, this could ultimately not be fully achieved. I hope and plan to publish some of these findings through other avenues in separate articles.

The analytical process and finding analytical leads

While research is often presented as unfolding temporally, in practice the different stages usually overlap. My interviewing, transcribing, analysing, and writing processes are better understood as reiterative where I went back and forth between

these tasks until I had figured out the overarching story of my research. Some of the analytical leads were in fact first noted during the interviewing stage while taking in-depth and reflexive notes after each interview.

When I started more actively analysing and getting to know the empirical material post-transcription, I did so from a broadly thematic approach. I saw it as a way to identify or generate central ideas or leads, basically identifying patterns and central tendencies across the interviews (Guest et al. 2012, 10). In doing so, I essentially followed the phases of Virginia Braun and Victoria Clarke's (2006; 2019) approach to doing a thematic analysis: 1. Familiarising yourself with your data, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, 6. Producing the report (Braun and Clarke, 2006, 87). While initially rather descriptive, it made me notice the range of relationships and relational contexts mentioned by participants. After noting down the different interpersonal relationships mentioned in the young people's stories around contraceptives, I grouped them into wider categories and constructed relational webs mapping them (*see figure 3 for one of these relational maps*).

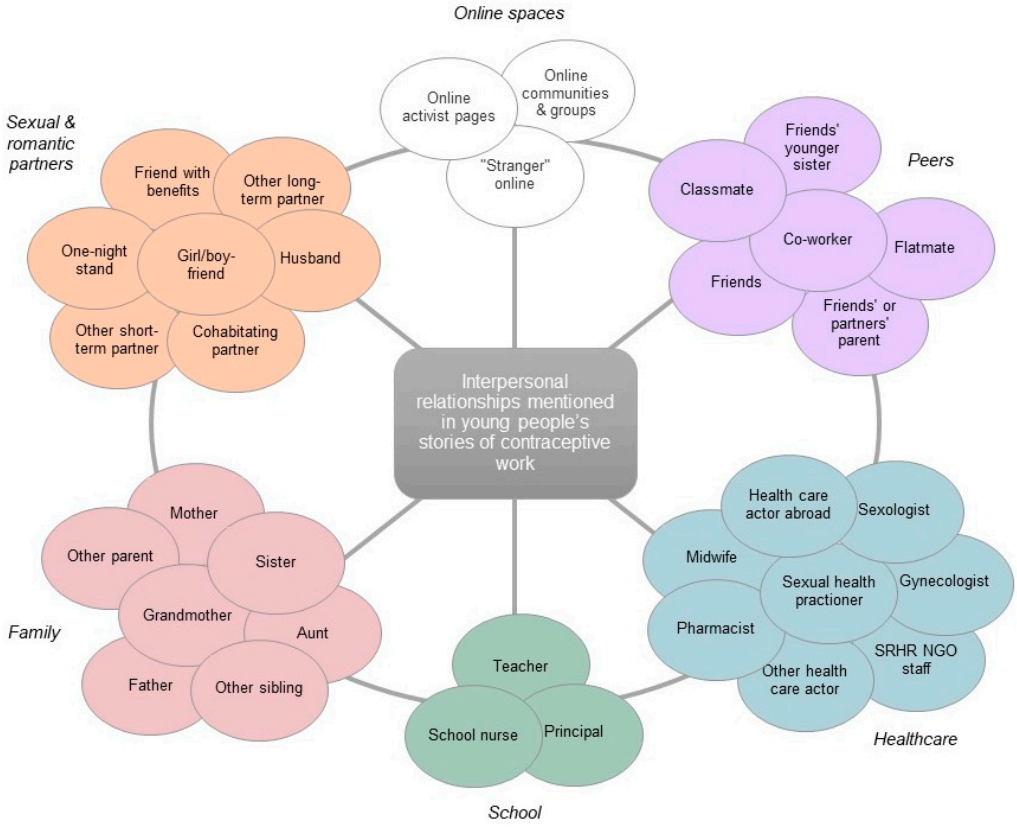


Figure 3. Interpersonal relationships mentioned in young people's stories of the work of contracepting: healthcare (blue), family (red) and school (green), sexual and romantic partners (orange), peers (purple) and online spaces (white).

While this was an interesting analytical lead, highlighting the array of actors and relationalities involved in the work of contracepting beyond what is often acknowledged, it did not answer what the experiences and practices of doing the work of contracepting *involved* within these relational contexts. Moreover, the map does not represent which relationalities came up more or were given more importance and meaning within participants' stories. As such, while I used a more descriptive or semantic thematic approach (Braun and Clarke 2006, 84-85) to initially get to know the material, I moved on to a more latent thematic analysis (sometimes referred to as a thematic discourse analysis) of underlying meanings, assumptions and conceptualisations (Braun and Clarke 2006, 84). That is, I went on to explore the main social dynamics within these different relational contexts and what the work of contracepting involved with different actors.

At this stage, I decided to put stories that related to school aside, as this was a smaller theme that largely revolved around young people not getting much support or learning about contraceptives from school. I also chose to see the relationalities around online spaces as rather part of other categories, such as peers and healthcare. As such, I ended up initially with five sketched-out empirical chapters based on the four remaining relational contexts (peers, sexual and romantic partners, family, and healthcare). Within the category of peers, the choice to specifically focus on the role of friends for young people in relation to the work of contracepting was clear early in the analysis. In addition to its widespread presence in participants' stories, I also wanted to highlight and take seriously this relationship which seldom gets discussed in relation to contraception. The second and third planned relational themes (or chapters) revolved around the central dynamics within short-term and long-term sexual relationships. I ultimately removed the short-term theme because fewer stories emerged around the work of contracepting in this theme and it instead became focused on well-trodden discussions of navigating risk. The fourth chapter and relational theme revolved around family. However, much like that of school, while fascinating and more complex, the stories mostly highlighted that parents and other family members played limited roles in supporting young people in the work of contracepting. The final chapter revolved around healthcare, medicine and the relationships between young people and different actors therein, as well as wider institutions and medical and scientific discourse. During the final analysis and writing process I split this chapter in two, to highlight the unique dynamics behind both becoming informed about contraception and making contraceptive

choices. Ultimately, this meant that during the analysis and writing stages, my five original relational themes transformed into four chapters. In order of weakest institutional ties to the strongest, these became: the role of friends, long-term relationships, becoming informed about contraceptives, and making contracepting choices.

Thinking with and through stories and storytelling

As I homed in on the relational contexts that emerged as the most central ones for participants, I also found it helpful to think with and through the lens and language of stories and storytelling. The notion of stories resonates with me strongly, and I understand stories in a rather expansive way as existing at different levels and which includes everything from concrete written down tales in storybooks to the more abstract stories we tell as a society about ourselves and others, and around how things work. Regardless of the level of the story, I see stories and storytelling as relational activities (Riessman 2012) and beyond their relational nature, I like the language of stories because stories – unlike themes or discourses – are something we all know. As Charmaz note, both 'lay persons and scholars alike valorize stories' (2002, 303). Not only that, but we are all storytellers: we tell stories about ourselves, of others, and the world to ourselves, others, and to the world.

While some narrative scholars are firm in differentiating between stories and narratives, like Francesca Polletta et al. (2011, 111), I use narratives and stories interchangeably. In fact, I analyse and explore stories more along the line of narrative inquirers, such as Jean Clandinin (2016) and Arthur Bochner and Nicholas Riggs (2014). For narrative inquiries, 'humans communicate their experiences using co-constructed narratives that offer an epistemological portal through which experiences can be viewed and interpreted and then re-presented using storied forms' (Lal et al. 2012, 7). Within this perspective, identity is something that is 'multiple, fluid, and negotiated (…) a process that is never complete as long as we live and interact with others' (Bochner and Riggs 2014, 195-196). I share this understanding of identity and experience. I also share Donald Polkinghorne's belief that 'storied descriptions people give about the meaning they attribute to life events is (…) the best evidence available to researchers about the realm of people's experience' (2007, 479).

While the interview material does not consist solely of stories but also conversations and sometimes questions and answers with shorter responses, there are still underlying or latent stories involved: stories of sex and sexuality, of science and technology, of gender and relationships, of being a young person growing up in Sweden, and much more. One great value I see in investigating stories and talking about the stories we tell, hear, grow up and live with, is that it becomes clear and possible to speak of reality, truths, and experiences as something subjective, fluid, and multifaceted. As such, it is not unusual at all for stories and storytelling to be contradictory, unfinished, unclear, out of order, or without a clear point. As Lisa Lewis writes, '[s]everal different, even conflicting, narratives may exist for someone to describe the same set of events (…) This does not discredit a narrative; rather, it demonstrates narrative inquiry can discover multiple truths' (Lewis 2018, 16). With this in mind, the academic storyteller or researcher's role and task is to try to understand the relationship between stories and the experienced, and to try to reflect this in a meaningful way through its retelling.

Another reason for investigating stories in sociology is their role and importance for producing change. Personal narratives are not only personal and relevant for the individual, but socially produced and connected to wider societal processes. Histories and stories play enormously important roles in society and hold great power. In that sense, they are discursive as well as material and concrete in their consequences. Depending on the histories and stories that exist in society, about society, about communities and individuals, we make possible or impossible different rules, norms, laws, structures, and social relations. While some stories are more influential than others, people (like the participants of this study) do resist stories that do not make sense to them, that they do not agree with, or that they cannot relate to. Thus, '[a]s we retell or inquire into stories, we may begin to relive the retold stories. We restory ourselves and perhaps begin to shift the institutional, social, and cultural narratives in which we are embedded' (Clandinin 2016, 34).

Analysing from a perspective of critical optimism

Before moving on to conclude and summarise this chapter, I want to highlight a final analytical inspiration, namely, that of analysing from a perspective of critical optimism (Holmes 2016). Sociology as a subject, discipline and tradition has historically tended to focus on studying society by bringing to the fore social

problems and *pathologies* and focusing on how to best solve said issues (Holmes 2016, 92). Yet, 'to consider sociology as the study of social problems rather than social questions might promote a pathology of social life' (Holmes 2016, 92). A parallel and connected tendency of sociology, which I believe makes it distinctively impactful, is the practice and skill of understanding and analysing oppressive social structures and their effect on individuals, groups, and the organisation of society. Combined, these two tendencies have a produced a rather pessimistic discipline where it can be easy to feel overwhelmed by the static, persistent and overwhelming structures that maintain inequalities and oppressions. Emotions have practical and theoretical impact – and in the case of the sociological canon, this gloomy tendency can seriously limit our analytical imagination and gaze.

When I first started thinking about making sense of and trying to better understand contraceptive dynamics, narratives and practices, my point of departure was a firm understanding that there was something ominous and violent going on here. After talking to more people and listening to more and more stories of different contraceptive experiences I felt increasingly convinced that there were significant inequalities within our contraceptive landscapes. My doctoral research has in many ways cemented and strengthened this view, especially through my development and employment of theoretical framework around the work of contracepting.

Often when I have spoken, written, discussed, and theorised the work of contracepting with others, I have deliberately and strategically tended to emphasise its tough, hard, and unfair nature. Finding a way to highlight and make utterable the emotional, mental, and epistemic activities that are required of contracepting – but that often remain unseen, unrecognised, and unacknowledged – was and remains a significant aim of my research. But, in reflecting on this aim and approach, and seeing this particular tendency in my analytical gaze, I started feeling worried that the discipline's pessimistic and problem-centric standpoint constrained my imagination and ability to *hear* my informants' stories more holistically and theorise their experiences and the context in which they do the work of contracepting.

After reading Mary Holmes' book *Sociology for Optimists* – at a time when I was feeling particularly lost and unsure of my own research and academic purpose – I became inspired by the practice which she refers to as 'critical optimism': to turn a critically optimistic lens on the stories of the work of contracepting that I had

heard. With critical optimism, Holmes does not mean a naïve, just-think-positively sort of psychological optimism, but rather one that makes a case against the traditionally pessimistic sociology. Because, as she concludes in the final chapter of the book,

> Pessimism alone cannot provide a full understanding of the complexity of the social world and optimism is a crucial tool for sociologists. An optimistic approach takes effort, it does not only see harmony, but can explore the conflict and struggles involved in creating change for the better, or seeking greater freedom. An optimistic sociology can make us think about how to live a good life, how to make a more equal society and how to maintain nourishing relationships with others. (Holmes 2016, 130)

I earnestly believe that sociological gazes and imaginations hold great transformative power. To me, studying and doing sociology has meant cultivating a growing empathy and care towards other people and communities – or at least a desire and attempt to practice these principles and values. In writing this thesis, I hope to humbly channel empathy and care: to consider why people might do what they do. This consideration does not come without a critical element, however. This thesis holds stories of power, privilege, and passivity: of injustice, oppression, inequality, violence, and carelessness. There is no denying that. However, these exist alongside stories of pleasure, enjoyment, and fun: of friendship, support, love, and care.

Thus, in doing my analytical work, I have been inspired by the practice of critical optimism – alongside my broader thematic and story-centred approach – when analysing the stories and accounts that my participants have shared with me. I have done so to challenge my own learned tendency to only see the problem. In doing so, I have tried to move beyond what feminist technoscience scholars discuss as the false dualism of only being either technophobic or technophilic. As Donna Haraway argues in her Cyborg Manifesto, the aim is not to be 'technophobic, nor technophilic (…) It is about exploring where real people are in the material semiotic systems of technoscience and what kinds of accountability, responsibility, pleasure, work, play, are engaged, and should be engaged' (quoted in Markussen et al. 2000, 11) Finally, I also want to echo Sarada Balagopalan, who maintains, (while writing specifically of the 'magic of Paulo Freire') that there can be 'a revolutionary hope, a 'critical optimism' that is neither

mechanistic in its imagination of the world nor naïve in its expectation of what the future can hold' (2011, 203).

Inspired by the feminist technoscience scholars and Holmes' optimistic sociology, what follows is therefore an exploration of what it might look like to engage in a more critically optimistic take on the work of contracepting and a forefronting of stories of hope, agency, care, and change. Emphasising the enjoyment that can emerge from, or be associated with, contracepting does not contradict conceptualising it as a form of work. In doing any work there is space for agency, and a possibility for radical change and hope.

Conclusion

In this chapter I have outlined and accounted for how I have gone about designing and doing this study, including its central methodological starting points and influences. I have explained how I draw from a feminist and critical methodological perspective and how I explore and investigate wider social dynamics, relations, and phenomena through everyday experiences and practices.

I have described how I went about designing my research project in order to investigate contracepting experiences and practices. I explained my choice and argument for relying on qualitative in-depth interviews and what this involved; described the type of interviewing tools and techniques used, and the recruitment strategies and plans I mobilised and the outcome of these efforts. I have also provided some methodological reflections from and on the research design: specifically, about navigating and negotiating some initial ethical considerations, and reflections from and on the interview encounters as well as the wider recruitment process. Finally, I described the analytical approach and process of my project including how I generated the empirical material, identified analytical leads, and went about analysing stories of contracepting influenced by narrative inquiry and critical optimism.

It is now time to move on to the substantial sections of this thesis where I present the main empirical and analytical findings, and where I start exploring what the participating young people's experiences and practices of doing the work of contracepting involved in different relational contexts.

Chapter 5. The importance of friends in the work of contracepting as a young person

Friends and friendship are rarely honestly recognised as important social actors, support systems and relational resources for young people when it comes to sexual and reproductive health and wellbeing. In 2017, the Swedish Public Health Agency released the results of a large-scale study on sexuality and health among young people aged 16 to 29 in Sweden (Folkhälsomyndigheten 2017). Amongst their various findings, they identified that young people obtained knowledge and information on 'relationships', 'sexuality', 'contraceptives' and 'STIs' from a wide range of sources:

> … the Internet (70 percent), friends (60 percent), education on gender equality, sexuality, sex and relationships in school (55 percent), Youth Centres (47 percent) the websites 1177, Vårdguiden and UMO (44 percent), TV, magazines and radio (32 percent), partner (24 percent), mother (22 percent) printed information (12 percent), father (11 percent), clinics within health and medical care (10 percent), siblings (10 percent), student health service (8 percent), other (3 percent), guardian (1 percent). (Folkhälsomyndigheten 2017, 79 [translated]).

In their conclusion, however, it is four state institutions (schools, Youth Centres, healthcare, and social services) that are singled out and identified as the most important arenas for further preventative and promoting work. While this conclusion was not drawn solely from where young people obtain *knowledge and information* on different sexual and reproductive issues, it is still noteworthy that it is only these arenas and actors that end up being singled out, highlighted, and constructed as relevant and important arenas. Despite evidence of their influence, friends (as well as partners or family members) were sidelined. School can of course be a place where your friends are, but targeting schools mainly reflected an

intent of teachers conferring knowledge to students as individuals. While most participants of this study shared the view that school and healthcare matter and have a particular responsibility to resource young people for doing the work of contracepting, many discussed the important roles that other more interpersonal relationships play, where friends emerged as the most important relationship for young people in their experiences and stories of doing the work of contracepting.

Previous researchers, particularly sociologists of friendship, have critiqued the sidelining of friendship and urged to have friendship taken seriously by policymakers (Allan 1998; Jamieson 1998; Roseneil 2004; Roseneil and Budgeon 2004; Budgeon 2006; Byron 2017). To a far lesser extent, similar arguments have been made in the context of young people's sexual and reproductive health. As Paul Byron notes, study on young people's sexual support and knowledge rarely 'engages with young people's friendship cultures' (2017, 488). In fact, as they continue, young people's peer relationships are often constructed mainly through the lens of peer pressure and thus mistrusted.

However, as Byron underscore, peers cannot be equated with friends and '[u]nfortunately, a mainstream public health commitment to a discourse of peers – as sanctioned or risky informers – further inhibits discussion of young people's everyday friendships and how these support sexual health knowledge and practice' (2017, 488). As such, as Byron concludes, '[w]ith the exception of the 'friends with benefits' literature, friendship remains mostly absent from sex research regarding young people, or is imbricated into discourses of peer education and/or peer pressure' (2017, 497). This conclusion strongly resonates in the Swedish context. Based on the stories and experiences of my interview participants, I want to contribute to a much-needed call to pay attention to, recognise, and investigate the complex and often central roles that friends play among young people in doing the work of contracepting, and for sexual and reproductive health and wellbeing more widely.

In this chapter I will illustrate and discuss how friends emerged in participants' stories and experiences around doing the work of contracepting from when they were in their early teens into young adulthood and today. I will first highlight stories of friends sharing, supporting, or helping with the work of contracepting in different ways. I will then consider some of the more nuanced ways in which friends emerged in participants stories and discuss how their role can be both a caring one and a controlling one. Finally, before concluding, I will be considering some of the limits of friendship and highlight the importance of online communities.

1. Stories of friends sharing, supporting, or helping with the work of contracepting

From early in the research process, the omnipresence of friends was felt in listening to participants' stories around contraceptives. It was one of the earliest themes I remember sharing with my supervisors as a finding. As I continued to reflect on and explore it through my interviews, it became cemented as the most important relational context for the participants' experiences of doing the work of contracepting. These conversations illustrated how the work of contracepting usually does not start in healthcare settings, but within the relational contexts of friends.

Many participants shared how they felt that they 'could speak very openly with friends' (Miriam) about contraceptives. Within friendships, it seemed easier to cultivate non-judgmental conversations, arguably since friends are not *normatively* responsible in the same way as parents, healthcare professionals or teachers when it comes to young people's sexual and reproductive lives. In fact, it has been argued that friendship is 'the least structured of intimate relationships' (Jamieson 1999, 482). Friendships are shaped by less distinct norms and less longstanding power dynamics than, for example, the family or long-term romantic relationships, and can be seen to provide what Harry Blatterer (2013) calls a particular 'normative freedom'. Blatterer argues that this freedom is 'based on its weak societal anchorage, which in turn makes it resistant to certain 'reifying' social trends. That weakness, in other words, is conceptualized as friendship's strength' (2013, 436).

In the first interview with Miriam, I asked whether she discussed contraceptives with friends, what about, and whether it was exciting to talk about. She shared that,

> From 14, 15 and up, you had pretty different experiences and knowledges about sex. Some friends had very long-term relationships and steady partners. Others had more, not so monogamous, more experiences with more people and perhaps of other genders. From that point of view, it was different. Not so much contraceptives in themselves but about sexual experiences. But it was… very open. Particularly with one friend. It felt like we could talk about anything, without judgment. (Miriam)

Miriam shows how sharing or having the same experiences is not necessarily – or at least not always – a defining condition for creating a relational space of support. Feeling like you can share whatever your experiences are 'without judgment' and 'openly' was central for creating the kind of relational context and intimacy

necessary for a positive experience of doing the work of contracepting. Amongst the participants of this study, friends and friendship has provided a *normative freedom* across the board and in various dimensions of the work of contracepting. They have provided (relatively) more normative freedom than other more institutionally anchored relationships.

Friends as co-explorers, co-educators, and playmates

When it came to the work of planning and considering potential contraceptive strategies to take, the importance of friends emerged clearly: particularly related to the epistemic work done in contracepting. What seemed to make friendship a conducive space for learning and knowledge production for young people was partly because of them being non-instrumental, and partly because of its more collective nature.

Most participants shared that in the relational context of friendship it was common to talk more broadly about sex, sexual health, sexuality, and contraceptives. Not always because someone had a direct issue or needed to find a contraceptive method or strategy, but simply because it was a topic of conversation. As such, learning about contraceptives with or among friends was both for non-instrumental and non-individualised purposes. Instead, it was connected to a general curiosity: a curiosity to find out more about friends' experiences that might be different from their own, like in the case of Hugo and Mehmed, both cis gay men who shared that they enjoyed learning about female contraceptives from friends who used them. In fact, in the very first interview with Mehmed, in response to my question about why he wanted to take part, he replied that he was 'intrigued' even though it would be highly unlikely that he would have a child 'in a traditional, conventional way' but that 'contraception is something I always hear about through mainly women friends'.

Like Byron found in their study on young people and sexual health promotion, sexual disclosure among friends – within which I would include talking about the work of contracepting – 'relies on established spaces of dialogue (...) openness (...) and non-judgement (...) they speak with friends to learn about sex (including sexual health and pleasure) and to reflect upon their sexual experiences – past, present and future' (Byron 2017, 493-494). Some of the epistemic dimensions of the work of contracepting that seem common among friends is thus the more general exploring of ideas, learning together, and sharing experiences and

knowledge, without the imbalance of epistemic power that comes from learning in other relational contexts. It could also include, as William shared, simply familiarising yourself with existing contraceptive methods and technologies. William shared that he had spoken to his girlfriend about her experiences of different contraceptive methods, that they 'had spoken about different methods' and that her friends had gotten the coil which, in turn, made it so that it did not feel so alien.

Another interesting aspect of the epistemic dimension of doing the work of contracepting with friends – related to its non-instrumentality – was the common experience of using chats with friends to explore and figure out your values and stances on issues related to contraceptives. One of these issues was the question of responsibility around paying for condoms, mentioned by both Pim and Edith. In my second interview with Pim, we talked about social norms and conventions around paying for condoms or other contraceptive methods. Pim explained how it became 'dedramatized' when they got together with their current cohabitating partner who was 'clear with that we're paying for this together when you won't get it for free anymore'. In discussing this, Pim explained that 'before, you would have spoken to friends about whether you should ask the guy to pay for it - to finance' even though they strongly felt like they wanted to do 'their own deal'. Speaking to friends about the issue of whether you can or should ask your sex partner to share the financial cost for condoms or other methods can become a way to explore and reassure yourself in your own strategy: and to figure out what the ethical or social boundaries are around responsibility in sex.

Besides this epistemic work in contracepting, other examples of exploring and trying to figure out strategies and feelings about different contraceptive-related issues through dialogues with friends, were issues around abortion and emerging male contraceptives. Like the question of whether or not to demand that a partner share the cost of condoms, working through, and mentally planning for a potential future sexual-reproductive scenario was something that Stina mentioned having done in relation to emerging male contraceptives, and Sally when it came to abortion. Sally told me,

> I have a friend who wants to get pregnant. She doesn't have sex with someone that she doesn't want to have kids with, because she doesn't want to have an abortion. She even felt bad when she took the morning after pill this one time. When I got the coil, I was 16-17. It was a non-question – *I am not having children.* Now when I removed it [the coil], almost 20, it's a different time in life. I didn't have to think

> about it for 2.5 years, now I'm not as sure. It wasn't something I had to think about in 2.5 years, now there still a chance. Now it's not as like self-evident. (Sally)

It is not entirely clear what the direct relationship was between Sally speaking and hearing about her friend's approach to sex, and her feelings about abortion and pregnancy. Yet the fact that she coupled these stories narratively, reflects that they were connected for her. As was echoed in other participants' stories, talking with friends about whether you would or would not get an abortion if you got pregnant can serve as an important thought experiment which in turn might influence your decisions around both sex and contraceptives.

In a similar but far more hypothetical vein, were conversations with friends around emerging male contraceptives: whether you would like them, whether others would use them, and so on. Stina shared,

> I spoke to a friend about this new contraceptive gel[23] (...) I've had that conversation with both girl and guy friends about whether you'd use them. Some girlfriends don't want to because you lose control, don't trust the men that are careless. You still have to take the consequences. Others think it's a really great thing. (Stina)

Through conversations with friends, views, feelings, and attitudes towards sexual and reproductive issues including existing or emerging contraceptives are produced and shaped. You may hear pros, cons, and new arguments for or against the use, for example, of a male contraceptive gel – perspectives one may not have thought of. You can find support for an inkling, feeling, or view, strengthening or clarifying your convictions and positions. They can change based on new insights from, or in being challenged by, friends. These conversations serve a multitude of purposes, one of which is the epistemic one, where conversations such as these can become sort of dress rehearsals for future potentialities and scenarios. Which really goes to show that the work of contracepting begins much earlier than the point of having sex or within the contraceptive counselling room.

The second important factor that makes the relational context of friendships a fruitful and supportive one for the epistemic dimensions of the work of contracepting is their collectivity. Friendship, unlike the more one-directionality of knowledge and information sharing in contraceptive counselling sessions or

[23] Still ongoing international clinical study called *Nestorone® (NES) and Testosterone (T) Combination Gel for Male Contraception* in which the Swedish research-led medical university Karolinska Institute is a partaking.

sexual education, provides more two-way communication, dialogical exchange as well as a space for collective learning. This then puts less pressure on the individual young person and can often be a more communal, casual process, like in the case of Miriam going with friends to the Youth Centre to grab condoms and pick up some stickers and other materials, or Nova who did not have access to a school counsellor or Youth Centre growing up, and thus relied on talking to friends (alongside figuring things out herself) when it came to contraceptives.

The collective learning process becomes quite evident in Sally's story, which exemplifies how the epistemic processes can begin before you become sexually active yourself, and instead when someone in your friendship group does. In response to my question of how they found out about 'contraceptives and such', Sally, responded: 'Mostly from… you've always known that it existed: media, movies… that the pill existed. But then it was when friends started getting boyfriends'. After veering off the topic for a bit I returned to it, asking how the topic of contraceptives came up in her conversations with friends. Sally explained,

> In high school, we were four girls. One had a boyfriend. She had the implant. I had the coil. So, we spoke a bit about it. Later on, she got the coil, so we spoke a lot about that. Had another friend who got the coil. We spoke about that like. You discussed more like, "do you have a problem…?" (Sally)

This indirect learning was mentioned by other participants as well, and I think raises an important question around the organisation of sexual education, healthcare services and policymaking. Most interventions regarding young people's sexual and reproductive health in Sweden are centred on the individual or the couple as the target audience, rather than considering other relationships that surround young people as important actors that can provide support, care, and aid.

When discussing the work of contracepting with the young people of this study, the biographic dimensions of friends also mattered in terms of learning from friends' embodied experiences. For example, in the second interview with Edith, I asked if she felt that her friends' experiences of contraceptives had affected her own perspective and how she related to and made choices around contraceptives,

> Yes, absolutely (…) I know that before I got contraceptives two or three of my closest friends had tried a few different stuffs. Like, one of my girlfriends had been

> on the pill for a really long time and I knew that she got, she had various problems with different pills and had a tried a couple of different ones. With one of them she got a lot of pimples – and that was like the same one I had a lot of problem with, it was incredibly triggering for me and my compulsive behaviours. So, then I was really, *aaah not the pill* (...) Before that she had the coil, one of the hormonal coils (...) she had a really bad experience with her coil, like horrible period pains, to such a degree that she couldn't function, so she took it out after three months. Then I became very spooked. To begin with I really didn't want the coil because I had heard so many horror stories (Edith)

Sharing experiences of side effects from using different hormonal contraceptive methods is incredibly common, including taking into account these embodied experiences of friends when making your own decisions. This echoes findings of previous studies around the need to consider alternative, embodied ways of knowing.

Another element of the communal aspects and collective learning with friends that came up in the interviews, particularly with William and Mehmed, was how it sometimes simply provided a space for play and fun exploration of contraceptives. One such story of contraceptive play was shared by William after being asked if he had any particular contraceptive memories that stood out in his memory:

> (...) I have a weird situation (*laughs*) that happened with a friend. I miss her. I'd like to meet up with her again. We went to high school together. (...) We were hanging out at my house. We were going to record a podcast – though we had never released a podcast – and it was supposed to be about sex. We were going to tell stories and talk about sex… And drink beer at the same time. The podcast never happened (*chuckles*). It came up that she had never [seen/used] a black condom, so then we decided, we decided that she wanted to see what it would look like on. So, I gave her my hard-on and saw what it looked like. And then we giggled. (...) So fucking stupid. But funny all in all. (William)

This story does not follow standard understandings of what the work of contracepting might entail. It was not a sexual situation that required the use of a condom per se and feels far away from the learning received in a counselling room or classroom. But it speaks to the more playful, non-judgemental, and open environment that certain friendship relationships can provide, which allows for play, curiosity, and shared discovery. Even though William called the situation 'weird' and 'fucking stupid', he recalled the moment and this friend with warmth

and appreciation. This might also be understood as a rhetorical move to refer to a more childish time in his life. This story further highlights friendly play as an important space for doing epistemic work which allows for levels of discovery that a healthcare setting or classroom could never emulate.

In a similar vein, though perhaps without the underlying flirtatious tension as in William's story, Mehmed recalls some 'funny', playful times with his friends in school playing around with condoms,

> Mehmed: (...) one time, we [Mehmed and his friends] were in a dorm room: "I heard like you can blow this, and it becomes like a balloon! (*laughs*) "let's see how large it'll get!". I remember one time we were blowing in air, making it as big as possible. Trying to see how big it'll get. Everyone was laughing and having fun. Children.
>
> Marie: That's nice [Mehmed: yeah yeah] How big did you manage to get it?
>
> Mehmed: It got really big and then it popped, exploded. Very loudly. (*laughs*) It was very very big; I was very impressed. And my friend (…) was like I told you, it's very safe (*both laugh*).

In messing about and using condoms as balloons, they not only familiarised themselves with condoms but also, as Mehmed concludes, learned hands-on how durable and stretchy condoms can be, hinting at previous conversations where the strength and safety of condoms seemed to have been somewhat in question. Mehmed did not speak more in-depth about the potential impact of this playful hangout session on the group of friends' future condom interactions and use. I unfortunately did not think to ask in the moment, being similarly caught up giggling with Mehmed about making condom balloons. Yet, there is an argument to be made for the benefit of learning about how condoms physically work, feel, and stretch from interactive, tangible play, compared to being told the same in a conversation.

Given the two themes identified illustrating the epistemic work done in contracepting – both its non-instrumental and collective approach to learning – it is unsurprising that most participants found it easier to ask their friends about their views, experiences, and input when it comes to contraceptive strategies. In fact, similar dynamics can also be found in the role of friends in participants' stories of more practically going about using contraceptives or managing contraceptive use, particularly around condoms.

Friends as practical helpers and guides

While the epistemic dimensions of doing the work of contracepting with friends was the most apparent interview theme, there were also several examples of ways in which friends supported or were part of more practical elements of contracepting. This was most clear when it came to experiences and practices around acquiring and accessing condoms, something Gabriella, Mehmed, Hugo, William, and Edith all spoke about.

Several participants spoke about having bought condoms for their friends when they were too nervous about going into the shop themselves. Mehmed, for example, bought his friends condoms several times when they felt too embarrassed or awkward, whereas Gabriella shared that she and her former housemate and friend bought and utilised a 'shared condom box… like the kind you saw on *Friends*[24]'. In doing so they split the cost of purchasing condoms, sharing the financial burden.

The other way friends supported each other when it came to condoms was the practice of having condoms around – either where you lived or simply on you – so you easily could offer some if needed. Hugo told me, in discussing the accessibility of condoms,

> It's altogether too expensive and difficult to access at unusual hours. There's spontaneity when you have sex–- when you'll need [condoms]. Maybe you don't have a source [of buying condoms] nearby. That's why it's smart with mail-order. Then I put condoms in different random places – in clothes, around the flat. Or, if you have a friend around and you're talking and they're going out to see someone, then like "here". It's only happened twice, but still. (Hugo)

While this strategy and practice that Hugo recounts was mainly for his own usage, the intention and (albeit limited) reality of sharing with friends was still part the work of preparing and making arrangements for potential contracepting needs. William similarly shared that he was the one in his friendship group that was 'like, here – take a condom' to his friends in high school. Besides supporting with condom use, a few participants shared stories of helping a friend out when they got unintentionally pregnant. Like Gabriella, whose friend, after getting pregnant, came to her asking her what to do and ended up having an abortion.

Another way in which participants gave or received advice and support to friends in managing contraceptive use was in managing the side effects of

[24] A well-known US sit-com airing between 1994 and 2004.

hormonal contraceptive methods: that is, in doing elements of patient work (Strauss et al. 1982; Corbin and Strauss 1985). On this issue, Sally, recounting how she and four girlfriends and high school learned a lot from each other's' experiences of hormonal methods also 'gave her some tips, like 'take this many painkillers' [after getting the coil inserted]'. This practical sort of advice-giving and hands-on support that friends sometimes provided can also be seen in another context, of sharing experiences around different sex partners and their approach to contraceptive use as a sort of caring activity or care work. Mehmed shared, for example, in response to my question,

> Marie: In the [particular geographic location] community, is there also talk in other ways, like "that guy doesn't use condoms or that guy is like that"?
>
> Mehmed: There's talks, there's talk. A couple of people, I won't know their name on their Grindr[25] profile, my friend would say – "he doesn't like to use condoms". If I knew someone didn't use condoms, I wouldn't even try.

Here, friends' previous sexual experiences served as sort of useful insight and help in navigating the dating life on the app Grindr letting Mehmed know about their views and approaches to condom-use. This in turn helped Mehmed to choose whether he wanted to meet up with, and potentially have sex with, one of these guys.

In addition to the more practical support and care friends sometimes provided, there was also important elements of providing emotional support, especially in the context of perceived contraceptive mishaps. In the second interview with Mehmed, I asked if he could recall any 'other memories of like fun or silly situations [connected to contraceptive methods]'. At first, he could not think of anything, so I asked,

> Marie: Never in like a sex situation either? Never really like, entering that territory.
>
> Mehmed: Ah yeah, I remember one time when I actually failed to open the condom wrapper (*laughs*) It was times, I just couldn't open, and it was funny. And we both laughed. Multiple times but I just couldn't open, and I remember people mentioning putting on in the wrong side, so it doesn't go. But I've never had that one, but I remember talking about to my friends about it, laughing about it.

[25] Grindr is a highly popular dating app for gay, bi, trans, and queer people – and particularly gay men.

While Mehmed felt it could be similarly funny for a bit with the sexual partner when you currently struggling to open a condom wrapper, after a while, 'two minutes or so, it becomes embarrassing'. On the other hand, recounting the experience with a friend – whether it was funny or embarrassing in the moment – can become a way to decrease the potential embarrassment of the contraceptive mishap and in so doing normalise the experience and change the memory into something you can laugh about.

Similar to Mehmed, albeit about a different contraceptive method, Edith told me – in vivid, humorous detail – about a recent time when her coil 'fell out' when taking out her menstrual cup at her 'dingy workplace toilet':

> Edith: (*laughs*) Yes, it was a bit funny (...) A bit comical, I mean. But ah. It probably has stabilised a bit. Then I had really called all of my close girlfriends and like "do you know what happened, so fucking sick" but yeah. Like a funny story that you tell, "do you know what happened to me?". And they were like "you can't be serious?!". More like a just comical. It wouldn't have been as fun if I had been sitting at home, it was like this, I was at work. Like, "Kitchen sink realism" thing.
>
> Marie: Yeah, it felt, you described it a bit like a movie. Kitchen sink realism – "now of all situations".
>
> Edith: Yes, exactly. So typical. It felt so like Swedish drama movie. The light in the toilet was this strong luminous tube and you're sitting there and there's so much disgusting toilet paper on the floor. So staged that it'll become this "eeeh" moment. A small thing, you wrap it in toilet paper and into [the bin]. It was so. I can really look back now and laugh. (...) It is a funny story. (...) It's always fun when you have a funny story, like "you know what happened to me?".

Both stories resonate with Byron's findings that '[s]exual storytelling among friends produces a range of ways to negotiate sexual experiences, relationships and futures, and these are not isolated to individuals but are socially produced through friendship and its cultural practices' (Byron 2017, 496). Additionally, Mehmed's and Edith's stories both show that sometimes talking about contraceptives is simply a fun thing to do with friends, like any other topic of conversation, and is not always oriented towards practical purposes.

The final way in which one can understand the positive and important role of friend in doing the work of contracepting is in navigating sexual and reproductive healthcare landscape and systems. Several participants shared that they had been

asked by friends or asked friends in turn to accompany them when going to get tested for STIs or going to the Youth Centre for contraceptive counselling. Helena told me she had tagged along several times, sitting in the waiting room while a friend got tested or to pick up a morning after pill. In fact, she thought it was a 'pretty common thing'. She had also had several friends asking her if she wanted company to similar appointments. Friends seem to be much easier to ask for the practical and emotional support of coming along to the Youth Centre, potentially because young people are not dependent on the permission or presence of guardians to seek its care or access its resources.

The supportive role of friends in navigating healthcare systems was perhaps most evident in Anna's stories of having the same friend come with her twice to different appointments: first to get the coil inserted, and the second time to see a male gynaecologist – which she recounted feeling quite anxious about. Anna explained how she had a friend with her, which was nice, even though it 'probably would have been fine anyway'. Anna explained,

> Anna: (…) Then I wanted to have a friend with me. Something was going into the uterus, I was a bit nervous, scared. Wanted someone with me. Also [they are] a person that picked me up from the hospital otherwise, a time that I had to wake up [from general anaesthesia].
>
> Marie: Yeah, it can be unpleasant to go by yourself.
>
> Anna: Yes, and this person has really good insight into the medical system. So, they know a bit about how healthcare works. I know pretty little.

Several interview participants expressed that they had, at one time or another, felt nervous or anxious about going for a gynaecological examination or to get a coil inserted. Throughout the interviews, it became increasingly clear that parents seemed to play little to no part in participants' contracepting. As such, I wonder if that partly explains why friends sometimes ended up filling roles that parents might have done in other cases, like helping you navigate the medical and healthcare system by accompanying you to an appointment.

As Byron suggests, when we engage with and take seriously young people's friendship cultures as researchers, we find stories that complicate the dominant discourse of peer pressure. We can see mutual caring and support, play and exploration and collective learning. We can also see resistance to individualising

discourse of sexual and reproductive health by their continued reliance on friendship, which, as Byron also maintained, has 'potential to disrupt normative hetero-relational systems that still pervade a public policy discourse on sexual health' (Byron 2017, 497).

2. Care and control: nuancing the notion of the normative freedom of friendship

In the previous section, I presented a story of friends as co-explorers, co-educators, playmates, and practical guides and helpers. These relationship dynamics were framed within a context of largely egalitarian relationship practices: free, open, and non-judgemental. However, this alone does not capture the full story of the meaning and experience of friendship when it came to doing the work of contracepting. Friendship, as has been argued repeatedly by more contemporary scholars of friendship, is not free from power dynamics (Byron 2017). What it means to be friends and do friendship is situational and contextual.

When it comes to the work of contracepting, and sexual and reproductive health and wellbeing, various practices and experiences emerged from participants' stories of the roles and responsibilities friends have or should have. This was mostly about what participants themselves and their friendship identity had involved and meant. These friendship roles and responsibilities largely involved caring and sharing (or disclosure) as well as elements of controlling and disciplining, that resembles the role and responsibilities of more conventional institutional healthcare and educational actors. As such, the stories of friendship and contracepting were not completely free from societal pressures or disciplining discourses found elsewhere. In the next two sub-sections I am going to present two archetypes that emerged in participants' stories when discussing the responsibility of friends and contracepting, nuancing the notion of the normative freedom of friendship: namely, the caring educator and the sexual health promoter.

The caring educator

A big part of the stories and discourses around friendship that emerged in the interviews, was the role – and in some instances even the responsibility – that you

inhabit or feel as a friend when it came to others' sexual and/or reproductive health or behaviours. This was especially clear in the context of a few participants becoming, being and feeling the need or responsibility to be the healthcare or sexual health expert of a friendship group, and to impart any knowledge they might have acquired through their own reading and researching. Mehmed explained that when he was young, because of having an older sister who was a doctor and being generally interested in sexual health, he became one of three people his friends went to for advice.

> Mehmed: (…) They'd ask. People would come to me, "I have this bump on my dick". I'm like, "I'm not a doctor. I'd go to doctor. Immediately." I'm so scared for these things.
>
> Marie: That's sweet though. How'd you become that health expert?
>
> Mehmed: Two friends of mine, we were really into sexual things. We'd read a lot. That's one of reasons. When we'd be talking, I'd be like, "if this happens, if you have these rashes…". They started thinking we were informed. They were more comfortable talking to us than teachers.
>
> Marie: Did you feel like you learned in conversation with others? Or read up and told others?
>
> Mehmed: Both. I learned from more sexually active friends.

Echoing my findings from the previous section, it seems common for friends to learn about sex, STIs, contraceptives and sexual health more collectively. Here, we can see that this sometimes involves friends more actively taking on the role of the educator. While Mehmed did not say so explicitly, there was still an underlying sense that as a friend you had an obligation or responsibility to share what you had learned with your friends. Paying it forward, educating as a practice of care emerges as part of what it means to be a good friend.

This was something that both Nova and Edith also expressed. During our first interview Nova shared some of the experiences she had had with different hormonal contraceptives, including quite unpleasant side effects, and conversations she had had with her partner. I asked her whether she spoke to friends about contraceptives these days, and she answered: 'I have no problem to tell/share about [my experience of different contraceptive methods] … I think it's

important to tell someone if there are maybe thinking [of trying a particular hormonal method]'. Nova felt quite strongly about the importance of sharing her embodied experiences of hormonal contraceptives with others who might try them and felt quite comfortable do so – despite the implied feeling that it might be a difficult thing to share. In relation to the importance of sharing personal experiences in order to combat stigma, Edith and I spoke at length about her experience of getting HPV[26] and the roller coaster of emotions she went through,

> Marie: Yes, but the idea of having an STI is really stigmatised even though it is so common.
>
> Edith: Yes, really. I made it into a thing. I told people that I have felt comfortable with telling. It's important that other people [know], in an educational purpose. Amongst my friends, I'm seen as sexually "återhållsam" [moderate, restrained]. Seen as the person that never gets an STI because you're a "duktig" [good, clever, capable] person. Often, "those who get STIs are those that are loose and slutty". I think it's important to talk about, "that's not how it works".

What I find particularly noteworthy in both Nova's and Edith's stories and reasoning, is how sharing emerges as a sort of obligation. By virtue of your experience, you have a responsibility to share to educate others so they can sort learn from your mistakes or experiences. The role of the friend here, thus, includes being some kind of advocate through self-confession and disclosure. Another implication for this role is that this is a responsibility they have because their friends will not have access to the "right" information otherwise, either due to a failure of the system to inform, or resistance to that system's chosen information. This reflects the participants' exertion of their own power and influence in contraceptive knowledge production, beyond what is recognised by academic, medical, and policy spaces.

Edith spoke a great deal about the responsibility you have as a friend to care and encourage responsible sexual health practices, which sometimes included contraceptive use. In the first interview we discussed the friendship culture of her past and present friendship groups. I asked if they spoke a lot about contraceptives,

[26] HPV stands for Human papillomavirus and is the name of a common group of viruses, sometimes considered an STI.

> Edith: Yes, but we were pretty open generally. We started talking about masturbation. Many of my friends were also, like, had a feminist awakening. So, by pure defiance we spoke about it. A bit "trotsigt" [defiant] that you were supposed to be open. It was really rewarding and good. I have collected a fair bit over the years. (…) I have gotten a lot of information from friends. If a friend found something, then I could say, "let's go to UMO [the Youth Centre], a bit mum-like. "Come now and I'll take care of you".
>
> Marie: Like, "you should go and get tested"?
>
> Edith: Yes, sort of. Careful with not stigmatising. "I can come with you, make sure everything's ok".

In re-listening to the interview, in between the first and second one, this stuck with me in particular: this feeling of being 'mum-like' towards her friends. I brought this up in the second interview, and asked more directly whether she had felt like she had some responsibility towards her friends, when it came to getting information about sexual health issues or general wellbeing. In asking, I referred to her calling herself 'mum-like'. Edith chuckled and confirmed,

> Mmh, yes, I can probably feel that I have. That I have had a bit like, felt a bit responsible or duty in my capacity as a person who is interested in, and maybe has, a bit, who has a bit more consequence-thinking than some of my friends. And that's not my trying to be, "I'm so mature" (*ironic tone*) but I think it comes from that I'm pretty worried and anxious as a person so then I've gotten used to "what are the consequences of…" But I think that I've felt a bit, when I know a bit more, I have an obligation, like "come now my little ducklings" and it's a bit in general, a girl-thing that you experience that you almost together take responsibility for each other when it comes to, particularly, like safe sex. (Edith)

Edith's reasoning parallels what Nicole Andrejek found in their recent Canadian study looking at 'shared rituals, practices, and perceived risks within women-centered friendship groups during a typical "girls' night out' (Andrejek 2021, 758). In which one of the identified social roles participants described was, like the role Edith have had amongst her women-centred friendship group, the 'house mom': a 'care-giving role [which] refers to the friend in the group who is the most protective and nervous about her friends, playing a sort of motherly social role' (Andrejek 2021, 771).

Edith partly accredited this role to personal attributes, her own worries and anxieties, and partly as a gendered 'girl-thing' where you collectively care and take responsibility for each other. This gendered sharing of risks and responsibilities goes far beyond contraceptive use and safe sex, like Edith hints at, and similar dynamics can be found in everyday care practices of girls and women. These include '[playing] the role of the shield to safeguard their friends from unwanted sexual touching on the dance floor… by dancing in circle formation' (Andrejek 2021, 769), and other practices, such as those discussed in the 2018 autobiography *Text Me When You Get Home: The Evolution and Triumph of Modern Female Friendship* (Schaefer 2018).

The sexual health promoter

Sometimes, however, the responsibility some participants felt when it came to sharing their contraceptive experiences for educational purposes with friends (particularly in girl or women-centred friendships), was a more difficult balancing act caught between sharing versus scaring. That is, some participants discussed that while they wanted and felt obligated to share their experiences with different hormonal contraceptives, including unpleasant and difficult side effects, they also felt some a responsibility not to "scare people off" the same methods. In the second interview with Sally, we discussed this dilemma,

> Sally: (…) I don't want to scare people away. For example, my friend's sister who has gotten a boyfriend. (...) But what would I say to her if she asked me? (...) It would've been difficult, I don't wanna feel like I say "no, it's really bad" and then she gets pregnant. I don't want to scare someone off. (…) it is maybe still, it is their choice to test. If they feel bad. They can try. And feel that it's okay, normal to. You can feel bad. [But] you don't have to like, go around with it in silence. They're aware if it comes a problem, "not just me". And take it seriously.
>
> Marie: Do you feel like you still have some sort of responsibility for this younger sister?
>
> Sally: Yes… like, particularly with her little sister. She's had issues with self-confidence and self-esteem. Not so careful with everything. If she had taken the pill, then I would've been worried – that she would remember and take it every day. If she didn't have anything then… then I still feel that it's more important that she, that she has a hormonal coil than that I scare her a lot (...)

It is fascinating the extent to which Sally expressed feeling responsible for her friend's little sister, including taking the hypothetical 'blame' in case the sibling would become pregnant. This, I would argue, is a narrative that one seldom encounters in academic or wider medical discourse. In this narrative lies an assumed causal relationship between Sally sharing 'too much' information about her experiences with the hormonal coil, and her friend's little sister becoming too scared to use any hormonal method, and thus risking an unwanted pregnancy.

In Sally's story, there is another role at play that goes beyond the caring educator, namely: the sexual health promoter. This second role or archetype which emerged in some participants' stories of contracepting is closely connected to, and sometimes not easily distinguished from, the role of the caring educator. Yet, it emphasises a slightly different role and relational dynamic that can exist between friends, which, echoing Byron's findings again, 'highlights informal practices of friendship-based sexual health promotion that sit apart from, yet are informed by, formal sexual health strategies' (2017, 494). Some participants expressed feeling very concretely responsible for their friends' sexual health and sexual practices including contraceptive practices. Others expressed it in more implicit ways.

Hugo was one of a few of my participants who very clearly stated that he 'always tries to propagandise for condoms' when talking to his guy friends (especially those that are straight). In the second interview, my first question was how things had been since we last met and whether there was anything he had reflected on since,

> Hugo: It was a bit funny actually, I spoke to a friend who sleeps around about condoms. So, we actually had a discussion, I thought *now I'm going to tell you.* I mean, I had learned quite a lot – that if you get chlamydia that you become sterile. I thought it was for men and women, but apparently only women. I wanted to say it to scare [him] a little, "use a condom!". Because you don't notice the effect of it if you get chlamydia. But he has a doctor-sister, and the effect on men isn't as strong as for women.
>
> Marie: But maybe you don't want to infect the…
>
> Hugo: There is no reason why you shouldn't do it [use condoms], but that was my biggest argument. Like this: "stop sleeping around without using condoms!".
>
> Marie: So that was like the time that you thought of…

> Hugo: Just came to think about it, speaking of contraceptives. I asked him how things were with his sex life and asked whether he has sex with or without condom, and he said without. I think it's unfortunate that it [condom promotion] is mainly aimed at guys who has sex with other guys – like safe sex.

Hugo was eager to share his newly acquired knowledge of chlamydia to his friend who 'sleeps around', effectively as an attempt to scare him into using condoms. Hugo ends the story with a reflection on social dynamics around condom promotion, reflecting and noting – perhaps related to his own embodied experience as a young man who has sex with other men – the stark difference in discourse and sense of responsibility around condom use for straight men compared to gay men. This reflects the individual-level impact of wider societal concern about different people's sexual health practices, in which straight men continue to be absent whereas homosexual men are consistently discursively constructed as 'risky groups' in public health settings (Shoveller and Johnson 2006, 50).

Another participant who shared similar stories of condom promotion, albeit through less explicitly forceful strategies, was Mehmed. In the second interview, recounting the people he had spoken to about the research project since the first interview, Mehmed told me he had spoken to one of his 'woman friends, to make sure that they know it's not their responsibility only [contraceptive use]'. He shared that this friend was on vacation where she had been having 'lots of sex' and Mehmed energetically queried: 'so, did you use [condoms]? Did you force them to use [condoms]?'. Within this friendship relationship, Mehmed had been pushing and trying to encourage his friend to be more assertive about condom use, even with me who 'sometimes refuse'. I asked him whether he – now or when he was younger – felt that it was sort of your responsibility to talk about these things and push for more condom use. Mehmed replied,

> Mehmed: I don't feel like it's my responsibility, but I feel like, especially with my close friends, I feel like it's my responsibility as a friend to tell that, "They should do this". Push for it, should be aware. I mean, if they had something, an unwanted pregnancy, or some STI, I would feel sad for them because we're friends. I feel like it's good to remind them that it's their… I don't think that they don't know but, I think it's good to remind them.
>
> Marie: Yeah, so do you think that's part of being a good friend?

Mehmed: I agree, mhmmh. I agree.

Marie: Do you feel like you have other friends that do that to you?

Mehmed: ... yes. Of course, oh my god! (*Both laugh*) Especially, those of my close friends who know that I'm gay, and if, during the time I wasn't in a relationship and when they knew that I was having sex with random people they were also like, "don't forget, this is important. Don't risk it". But I think they're aware that I wouldn't do that. Because I'm much more nagging about this.

Like Hugo, Mehmed had taken on the role of the sexual health promoter friend, who really tried to push his friends to use contraceptives to avoid getting an STI or an unwanted pregnancy. With close friends, he felt and reasoned that this was his responsibility as a friend and part of what it meant to be a good friend: trying to remind and sometimes push friends to practice 'safer sex' and hinder them 'doing something wrong'. Unlike Hugo, Mehmed also shared that he had friends who played this role for him, especially those that knew he was gay and when he 'was having sex with random people'. Though, he downplayed the necessity of this type of friendship role for his own sake since he 'wouldn't do that', that is, have condom-less sex in one-night stand situations.

It is noteworthy that the two men amongst my participants who identified as gay were some of the people who felt most strongly and spoke most about the need to push friends to use condoms. While they were not the only ones doing so, Hugo and Mehmed came across as feeling particularly fervent about it. It is difficult to say exactly why this was, but it is possible that as men who have sex with men, they had particularly internalised messaging around the importance of condom use as well as the moral obligation and responsibility to practice safer sex.

Among the friendship role of the sexual health promoter, it was not only narratives and discourses around condoms that emerged. Another participant who took on this role, in addition to the more caring educator one, was Edith who shared a story of encouraging and trying to push a friend to get on a more secure long-acting contraceptive method alongside condom use.

Edith: (...) Then I know, I remember one situation that was really nice, when I – I try not to be judgey, because that doesn't like help "hey you that was stupid". There was this girlfriend of mine who said that she never uses condoms or any hormonal contraceptive, and I was like: "Oh dear – this doesn't sound good". Not because, not to like, judge her. But I mean sooner or later you'll get potentially pregnant,

and it isn't worth it. She was just, "It's not nice with a condom". "But there are so many other alternatives!". When I finally decided to get the hormonal coil inserted, that I was gonna have hormonal contraceptive methods, then I started talking to her about it and then she was like this. I remember that after a while, when we had spoken, then she came back and we met up at some point after that, and like "Now I'm going to get the coil. Now I'm gonna deal with this". And I was like, "God, that's good to hear" (*both laugh*). It was really, another time before she did that: "Now I started to use condom!" (*laughs*) and I was like "Yeeees, thank you!".

Marie: "Gold star to you!"

Edith: Yes, I mean, back then it was a bit implied that it was through our conversation that she realised that it was a good idea. Then I felt a bit proud. *Now I've done a good deed for someone*. (*laughs*) Ehm, but yeah.

Though Edith is vocal about not trying to judge her friend for not using condoms or hormonal methods, she still seemed somewhat appalled by it and concerned about trying to change this friend's mind. Her initial strategy was, much like conventional sexual health promotion, trying to convey the abundance of contraceptive method options that exist beyond condoms – a market of choices to shop around in. What followed was a different strategy from conventional contraceptive counselling, namely bringing her friend along o her own journey of getting the hormonal coil. Throughout the story, it is very clear how proud and happy Edith was, and it shares some features of a personal success story: someone going from being in a very bad situation (in this case completely "unprotected sex") to a great one (using both a hormonal method and condoms). It is worth noting how this narrative of a "good" contraceptive situation must be understood situationally, because, at other times and situations the same participants would problematise the notion that hormonal contraceptives or condoms are always great. I will return to this in later chapters.

It was not that unusual that some participants had quite strong emotional reactions to friends they perceived being irresponsible. Edith implicitly constructed her friend's actions as risky and irresponsible, which is why she expressed such relief and almost frustrated vindication in her 'yeeees, thank you!'. Another participant that expressed similar frustrations was Gabriella in our first interview. She shared a story of two of her friends that she found out, 'doesn't even use contraceptives. Completely unprotected. Just pulling out. I got a bit upset. So fucking risky. If you're not ready to get pregnant with this person. Then

later she did get pregnant'. Mehmed, mirroring similar frustrations to Gabriella but in relation to STI prevention, shared that he had always been concerned with STIs, even when he had a girlfriend who was very afraid of getting pregnant, when he was younger before realising he was gay. He told me,

> (...) my concern was always STIs. I always shared this with straight friends. In [town he lives in now], I have mostly straight friends, I was like, "did you use condoms?" They're like, "you know, I'm on pills". "But what it's not the same, it doesn't prevent STIs!" They're like "You know Swedish guys don't want to use condoms". "It's not the same, you can still catch it!" It's not like when you're straight there's a barrier. (Mehmed)

Edith, Gabriella, and Mehmed's strong emotional reactions to their friends' perceived irresponsible and risky behaviours can better be understood through the lens of common disciplining discourses and strong narratives in Sweden around the importance of being responsible and good healthy citizen. It highlights the varying, more nuanced roles and dynamics that exist within friendships beyond altruistic caring as well as the wider social, cultural, and political context in which friends exist. Caring, in these stories, get mixed up with some elements of control: of disciplining and surveilling friends, even though it might not be experienced as such within friendship contexts compared to other relational contexts like healthcare or the family.

When it came to the work of contracepting, those who took on the role of the sexual health promoter within friendships reasoned, and in some cases justified, their explicit pushing and promotion of safer sex among their friends with the idea that sometimes one might know better and sometimes surveilling of each other is needed. As such, friendship disciplining, and surveillance was not necessarily constructed or thought of as oppressively controlling or negatively perceived.

> (...) Before maybe I would have said that it's the responsibility of society [to inform and encourage contraceptive use among young people] but at the same time it becomes a bit… it can become a bit moralising and wrong when it must be society's responsibility. It is difficult for society to be impartial (…) But it's a bit nice and a bit good as a friend, or in general, socially close surroundings including parents and partner and such, that you a bit together make sure that you're keeping tabs on each other. A bit like, "it takes a village" because it's always, you maybe don't always see clearly what is best for yourself. Because you're not as likely to see your own patterns than another person who can see, "you have a tendency to act

> like this". So, I think it's good if there's a like, conversation that you have with others in a non-judgmental but informative way. Where you, still help each other, to understand yourself through others. I think. (…) Still understanding and having respect for others' decisions and choices but that you maybe can, you know, you can push a bit, maybe you can group-pressure a bit where needed about like a friend. "You know, this is not healthy for you". That's what we've gotten to, maybe you can't see it [Marie: intervention like] Yeah, exactly, you can. That's why it's so damn good that you speak openly about it, like your sex life, habits and stuff with your friends, because the more open you are the easier it is for other people to more objectively monitor than the monitoring you can do yourself (…) I think it's good with friends, but with society it can get a bit wrong. (Edith)

This quotes again lends credence to the idea that Edith's sense of responsibility comes from believing that the systems cannot, nor do they intend to, give the right contraceptive support. Throughout this long journey of reasoning and sense-making, Edith starts and ends with contrasting the outcome of when society attempts to take responsibility and influence young people's sexual health practices and choices as controlling in an uncomfortable and ominous way, violent and potentially oppressive, with that of intimate others – particularly friends – as a more caring, helpful, and ultimately kind type of control. Society has an ulterior motive while friends – who she returns to the most in the story – can be more 'objective' about you and your behaviours and can monitor and push you in a more non-judgmental, honest way.

The distinction and boundary between care and control is not always clearly or easily distinguished, or necessarily straightforward dichotomies, in the case of friendship and the work of contracepting. The question of whether comments, suggestions, or more forceful pressing about safer sex practices is felt and experienced as controlling in an oppressive way, relates to the context of the overall relationship. In the stories of Hugo, Edith, Gabriella, and Mehmed the actions they took in inhabiting (to varying extents) the sexual health promotor role did seem to feel less controlling to them because it was within the relational context of friendship. This highlights the importance of differentiating between peer pressure and friendship pressure. As Byron found in their data, 'sexual advice between friends is afforded through established care and intimacy and has no equivalent formal source. It is informed by an intimate knowledge of the friend's sexual values, history, preferences and support needs' (Byron 2017, 496-497). With that said, we are only getting to hear one side of the story in these examples.

While the dynamics I have outlined here may be or sound benign from the perspective of the one doing the promoting, we do not know how it was received. As such, these stories also reflect how the power friends have over each other can be a source of oppression.

Many similar concerns and discourses around young people's sexual health and sexual practices were present in the fears, anxieties, and frustrations some participants felt towards their friends. The difference however between these emotions within young people's friendships and that of wider societal moral panics, is, as Byron notes, the intimate knowledge friends have of each other. It seems that friends can therefore, in some instances, get away with more attempts of caringly controlling, disciplining and surveilling than other relational contexts can without it becoming violent and oppressive. This, I would argue, is related to the relative normative freedom of friendships.

3. Considering the limits of friendship within the work of contracepting

Building on the previous section, I want to move to discuss normative boundaries and limits that exist and persist within friendships, that illustrates the need to consider the relative normative freedom of friendships as an embedded freedom (Blatterer 2013). While friendships can provide a relational context in which young people feel accepted and not judged, there were still topics of conversations and experiences that some participants felt they could not share as easily. Friendships are not absent of power inequalities and wider societal normative influences that structure how people feel, relate to, can share, and talk about different contraceptive experiences. Thus, while participants – especially when they were younger – felt that it was easier to talk about contraception, sex and relationships with friends compared to parents, teachers, or healthcare staff, it did not mean that all conversations and experiences were easy or constructed as equally allowed and possible.

One clear example raised by Stina, affecting what you may or may not share with friends, related to privacy concerns, specifically of their sexual partners. Some felt ambivalent about sharing too much with their friends due to, as in Stina's case, fears of 'outing your partner'. This, she reasoned, made it difficult to talk to

people other than her partner and why she 'might not tell everything uncensored to friends' when it comes to sex and related matters. This hesitancy and concern about overstepping boundaries was also reflected in the interview setting in some instances. William and Nova, for example, both at one point asked me – before going on to share a story – whether it might be 'TMI' (too much information). The implication being that it was potentially crossing a boundary of what is too intimate, too private, or too visceral to share. Even in the interviews with individuals that I had pre-existing relationship with, whether as an acquaintance or friend, this was sometimes raised. As such, in this final section of this chapter, I want to consider what some of the limits of friendship can be within the work of contracepting as a young person.

Contracepting failures: the stuff friends might not talk about

Thinking across all the interviews I conducted and reflecting on my own embodied reactions and emotional responses to different topics of conversations, it is clear that certain contraceptive experiences and topics remained more stigmatised than others including in the context of friendship. Thus, while friendships broadly speaking can provide a more open, non-judgmental relational context than is available elsewhere, ideas and feelings still came into play around what is "normal" and respectable to talk about and what is not. Very few participants spoke explicitly with their friends about contracepting failures (Beynon-Jones 2013), such as getting an STI, needing emergency contraceptives, or abortions. This is understandable, given the immense importance placed on individual responsibility when it comes to sexual and reproductive health in Sweden. By contracepting failures, I mean instances which conventionally and normatively are understood as (whether accidentally or not) "failing" to prevent an unwanted or unplanned pregnancy or STI.

Helena reflected on this, contrasting how she perceived the culture around abortions where her mother grew up compared to Sweden. She shared how her mother's friends have had 'like ten abortions' and that this was not constructed as such a big thing, while in Sweden, 'it is more shameful. Like, "when there are so many contraceptives, why do you need to have an abortion?"'. I never explicitly asked a participant about whether they had any experience of having an abortion, wanting to avoid directly asking about something that could be potentially traumatising or difficult. The topic did come up, but it was only on the initiative

of the interviewee. Yet, in hindsight, this hesitancy of mine to ask about abortions is part of the social process of reproducing abortion stigma (Hanschmidt et al. 2016; Millar 2020), contributing to the culture of silence (Greenhouse 2021) that envelopes abortion experiences. I now wish I would have asked about them (with care, of course) and thus made clear that I see abortions as part of existing contraceptive repetoirs.

In contrast to my approach to abortion in the interview context, I did ask more explicitly about participants' experiences with emergency contraceptives in some of the interviews. It was not a topic discussed in great depth, however, and Miriam reflected on why that might be after I asked her whether she had ever heard about friends having taken the morning after pill.

> Eh… yes, naah. Not explicitly. It feels like it's something that everyone has taken, but nothing you like. It's not like sitting around and talking about your birth control pills or minipills. There is this understanding that this is something everyone who has had to take this thing have taken it, but it's not like "What did you do this weekend?" "I took the morning after pill." I mean, it feels like a really… thing that you keep to yourself, or that you don't… Maybe it's not such a big thing. Maybe not the same commitment, like, for example, now I've signed up to take the pill every day at 12 o'clock, or getting the implant inserted. (Miriam)

Miriam contrasts emergency contraceptives with 'regular' forms of contraceptive, which is more normalised to talk about with your friends. She struggled to explain exactly why it is the sort of thing 'you keep to yourself', perhaps because it is not 'such a big thing'. You go to the pharmacy, get the pill, you take the pill and then it is done unlike more extensive commitment and work required to remember to take the pill every day or greater physical intervention of getting the implant.

The topic of emergency contraceptives was also brought up by Edith, who shared Miriam's experience that it was not something you discuss so much but – unlike Miriam – felt that it was more connected to taboos and moralising discourse,

> Edith: One thing that I, the only thing that I can feel that you never, – reflecting on it now – never been a part of the contraceptive situation for real is the morning after pill. You're not really supposed to use it as a contraceptive. (…) It's very taboo-ridden. Much connected to that you're very irresponsible, and that you don't care. You get to the crossroad between abortion discussions and contraceptives. "You would *risk* getting pregnant? Oh, lord you're a horrible human being". Because I

have, personally, taken quite many and I have many girlfriends who have taken it. [Marie: It's pretty common.] Yes, and it's good that it exists. Before, before I told girlfriends, because I'm pretty open, there was no one who said that they had taken the morning after pill. (…) I knew a bit about how you take it, mostly from American sources. (…) But I realised now, no one has like mentioned it more than that it exists, how it effects the body and works. It's like almost, it's only sluts that take the morning after pill. Only irresponsible people.

Marie: Strongly connected to…

Edith: … some kind of failing. It's a bit brutal when you think about it. especially when it's about a person who like, didn't have a choice. You know, you don't feel comfortable to say or a forced situation.

Marie: A lot of reasons – condoms can break, fall off. A lot of situations. Especially a failing… it's not always easy to use contraceptives in all situations.

Edith: No exactly. Yes. Extremely. About that. Strongly moralising. Condoms and morning after pill. Mostly, "peka med hela handen" [forcefully instruct/suggest]. With the hormonal it's a bit more open, what suits you. But with that, it's black and white: you're a failure/failing if you need to take the morning after pill. Like, stamped as a slut.

Edith felt that the discourse around emergency contraceptives was that of failure, irresponsibility, and carelessness. Because if you need to take it, it somehow means that you have failed to contracept "properly" in the first place, though not quite on the scale of abortion.

This cultural repertoire has been discussed in various other contexts and by different scholars, like Sandya Hewamanne's study from Sri Lanka on global factory workers negotiating reproductive health, particularly around emergency contraceptives. They found that while workers themselves mostly spoke of the option of emergency contraceptives as a 'godsend' for their needs, NGO staff and neighbours were more 'conflicted' about it. 'While they realized it was useful in cases of rape and unplanned sexual encounters, some felt the easy availability of emergency contraceptives would encourage irresponsible behavior' (Hewamanne 2021, 47). Similarly, Debbie Fallon argued, based on a UK study on young females accessing emergency contraceptives, that emergency contraception is,

> … an interesting catalyst to discussions about shame since it is so bound up in discourses of risk and responsibility that inevitably draw attention to unprotected sex as an irresponsible behaviour rather than acknowledging access as a responsible health action. One of the most significant aspects of this experience is that the private is made public, revealing a hitherto private activity in the same way that abortion renders sex, and particularly 'risky' sex, visible. (Fallon 2013, 320)

Both Edith and Miriam challenged and resisted these discourses in their different ways: Miriam, by downplaying the extraordinariness of taking emergency contraceptives, and Edith – together and through conversing with me back and forth – by arguing for all the different reasons why emergency contraceptives might reasonably be needed.

Another type of "contraceptive failure" that was less spoken of by participants and accounted for as less of a conversation among friends was STIs, particularly HIV. While some participants more casually mentioned that they had had an STI, it was not as common of a theme. In the interview with Miriam, she noted that a friend of hers had mentioned getting herpes. I asked whether she had heard from many other friends about similar experiences, of getting an STI. She replied that she had not, only a few acquaintances and someone she has been in a relationship with where they had to use condoms. I asked whether STIs felt like an easy thing to talk about with others. She said both yes and no, only with friends she trusts. She thought, 'for example, that it's much more stigmatised to talk about HIV'. This is something that Hugo spoke of as well in our second interview, sharing about the times he had worried about getting an STI or HIV. He discussed finding out a year ago that a friend of his had gotten HIV but,

> (…) that it took a long time before he told [people]. He felt ashamed quite a lot. We didn't treat him differently for it, but there's stigma around it. He maybe felt *of course it was me who got it.* Feelings of guilt. All of my friends took it a bit more like, a bit like when someone got cancer, I guess. A bit that reaction. Folks are very, "Oh". More like silence. (Hugo)

The stigma of HIV and living with HIV is a well-documented issue and societal challenge (Duffy 2005; Poindexter and Shippy 2010; Fielden et al. 2011; Emlet et al. 2015; Eaton et al. 2018) with silence usually emerging as 'one of the most common reactions to HIV stigma' (Fielden et al. 2011, 275). Silence and shame are powerful mechanisms for maintaining and reproducing the stigma of certain contracepting forms and experiences. The relative silence around emergency

contraceptives and getting an STI, especially HIV, particularly highlights the different social boundaries and hierarchies that exist between contraceptive strategies, in which some were deemed more "respectable" and thus more possible to speak of than others. It is important to keep in mind the functioning of these different social boundaries and consider what other contraceptive matters might be impacted by them, limiting the support that young people can seek and receive from their friends.

Friendly strangers: care work online

As I have shown, friendships can provide a relational context in which young people feel accepted and not judged. Yet, there are still stigmatised topics of conversations and experiences that some participants felt they could not share as easily, such as different contraceptive "failures". Other examples that were raised as difficult to share was when sex did not feel good, positive, or fun. This led to the important role ´that different online communities and spaces, and that of friendly strangers, played in providing the support that might be lacking or more difficult to gain from friends that you share a longer preestablished history and relationship with. Amongst the participants, there were several stories indicating this apparent need: situations where participants sought out different online groups or spaces to ask particular questions related to contraceptives or seek support. Friendly online communities and people thus sometimes served an important complementary form of social support and care for young people in doing elements of the work of contracepting. Moreover, considering the blurry boundaries between what constitutes a friend especially in virtual contexts (Perry et al. 2018; Lai and Fung 2020), I think these are important to include in the general space of young people's friendship cultures.

One such story came from Sally, who referenced being more or less active at different times in some particular Facebook groups. It was a group dedicated to women's health issues and where she had spent a lot of time reading up on how to deal with repeated and unpleasant yeast infections (as a result of their contraceptive method) which had made having vaginal penetrative sex painful. I asked her about this and whether she had gotten a diagnosis yet and whether this Facebook group had been helpful,

Sally: This group, I am very active on Facebook – I read around a lot. There isn't much to do. You can rearrange your diet, relaxation exercises, physiotherapy… I'm saving myself the time it takes to go the Youth Centre, to cycle there. It feels hard, like traumatising. It feels better – doesn't affect me so much. I'm trying to find other knowledge.

Marie: Has the [Facebook] group been helpful?

Sally: It's been nice with the penetrative sex thing. I have a friend, she had a very bad experience of her first sex – there wasn't like consent. She's had a lot of issues with penetrative sex. Broke up, got a new boyfriend, had panic anxiety. So, I've been able to talk to her, but I didn't understand the problems. Now I do better. Now she thinks it's super nice. But I mean, I can't, it feels a bit like a failure. That's the hardest bit. That's what sex is. (…) I have spoken to girlfriends who didn't really understand. So, it has been nice with this group, others who… They also feel like they failed. They have been living with it for so long. So, I get some support in it, not being alone or like weird.

For Sally some of the Facebook groups has been a source of information and knowledge, of hearing about alternative ways that others have tried to deal with similar issues. Though it seemed like she appreciated being able to get knowledge from these online communities, what she mainly appreciated was being able to hear that others have had similar issues to her, particularly related to not being able to have penetrative sex. She also spoke of another friend and finding solace and support in each other and their shared experiences. However, Sally also felt that it was "nice", what I took as a sense of relief, that there were others, even more people who could not have penetrative sex for pain reasons and, like Sally, felt a bit like they had "failed".

Hugo also shared that it was not only his friends, but also friendly strangers on the dating app Grindr, who sometimes served as sources of support, knowledge, and advice when it came to sex, including contraceptives, especially when he was younger.

Hugo: There's more openness to talk about it with your friends and in asking strangers. That has happened to me too. Been given advice on shaving. Or about contraceptives… it feels like there is a community. Maybe because nobody talks about it. If you're younger and don't know… then it helps.

Marie: That sounds really nice.

> Hugo: Mmh, I think it is really nice too. I have learned a lot. Learning is not always positive. More trial and error. I have done stupid things too… like, I don't know what I don't know. This thing with condoms, I didn't learn until in the last two years. It wasn't something I didn't know that I didn't know.

In further explaining the reason why those whose sexuality fall outside the norm often need to rely even more on looking for information, expertise, and support online, Hugo continued, '[g]enerally speaking, maybe, when you have a sexuality outside the norm that you have to investigate by yourself on the internet' (Hugo). Thus, it would seem that whilst online friends or friendly communities online are a necessary support structure for most young people when it comes to doing the work of contracepting, they might be even more essential to those whose sexuality or gender identity fall outside established norms. Hugo and other participants partly explained this in how sexual education in school rarely (if ever) mentioned other sexual orientations and practices than heterosexuality and hetero-sex.

Relying on friends, both online and offline, becomes a way to navigate the current sexual and reproductive landscape, where the individual is left to fend for themselves, often alone. Friendships sometimes provide an important sense of community, and a collective way of doing elements of the work of contracepting. This is part of their strength. However, when friendships fail to provide this sense, it can become even more alienating, making alternative communities and spaces especially important. It highlights the immensely vital and powerful, roles that friendship play for young people in doing the work of contracepting and learning about themselves, their bodies, and sexual and gender identities – albeit, with certain normative limits and social boundaries.

Conclusion

> I think it's interesting that, as a little sister I didn't go to my older sister, but I think it has to do with, I guess, that we're not *friends* – [we were] not close friends until I was done with that part and figured out how it works with contraceptives. (Gabriella) [*emphasis added*]

Through this chapter I have shown some of the reasons why it is important to pay attention to friendships when it comes to young people's sexual and reproductive health experiences. They can provide important emotional and practical support, including in the epistemic dimensions of the work of contracepting. Factors that

I see as playing particularly important roles in creating favourable conditions for doing (elements of) the work of contracepting with friends include their playfulness, non-instrumentality, collectiveness, and mutuality. Friends clearly do not have the same normative responsibilities for other young people, compared to healthcare, parents, or school, which seems to make it easier for young people to seek their support and help, without fearing judgment or cautioning.

Yet, themes and dynamics around responsibility still played a central role in the stories participants shared around contraceptives, sex, and friends. As I highlighted in the second section of this chapter, despite not being normatively responsible for other young people's sexual practices, themes around responsibility towards friends still emerged: out of care but also care that could function as control. Even while acknowledging the immense importance friends and normative freedom friends can provide in the work of contracepting, some participants still shared stories indicating the normative boundaries, taboos, and stigmatised topics that can exist among friends which also resulted in some seeking care and support from friendly online communities.

There are different kinds of friendships, that fulfil different functions and roles for young people. Friendship groups are not relational utopias in all instances, as sociologists of friendship have shown and which this chapter also highlights. The less institutionalised nature of friendship evidently has its benefits but are still constrained and shaped by wider societal discourses. Friendships are diverse social relationships and can be helpful, comforting, caring, controlling, and much more. Without overly romanticising the power of friendship, I still believe there is cause for optimism about the role friends and friendly communities play for young people in doing the work of contracepting and that deserves more attention.

In the next chapter, I will continue to explore nuanced and various experiences and practices of the participating young people when it comes to sharing the work of contracepting with others: specifically, within longer-term sexual relationships.

Chapter 6. Navigating how to share the work of contracepting in long-term sexual relationships

In the previous chapter, I explored the important and nuanced roles friends played for young people in the study, highlighting some ways in which they helped with or shared the epistemic, emotional, and practical work involved in contracepting. In this chapter, I will explore what the experiences and practices of contracepting involved in the relational context of longer-term sexual relationships for participants. Specifically, I will focus on how participants navigated how to share, as well as the notion of sharing, the work of contracepting, which emerged as the central ongoing relational dynamic in many long-term relationships.

Previous research and many societal debates have centred on the work of pregnancy prevention within heterosexual cis couples, calling for men to share the burden of pregnancy prevention historically shouldered by women (Oudshoorn 2003; Eberhardt, Wersch, et al. 2009; Fennell 2011; Campo-Engelstein 2012; Lawson 2017). This has also included calls for more pregnancy preventing contraceptive technologies which men and people with penises can use. I agree with these sentiments, but also want to highlight the ways in which existing contraceptive strategies for both pregnancy and STI prevention can be shared within different long-term sexual relationships. By analysing contracepting through the lens of the work, one can see that there are several types of work, efforts or burdens involved which require different types of resources beyond the physical usage of a contraceptive technology. In fact, by looking more widely than relational dynamics within cis straight relationships, one also finds that there are many ways that the work of contracepting can be done and shared.

With my critical understanding of work, one is also reminded to consider that whether something is or is not considered work or burdensome is not a question

of the discrete type of activity but a question of circumstances. That is, an activity can be more or less work depending on the wider social context and the relationship between the person or persons doing the work, the nature of the work and the wider context in which the work is carried out. In a similar vein, the meaning of whether contracepting in fact is felt and experienced as desirable or a benefit, as laborious or a burden you would rather not take on, is similarly context dependent, and important to keep in mind.

When it came to practices and negotiations around sharing the work of contracepting, the stories that took centre stage largely revolved around contraceptive dynamics in relationships between a cis woman and a cis man. For some participants, these were heterosexual relationships within a cis couple; for others it was individuals identifying as, for example, bisexual or pansexual but speaking of a past or current relationship with a person of the opposite sex, and for some; it was nonbinary couples or couples between nonbinary and cis people. Nevertheless, what connected them, was that they were in long-term sexual relationships in couples that were concerned with not only STI prevention but also pregnancy prevention, and a lot of the emergent relational dynamics related to gender, and gendered dynamics between men and women. Additionally, while some shared experiences of STI prevention work in long-term relationships, most stories focused on pregnancy prevention. Sometimes STI prevention, depending on whether one is monogamous or have multiple sexual partners, is a long-term contracepting concern. Usually, however, it tended to be something that decreased in necessity or perceived importance with growing trust and, for some, becoming exclusive sexual partners. Pregnancy prevention on the other hand was never less necessary for my participants unless their desire to get pregnant changed.

In this chapter, I will focus on what many participants who (either at the time were or had been in longer-term sexual relationships) reflected on when it came to pregnancy and/or STI prevention with partners. In the first half of the chapter, I will consider and outline some of the practices of sharing the work of contracepting that came up in the stories of some participants. I will discuss what sharing the work of contracepting can entail in everyday life. In the second half, I will shift and consider how some of the participating young people described how they felt and emotionally made sense of sharing the work of contracepting, highlighting how this included navigating the un-shareable elements of contracepting. Finally, I will provide my conclusions for this chapter.

1. Practices of sharing the work of contracepting

Talking about sharing the work of contracepting, as well as the importance of doing so, was a central theme in participating young people's stories of contracepting in the context of more long-term sexual and romantic relationships. In this section, I will consider some of the practices of sharing this work that came up in the stories of some participants. I will discuss what sharing elements of the work of contracepting can entail, and the negotiations ongoing within these shared practices.

Sharing the epistemic work of contracepting: exploring, experimenting, and learning together

Within this theme, some echoes emerged of friends' practices of sharing facets of the work of contracepting. Specifically, regarding the more epistemic dimensions of the work of contracepting around exploring, experimenting, and learning together or talking more broadly about contraceptive strategies. However, the relational context is different and matters here, in that the exploration of contraceptive strategies and the use of said strategies are intertwined. The talk between sexual partners becomes instrumental, unlike that between friends who do not have sex together, highlighting different uses and functions of talk.

Pim told me they had spoken a fair bit about contraceptives, especially within their current long-term relationships. They shared how, together with their girlfriend early in their relationship, they explored more creative means of STI prevention when dental dams were difficult to access,

> But with my girlfriend, of 10 years (…) the dental dam has been a natural part [of their contraceptive strategies]. We cut up condoms. In the beginning when we were exploring, up in Norrland [northern region of Sweden], it's a bit more taboo to have a lesbian relationship. A bit more like exploring each other, it became a fun thing. We do this thing with condoms. Not as serious, we can't get pregnant. With her – more for disease purpose. She hasn't had anyone else but me, while I've had several others. Only in more recent years that she's dating a dude. We sat and giggled and cut up condoms. (Pim)

This story echoes some of that from the previous chapter on friendships, where playful exploration of contraceptive methods and sex was quite common. Pim

spoke fondly of these memories and describes the experience of experimenting with condoms as dental dams as a 'fun thing'. Exploring contraceptive strategies accompanied exploring their sexuality and was done in a "less serious" context as they were not at risk of getting pregnant. Pim thus constructed this experiment as less risky and thus as an enjoyable, fun, and playful way of learning and figuring out how to go about STI prevention as two people with vaginas having sex.

Pim's story also highlights, however, the heteronormative organisation of healthcare services and its intersection with the rural-urban divide. Pim grew up in the north of Sweden, in a smaller community, where access to dental dams were difficult or non-existent. As such, they had to be inventive and creative, using condoms as make-shift dental dams. In more rural contexts, thinking ahead and making practical contracepting arrangements in advance becomes even more necessary as access to any sort of healthcare services or purchasing of, for example, condoms, requires a lot of forward planning. You need to travel further and are reliant on either sparse public transportation or parents or family's ability to drive you. For young people, especially young queer people (Drumheller and McQuay 2010; Sorgen and Rogers 2020), living more rurally can present quite the challenge to accessing sexual or reproductive healthcare services or support.

Unlike within friendships, the exploration of contraceptive strategies was not divorced from more concrete implementation of some sort of contraceptive strategy or method use. That is, it was not non-instrumental in the same way as conversing and playing around with contraceptives can be among friends. Thus, while several participants (especially those concerned with pregnancy prevention) shared that they do talk about contraception as a wider social issue it was usually coupled with considering possible contraceptive strategies for their own relationship. As Nova explained,

> I talk a lot with my current partner about contraceptive methods. He doesn't want to be the person who feels like he's forcing me to… sometimes I joke that "I've had to sacrifice an awful lot for our sex life, had pain…" (*laughs*). He's been very clear – it's been okay to use condoms, even if I know that we both prefer without. We've spoken a lot about it. (Nova)

The conversations that occur within more long-term sexual relationships are different from those within long-term friendships, as they are more centred on figuring out as well as signalling and trying to communicate with your sexual partner the possible contraceptive strategies you prefer, find acceptable, NS are

okay with using or not. It is not unusual to start using a particular contraceptive method or strategy, and through experiencing it, re-evaluating, and considering an alternative approach. This planning and evaluation within long-term relationships like Nova's occurs in relation to her own, her partner's and their shared desires and preferences structured by what available contraceptive methods.

There is some tension and ambivalence in Nova's accounts of her relationship in which Nova has enabled 'their sex life' by using different long-acting (often hormonal) contraceptives. Here the language of burden shines through as she describes, only somewhat jokingly, the 'sacrifice' in terms of physical and mental health she has suffered because of their contraceptive strategy choices. She spoke of how her partner did not want to feel like he was 'forcing her' to use these methods, signalling this through condom use. Throughout our interview (and reflected within this excerpt) I think there might have been two conversations going on between Nova and her partner: the explicit one and the implicit one. The explicit communication involves what you state that you are ok with, while the more implicit, unspoken one is about expectations and who has taken the burden of work of contracepting. I will continue exploring and discussing this tension and ambivalence later in this chapter.

As Fiona McQueen and Sharani Osborn (2020, 105-106) have argued, as scholars we must be careful in how we interpret and extrapolate from talk meanings around emotionality and equating intimacy with communication. In Nova's story we can see some of the 'constraints *on* talking about emotions as much as the constraints *of* talk' (Brownlie 2014, 128). The value of talking about things is evident as a cultural ideal here, but I also see a clear tension between talk and practice. Because as Julie Brownlie (2014) clearly illustrates through their work on emotions, reflexivity, and culture in 'ordinary relationships', talk does not (always, or straightforwardly) equate with practice or action. In fact, there can sometimes even be an emptiness and inaction in talk.

Sharing the planning and practicalities of contracepting: negotiations, routines, and intimacy

Much like with friends, the epistemic work of contracepting seems to be the easiest element to share or help a partner with, as it largely centres around talk. However, participants also discussed sharing more practical or logistical

dimensions of the work of contracepting, albeit to different extents and in different ways.

Within heterosexual relationships between cis men and women, the invisible planning or articulation work of contracepting casts a light on the often-uneven distribution of energy, time and sometimes stress and worry spent on anticipating, preparing, thinking ahead, and avoiding potential risks of particularly unwanted pregnancies. This echoes common trends in gender distribution of household and care work within heterosexual couples or families. This gendered dynamic was found across several stories of participating young people. Sally, for example, recounted her attempts to get her boyfriend to go to the Youth Centre. Partly because she feels that it is important to go there, and partly to get free condoms and make sure that they always have condoms at home after she stopped using the hormonal coil (due to intense side effects). I asked Sally why she thinks her boyfriend does not want to go to the Youth Centre for free condoms. She replied,

> Don't know, I think it's weird. Partly because he doesn't like have the time. The Youth Centre is a bit off. It's pretty central [in the city] but he studies at [place further away]. At some point you're gonna be in town. (…) But it feels… maybe like I'm thinking about it more. That you're not standing there one day and like *shit now there's none left [condoms]* and like preventively, get them. It feels like something I've thought more about than something he's thought about. (Sally)

Sally felt that planning ahead and ensuring that they always had condoms was something she thought about more than her boyfriend. This illustrates the mental dimensions of the work of contracepting, of the forward-planning required in pre-purchasing for example condoms or, even more so, in planning to get more long-acting contraceptive methods. We can also understand how contracepting can become constructed and emerge as a contentious household chore in some long-term relationships.

Sally's story also highlights how planning of contraceptive strategies sometimes involves interpersonal negotiations around priorities, trade-offs, ease, cost, and effort you want to put into the way you go about doing the work of contracepting. Later in the second interview, Sally returned to this planning-talk with her boyfriend, bringing up the different considerations that goes into her contraceptive choices. She compared the utility and negative impact of the coil with the somewhat 'wasteful' nature from an 'environmental perspective' and

slight hassle of condoms during sex, raising the different pros and cons of each method from her experience. She reasoned,

> (…) I mean it was still nicer when you didn't have to think… didn't have to go and buy. I mean it still costs money. I think he should pay for it or shall we like divide it, or shall I? I think it it's easier to go the Youth Centre because it's free, but he thinks it's easier to go to the store. But then it costs money. But I don't think it's worth it to pay like 50 SEK [approximately 5 pounds/euros] when I can get it for free. It becomes like, a bit of a money question that you don't want to waste too much. Yeah. (Sally)

Sense-making, feelings, and thoughts around the cost of contraceptive methods as well as what is considered a 'hassle', too much work or 'worth it' are questions that are particularly structured by experience of class, socio-economic status, and financial means. As young people, this can be even more compounded as your financial means are more likely to be limited compared to adults. Sally's narrative highlights the uneven distribution of work that sometimes is needed to access cheaper contraceptive options. Choosing to pay for your condoms instead of making the trip the clinic where you get them for free is not a choice that is readily available to everyone. And sometimes you may have to travel further or take more time to access the cheaper or free options.

The everyday work of planning ahead and preparing for contraceptive strategies was not always experienced as a tense negotiation or contentious household chore, however. Another example where this sort of everyday articulation work emerged more as an organic or mundane daily household routine, was in Pim's experience with their girlfriend and their cohabitating partner. Pim explained that 'I've liked that, with my girlfriend, that we've discussed – "are you going to the store? Can you buy some dental dams or condoms?". With my co-habitating partner too, "it's on the list"'. For Pim with their two partners, the purchasing of condoms or dental dams had become part of their relational, daily routines. Much like checking whether they are out of bread or need some extra shampoo, it gets put on the grocery shopping list and that is taken responsibility for keeping mind in a more shared manner.

Another example of planning, preparing for, and implementing contraceptive strategies being a more valued part of the relationship can be found in Mehmed's story:

> Mehmed: With [current boyfriend], it was more natural. It's time. With [ex-boyfriend], a more conscious decision. "Let's get tested, if nothing, then we can stop using condoms" (…) We were both concerned with STIs. Wanted to know before removing protection. I think it was both. [Ex-boyfriend] had never been to centre for sexual health, how? It's so close. It was a nice event for us as a couple. Taking something together.
>
> Marie: What was nice about it?
>
> Mehmed: The first time in life to go get tested with partner. So, the relationship can take a step. It's a trust point. If he'd just told me he didn't have any STIs, I'd probably believe [him], but without getting tested. We'd have proof. A step together. Going to doctor, like "he's my partner, my partner". It's cute. [Marie: Couple outing] Yeah.

Mehmed's story brings out interesting insights into the role of condoms and STI testing in his relationship. Mehmed constructed condoms both as an easy, convenient method and as a 'chore' in long-term relationships. To get around this chore, the solution has been to get tested for STIs to know for sure, and have 'proof', that neither person has any STIs. With his ex-boyfriend, Mehmed shared that they went together to get tested: describing that it was a nice thing to do as a couple that felt 'cute'. Visiting the sexual health clinic with his partner was also a way to confirm and show their commitment and love for each other in front of an official figure like a doctor. As such, the process became something of an intimacy ritual. As Mehmed explained, asking or being asked by gay friends if you 'stopped using condoms?', meant asking about the seriousness or exclusiveness of the relationship: whether they had potentially stopped seeing and having sex with other men. This story highlights the more nuanced meanings and functions that getting tested for STIs can play beyond managing risk.

Sharing the un-shareable: assisting with and delegating the work of contracepting

In the previous two sub-sections, I have highlighted practices of sharing the epistemic work and more practical everyday work around contracepting in longer term sexual relationships. In the interviews, participants also explored how they tried to go about sharing some of the less easily shared or un-shareable elements of the work of contracepting.

For my participants, the more un-shareable work could include organising and attending appointments with a midwife at a Youth Centre to get contraceptive counselling, or physically receive some sort of contraceptive method. Sally and Nova shared very similar stories of this, particularly of getting or taking out a coil. Sally shared, 'He was there the last time I was at the Youth Centre. He's been there some time or another. If I… I took out the coil, but it was pretty chill. Otherwise, he'd been there. It's not that he refuses to go. Just not of his own accord'. She explained that it felt important to her that her boyfriend takes an interest in their contraceptive strategies. However, Sally described his involvement, from her point of view, in passive terms. He was not actively resisting taking part, but Sally was the initiator of going together and the one taking the lead and attending the appointment while he, as she explained, 'came with' and 'sat in the waiting room'.

Nova and I discussed this dynamic in some depth, about how her boyfriend came along to her contraceptive counselling appointment by sitting in the waiting room like Sally's boyfriend. Like Sally, Nova did not want to minimise the importance of one's partner coming with to the appointment and *being there* as a support.

> Marie: (…) but do you feel like he's a part of? It's you who have the hormonal coil… are there any other aspects where you feel like "we're doing this together", or that he's supporting?
>
> Nova: If he had said that he absolutely didn't want me to have the hormonal coil then I would've thought about it… but it's my thing. Yeah, good question. (*quizzical tone and some pause*) I mean he's come with practically, at the midwife. And that I'm thinking can do a lot. He gets to sit in the waiting room. Mmmh.
>
> Marie: And that has felt good?
>
> Nova: Mmh, perhaps I'm a bit independent there. I feel like, I can do this myself. If it were that we would go there to talk about different alternatives. But it still feels like it's my meeting.
>
> Marie: Like you're the main one responsible?
>
> Nova: I want to be the main one responsible. (*laughs*)

> Marie: It's ambivalent. Because there's only so much you can share, even if we wanted that…
>
> Nova: A shared burden, but that doesn't quite work.

As Nova reflected, the meaning of sharing the work of contracepting is not straightforward for many reasons: there is only so much you can share or want to share. It is a shared burden more in theory or as a hypothetical ideal than in practice. Like Sally, but in more explicit terms, Nova reflected that while she does take her partner's desires and wishes into consideration, it is still 'her thing' and 'her meeting'. Nova is the main one responsible, but that is in part because she wants to be – to feel and be in control, something I will return to later in this chapter.

In the end, considering the structural and social organisation and meanings of the everyday work of contracepting, cis men in long-term sexual relationships with cis women tend to take more of a backseat role, implicitly reproducing the work of contracepting as women's work. As such, it is perhaps more accurate to say that men in these contexts do not quite share but rather assist in the work of contracepting. Beyond the already mentioned examples, Helena reasoned that there are more ways that men can be involved in managing contraceptive strategies. In our third interview[27] I returned to a discussion we had in the second interview on meanings around sharing responsibility for contraception,

> Marie: (…) One thing that I don't know if I asked, or if I forgot, when we spoke about responsibility and how you felt about personal responsibility or whether to share or not. Can you imagine that your cohabitating partner or someone you would have sex with could help you with the responsibility you carry still?
>
> Helena: I think we spoke about that. I feel/experience it as that my cohabitating partner is aware and pays attention to side effects. You don't always see it. Malaise is a side effect, and I feel/experience it as that my partner or the person I live with is lower in mood… it's a good support. Someone who's a bit forgetful… [you] can take some responsibility and have an alarm on your mobile phone. Tag along as a

[27] Helena was the only person I conducted three interviews with. The reason for this was that the batteries of my dictaphone ran out – without me noticing – 30 minutes into our second interview. I only caught my mistake at the end of the interview and took intensive notes post-interview. But because of this I asked, and Helena kindly agreed, to do a third interview to cover some of the questions and discussions we had, that was lost.

> partner if you're getting the coil inserted. I wouldn't have wanted that. But we've always hung out afterwards. We've eaten candy or crisps afterwards. Like a bit of support. It's super nice. Not a must but a bonus.

Helena brings up a series of ways in which a partner, especially one you might live with and see more regularly, can provide a 'bit of support' in managing contraceptive strategies. Her response mixes statements about how she thinks things should be between partners, what might be useful for others and her own feelings about such measures and some of the ways her partner has been of some support to her doing the work of contracepting.

In contrast to Helena (who throughout the interviews seemed quite comfortable to attend contraceptive or gynaecological visits by herself and preferred it that way), Sandra very pointedly and deliberately decided to bring her male partner along when she was getting the coil inserted. This was for similar emotional support as Sally and Nova described, but unlike them she insisted on bringing her partner into the counselling room. She described,

> (…) Then it was also incredibly painful to get the coil inserted. But it's short-lasting pain versus periods – an easy choice. I had my partner with me – a feminist agenda – he's gonna see how rough it is. Not doing it in silence, out of sight. All cis men who have sex with cis women should tag along to a gyno visit. A pedagogical experience for him. I'm glad I wasn't alone. I cried and such. It's difficult to imagine that pain. (Sandra)

For Sandra, bringing along her partner to see how painful coil-insertion was for her was a political and educational act: constructed as a sort of act of defiance. That is, an everyday political and pedagogical practice to make visible and visceral that which is usually hidden or managed in silence by women for men's convenience or benefit.

One participant whose story stood out in terms of how to 'bring in' (Inhorn 2009) one's male partner into the work of contracepting was Gabriella. In our first interview we were discussing the time she got an infection from the Mirena (hormone-releasing) coil and had to go to the hospital.

> Gabriella: Yes, it was a bit dramatic. High on fever. I drove to the ER – shouldn't have done that. But it went alright in the end. (…) Since then, I've been on the injection. My partner has gotten needle "delegering" [delegation, or permission to give injections] so that he can give them to me at home.

Marie: Perfect. So, you've involved this person…?

Gabriella: Exactly, so he has to make sure that we have [the injections] at home and remember when it's time and give me the injection. So, the only thing I do now is to get a small needle prick in the butt cheek. Nice.

Marie: Nice that you've divided…

Gabriella: Mmh, partly he had to meet some professional that knows how you do it [give the injection]. And, since it's pretty far in between [each injection], he has to look on YouTube how you do it. There are many of those – IVF. The same injection technique… it works really well. I'm not afraid of needles. A lot of taking blood tests in the arm. And it is sooo thin [the needle]. You barely feel it. He's more nervous than I am.

After a difficult experience with the hormonal coil, Gabriella switched over to the contraceptive injection, which, depending on the kind, needs to be given every two to three months. In doing so, Gabriella's partner (a cis man) got trained by her mum and aunt to learn how to administer the injection. Besides the initial training and learning to give injections, the partner was also tasked with maintaining and honing his skill and knowledge of injection-giving, as well as other invisible work tasks such as ensuring that they have injections and remembering when it is time for the next dose.

This arrangement was unusual compared to the stories of other participants, but clearly illustrates the ways in which the different elements or types of work in contracepting can be taken on, shared, or delegated to a partner in a heterosexual relationship, even when the woman is still the one taking the contraception. In this context, in theory, Gabriella has delegated all non-physical components of the work of contracepting, taking on the more passive patient role. This arrangement was in many ways enabled by the specific material and technological conditions of the contraceptive injection itself. Firstly, it works in an external way that, for example, the coil (which needs to be inserted into the uterus) or the patch (which needs to be worn on the body) does not. That is, it is an injection which can be more easily administered by another person than oneself, and (similarly to IVF) it is possible for a partner to administer without needing expert medical knowledge, as the injections come pre-prepared and do not require a very precise injection location like a vein. Moreover, as was pointed out by other interview participants in discussing the pill, there is a lower risk of injection-giving coming

off as controlling compared to what giving the pill might, if a partner would be tasked to remind and physically give the pill to their partner every day.

This arrangement and delegation of responsibility is also enabled by wider relational factors and resources: one, the presumed trust and intimacy between Gabriella and her partner which enabled her to pass over this responsibility to her partner, and two, the wider working cast around Gabriella. Namely, her mother and aunt, who were part of the epistemic community of healthcare practitioners. Gabriella also described having previous embodied knowledge and experience of getting injections, presumably making it easier for her to be comfortable with her partner giving injections rather than trained medical staff. With these factors in mind, the depiction of Gabriella as embodying the more passive role and her partner the more active role, is somewhat problematised and involves a lot of clear agency and control on Gabriella's part.

There are clearly limits to what partners can share regarding the more practical, physical, or logistical elements of contracepting in couples where pregnancy prevention is a concern. As the stories above suggest, they can accompany their partners to appointments, thus also taking time out of their day, and provide emotional support before and after (or during) the appointment, help with reminders about taking your pill, or manage contraceptive injections. However, there is a tension in what taking a more active role in the arrangements of your partner's contracepting might imply. Someone taking an active role in their partner's contracepting, including planning appointments and reminding them about their daily pills, can easily look, feel, or function like control. Reproductive control, whether by sabotaging a person's contraceptives or coercing someone to use a particular contraceptive technology, is a well-known strategy employed by men in abusive intimate relationships (Moore et al. 2010; Thiel de Bocanegra et al. 2010; Sutherland et al. 2015; Burry et al. 2020; Tarzia and Hegarty 2021). I am not suggesting that any of the above-mentioned relationships were coercive or controlling, but only want to highlight the importance of context again: namely, that it takes very specific conditions, and a lot of thought and work, for a woman or person who can get pregnant to involve or have their long-term partner share the work of contracepting with them.

2. Ambivalent emotional negotiations, and feeling your way around sharing the work of contracepting

An important finding from discussing practices of sharing the work of contracepting in long-term sexual relationships with participants was the amount of energy put into emotionally negotiating and 'feeling their way' (Ahmed 2014) around what this sharing meant, and how they felt or should feel about it. When it came to participants making sense of sharing the work of contracepting, questions around knowledge, feeling, and morality seemed intertwined – sometimes in rather messy ways. It involved trying to figure out what you know about contracepting possibilities and how you feel about sharing or not sharing (elements of) the contracepting. It highlighted how young people often experienced the work of contracepting as involving a lot of ambivalence and uncertainty, of reflecting and making sense of what you are feeling as well as assessing whether those feelings are appropriate, fair, or accurate given the situation.

In that sense, the work of contracepting involves significant emotion work (Hochschild 1979a, 1979b), or, rather, as many sociologists of emotion instead put it (Burkitt 2012; Brownlie 2014; Holmes 2015), it involves emotional reflexivity. Talking about participant's emotional reflexivity, rather than for example, their adherence or not to feeling rules (Hochschild 1979b), is to emphasise how emotion norms are not static but fluid. And, that social change contributes to and impacts how you think about notions such as sharing the work of contracepting, and how you reflect on what you should or should not feel in different social situations. Moreover, the emotional negotiations that participants did around what it means to share the work of contracepting also problematise the division of emotion work as private and emotional labour as public (Hochschild 1979a, 2003). The distinction between private and public is not easily distinguishable, and the work of contracepting spans the two, being done both in private and in public.

What I find particularly noteworthy in analysing the stories and storytelling of participating young people is the question of what happens with emotions in private when the situation or problem the emotions respond to is structural. What happens (and what do you do) when the contraceptive problem or inequality is experienced interpersonally but the cause of this problem or inequality is something more ubiquitous like societal structures? For many participants, this

seemed to end up resulting in undirected feelings of anger, frustration, sadness, doubt and guilt, and a lot of ambivalence.

Zygmunt Bauman has argued that post-modern societies are inherently ambivalent and uncertain, 'though its colonizers and rulers do not like it to be such and by hook or by crook try to pass it off for one that is not' (1991, 179). Yet, in his view, ambivalence should not be 'bewailed' but rather 'celebrated' as it 'is the limit to power of the powerful' (1991, 179). Barry Smart adds, 'if ambivalence undermines the ordering and designing objectives of the powerful does it necessarily follow, as Bauman proceeds to suggest, that it simultaneously constitutes the 'freedom of the powerless'?' (Smart 1999, 4). I share Smart's query and I am hesitant to approach ambivalence through either an overly optimistic or pessimistic lens. In looking at the stories and experiences of my participants, I find that ambivalence can be, as Bauman suggests, a challenging of the social order and power relations. However, sometimes ambivalence in the form of undirected anger, frustration or grief can result in intense levels of stress and anxiety on behalf of the individual with no emotional relief or clarity in who to "blame" for felt inequalities and unfairness. Here, I return to Terpe's concepts of epistemic feelings, and dynamics of moral elaboration, moral relativization, and moral closure (2016, 8-9) as ways to analyse ambivalence.

Smart suggests that ambiguity is an inevitable part of life in modern societies (1999, 5) and that is both analytical and existential (1999, 11). I would add to this the description of ambivalent emotions and feeling; that ambivalence involves the feeling of not knowing, or not knowing what to think or feel. In the following section, I will specifically investigate the ongoing emotional negotiations and emotional reflexivity of participants around practices and ideals of sharing the work of contracepting, focusing on the emotions involved in these processes as well as questions of trust, power, care, and intimacy.

Navigating feelings around hormonal contraception in long-term relationships

Within the current reproductive and sexual landscape, the dearth of male contraceptive methods and relative abundance of female ones has created a system in which there is practically quite little for men or people with penises to do to physically take on the work of contracepting for pregnancy prevention. Thus, while a partner with a penis might wish that they could do more to remove the

physical burden of (usually hormonal) contraceptive methods, it is difficult for them to do so beyond using condoms or getting a vasectomy. These structural conditions and issues were something that the participating young people were very aware of – that they were stuck within a finite reproductive healthcare system.

In my first interview with Helena, we spoke about her relationship with her cohabitating partner and his feelings around their contraceptive strategies. I asked whether he was content with the situation they have today or not, to which she replied:

> As we have it today. I don't think that he's ever been discontent ever really. On the other hand, he's thought that it's really unfortunate that I've had pain and yeast infections and felt like crap for so long and gotten a broader perspective. So, it has ruined things for the relationships of course, not the method itself but how you feel and stuff. But since I've found something that works and now, so he's content as long as… he's like "pretty nice" when it comes to. Content. I'm content. (Helena)

Helena described how, from her point of view, her partner's contentment with their current contraceptive arrangement largely came from and was dependent on whether she was 'content' or not. She explained how her experience of negative side effects of different contraceptive methods have made him feel sad or perhaps pity for her, and that it 'has ruined things for the relationships of course' as well. She only briefly touched on this, and swiftly went on to explain that since she has now found a method that 'works' they are both content, and their previous struggles are seemingly in the past. While Helena recounted this with certainty, her interview reflected some remaining ambivalent feeling, of resignation and grief as she continued to conclude that while he has been supportive, 'it's a bigger issue than just my life' and a 'societal problem' that evidently cannot be solved fully within the bounds of their relationship.

Some participants (including Helena at other points during our interviews), felt their way around the societal and structural reasons for the unequal division and experience of doing the work of contraceptive in heterosexual relationships through stronger, albeit more ambivalent, emotional expressions. Like Helena, Nova spoke in some length about her experiences of hormonal contraceptives and how that had also affected her partner. In the second interview, I returned to this,

Marie: Another thing that you already mentioned a bit that I also picked up on, was [name of partner] – and his part in your or your shared contraceptive history. It's been tough for him that you've been affected by hormones. Can you tell me a bit more?

Nova: I think I know what you mean. It's been clear that it has been my choice. He hasn't wanted to tell me that I have to get a hormonal coil inserted. But then he's told me several times that, he has said that "if the hormonal coil or the pill doesn't work then we can do condoms, that's okay with me". But I know that he doesn't want to, really. [Marie: Mmh, right] Somewhere it's something that is in me. I know that he wouldn't leave me if I didn't have the coil. But I know somewhere, that he doesn't like condoms. Then he's been clear, "that you get to choose yourself". But, like I said, he has still commented, that I was moody. That's what I can come up with. Then, he's not at all affected. I mean it's me who… It becomes really weird. I can always pull that card, "I am ruining my body for you!". We can joke about that.

Marie: But do you feel that, or what should you say. You spoke a bit about that he has a slightly bad conscience sometimes.

Nova: I think that he, more like when I joke about "Yes, shit, the amount of stuff I go through in order for us to have sex without condoms" and he's like "Ah, stop it." He feels some guilt. Because I place guilt/blame on him. But I don't think that he actively thinks about it. But also because it's so fucking normal that it's the woman! I wonder if there was a contraceptive method that was as painful, would he have done it? I don't think so. I don't know. Nah, I don't really know. Mmh. I haven't really thought about it that much from his perspective. Probably [I am] a bit selfish in that. He is pretty powerless. He can't do so much if it's painful for me. But that's not something to pity him for.

In the process of responding to my question, reflecting on her answer and her feelings about her partner's emotions, role and their relational dynamic, a lot happens. Throughout, there is negotiation between ideals around gender equality, women's choice, and men's role as being supporters closely associated to the ideal of sharing the burden of contracepting, with more concrete practices and the emotional experiences of attempting and ultimately struggling to share the work.

Nova recounts how she, and sometimes they, recurringly 'joke' about the 'sacrifice' she is making for them as a couple, their sex life, and to have condomless sex. In fact, she also explained how this joke and claim has become a sort of

card that she can pull (perhaps in trying to settle an argument). Jokes in general, and this recounted joke in particular, often hide and communicate more serious messages and can serve as a rhetoric device to get a more critical point across while softening the message and the messaging (Tianli et al. 2022). And it seemed like the humour of this joke ebbed and flowed, sometimes blurring, or crossing the line of humour into the space of not-joke and not-joking-anymore. Taking the joke too far perhaps, her partner would ask her to stop, as it makes him feel bad. Nova had mentioned this briefly in our first interview, specifically mentioning, more in passing, that he has a 'bad conscience' sometimes. Notably, though, she follows this by expressing her own responsibility for the guilt he felt, because, as she puts it, she 'places the guilt/blame on him'.

In this part of the story and response however, there is another shift: including an abrupt tonal shift, going from hints of shame and guilt in guilting her partner, to frustration and anger. It is almost as if she remembers the initial reason, and emotional space she also occupies, when joking about the sacrifice she has been making. First, she notes, 'but, it probably doesn't affect him that much' followed by more forceful exclaiming 'but also, because it's so fucking normal that it's the woman!'. This, almost as if hitting a nerve, points to a notable issue: the gendered dynamics in heterosexual sexual relationships, captured in the frustration and anger at this societal inequality at the general level. She does not say "it's always me!" but rather 'it's always the woman!', pointing to the wider dynamic. Moreover, expressed in the more tentative elaboration and suspicion whether he even would "take on the physical burden" if he could, I find more hesitation, uncertainty, and emotional ambivalence, clearly signalled by several "I don't know" statements, as if backtracking and questioning her anger and frustration and whether it is justified. This is a clear example of epistemic feelings addressing both 'the quality of one's knowledge and beliefs, but also the quality of one's emotions' (Terpe 2016, 6).

In Nova's response, there are ebbs and flows of emotional certainty and clarity: of moral closure to moral relativization/elaboration. She moves between her own perspective to her partner's perspective, back and forth, practicing emotional reflexivity. She questions towards the end whether, in fact, she might be selfish: the selfish one of the two. She is uncertain whether guilting and blaming him for her embodied sacrifice is justified and fair, because, as she notes maybe he is 'pretty powerless' structurally speaking, but at this does not automatically make him the victim either, or someone that deserves her pity.

Helena also reflected a great deal on the 'sacrifice' of hormonal contraceptives on her health when she is seeing a man compared to having sex with women. Like Nova, I felt that Helena also had been very ambivalent about weighing the benefits and costs of the contraceptive burden, trying to figure out when a relationship is 'worth it', worth the sacrifice or not. However, unlike Nova who reasoned less around whether it was 'worth it' and more whether it was fair or unfair, Helena reasoned through the lens and feelings of love and the meaning of the relationship she had with the person, and whether the relationship felt 'worth it' for her to feel ok with not sharing the burden but take on the burden herself. This was especially important for Helena when considering maintaining this sexual relationship with a man, instead of dating and sleeping with women, as she identified as bisexual and had previously mainly dated girls and women.

Helena told me of the first time she really thought about contraceptive methods which she was 18 and dating a cis man. After the guy consistently refused to use a condom, she decided to investigate getting a more long-acting contraceptive method but eventually realised that this man was an "asshole" and "not worth it". This story gives an important backdrop and sense-making framework for how Helena moved forward, made sense of, and felt when it came to contraceptive control. She contrasted the story and experience of this ex with her current partner (also a cis man), explaining that the feelings were different this time around. She met her current partner, who she lived with at the time of the interview, a year later at 19. At this point, however, she was so 'scarred by his [the ex] not wanting to use condoms' and the fear and risk of pregnancy that she decided to get the copper coil, to 'never end up in that situation' again, as a way to regain and maintain control and power. However, she got what she described as 'crazy' side effects and tried to find alternatives.

Later in the interview, Helena returned to describing what she went through emotionally when she met her current partner and the stress of needing to start thinking about more long-term contraceptives again. She explained how she was 'really, really stressed' about it and considered calling it off before they started having sex because of wanting to avoid having to 'get into the whole contraceptive method thing again'. I asked how she figured out that it was 'worth it' in the end,

> But I mean I was like "fett kär" [insanely in love] and I got over it. (…) I mean, you do crazy [things] when you're in love, like you… I guess I also think that it's crazy that you choose to stuff yourself with something that gives you lots of side effects just because you're in love, but I have obviously done it so it was really just

> love. But. But had this thing with sex come up earlier than maybe maybe we'd broken things off (…) (Helena)

She continued to discuss how she really struggled with figuring out in the beginning whether it was 'worth it' and whether she 'really could be bothered'. Helena knew from beforehand about some of the various kinds of side effects that different methods could cause, from hearing from other friends' experiences, and from reading and researching herself. However, she did not know exactly the kinds of side effects and severity of them that she would experience herself. I asked whether she might have made a different decision if she had known the types of side effects that she would end up experiencing,

> Helena: (…) I don't think that I could straightforwardly say no now, just by knowing the side effects. No. for me it's clear that I take these side effects for someone I love but I don't think I should have to do it. I guess it's only that. Of course, my partner can't compare/measure up to some side effects but that shouldn't have to like to be an argument either but on the other hand for me, a completely random man that I don't have feelings for and side effects? That's easy. That equation for me is just to end things with that man.
>
> Marie: So, then it would be partly that you know that you don't think that that type of sex, or relationship is worth it or sex you have would mean so many complications…?
>
> Helena: The type of sex, for me, if I would become single and let's say if I would become single and go out in the world again. No, then I wouldn't take any pills just to have that kind of sex (…) Had it been really important to me to have particularly this type of sex then I'd probably not been bi (…) I don't think it's that important. But when I'm with someone that I like and such… then I want to have that type of [sex], but that's what I've done. (…) But, yes. It's complicated.

In explaining how she reached the conclusion that it was worth it, Helena drew on the sense-making framework of love. For her, if it came to choosing between 'crazy side effects' and love when you are 'crazy in love', you obviously choose love. In her account, she also pressed the importance of timing of sex and feelings in the relationship for choosing or skipping more long-acting contraceptive methods. If the type of sex that would call for pills would come before the feelings were there, then she would not deem it worth it and rather skip it and seek out other forms of sexual relationships. Because, as she clarifies, while being able to

have 'that kind of sex' [penetrative penile-vaginal sex] might be important for someone else, it was not so important to her.

However, if the feelings of love developed first – like with her current partner – then she would make that sacrifice. Perhaps not gladly, but willingly, albeit it with the belief that it should not have to be that way. In fact, she initially responded with aversion to my question whether she would have made a different choice with her partner if she had known the side effects. Ultimately, she seemed to have reached a moral closure around feeling her way around carrying the burden of the work of contracepting in her current relationship, by drawing on the power and reasoning of love to confirm her feelings of certainty. I think this illustrates the importance that emotions have in shaping not only the contraceptive choices participants made, but the complex and nuanced ways that they rationalised, committed themselves to, or distanced themselves from them.

Negotiating gendered expectations, responsibilisation, and autonomy within an unequal reproductive system

Most participants discussed matters of responsibility, expectations, and fairness around contraceptive divisions of labour and dynamics in our interviews. However, when delving deeper into the ideal of equal responsibility, more complicated questions arose around what one can and should expect or demand of partners (especially of men by women). This also raised whether these expectations and demands – alongside feelings of anger, frustration, and sadness – were fair to one's partner. A messy, ambivalent negotiation thus emerges, around knowing what to feel and constantly evaluating what is morally right or wrong. This could at times intensify some emotional experiences around doubt and uncertainty (Terpe 2016, 7).

One of the instances where a participant expressed ambivalence around sharing the work of contracepting was when it came to sharing responsibility, particularly through the frame of financial responsibility. In the chapter on the role of friendship for young people's doing of the work of contracepting, I discussed how some participants had asked friends for advice and discussed whether you should ask your sexual partner to share the cost of, for example, condoms or the pill, and, if so, how you go about doing this. Already in this section the uncertainties about whose responsibility it is to provide and pay for contraception emerged, and whether it is fair or unfair, right or wrong to ask a sexual partner to share the cost.

I argued that this experience and feeling around financial sharing is immensely shaped by classed experience and class privilege.

In our second interview, I asked Pim about their thoughts on contraceptive responsibility and who they think should have it. They explained how this for them was really tied up with questions of power and vulnerability, and fear of giving up or losing control,

> I like the agency and the control, so I thought that it was your own responsibility. But I often became disappointed in my counterpart, that the thought wasn't there with my counterpart. *Come on, take some responsibility!* (…) That they didn't take responsibility for their own annoyed me. But I don't want to hand over the economic bit, it was important not to be dependent on someone else. I don't feel like it should be my responsibility, it's a shared responsibility. Even if I want to have responsibility for my own, I want my partner to take responsibility for theirs. With my cohabitating partner it became shared. I didn't have a problem with money at that point, so it became a bit more dedramatized to pay together… if it's only me doing half, then all responsibility is on me. (…) I liked that he [current partner] brought it up and wanted to take responsibility. And that he asked about the financial bit. I appreciated that. He was part of it and took an interest. Not just, "you'll sort it". (…) He has his responsibility and I have mine, but he also takes an interest in my responsibility and me in his. In one-nightstands… then I want, when it's more fleeting, then I want my own responsibility. Full stop. (Pim)

For Pim, the issue of sharing the financial burden of contraceptive was a fraught one and tied up with, like Helena in some way, the quality, trust, and intimacy of the relationship. Pim was really frustrated, angry, and disappointed in being forced to take on the whole burden alone and desperately wished that the people she had slept with in the past would have taken more responsibility. Pim had had difficult sexual experiences when they were younger with boys and young men who (like Helena's 'asshole-ex') did not care about their sexual wants, needs, or desires. This, compounded with their financial constraints, made the cost-sharing issue important.

While Pim articulated a way in which they felt that their partner took an interest in their pregnancy-prevention efforts (by asking questions and showing that they are aware and interested in 'being safe'), other participants like Sandra felt more uncertain and ambivalent about the extent to which her male partner could be involved and how his potential involvement might make her feel. In our second meeting, Sandra and I got onto the topic of her partner and his

relationship to going to the Youth Centre and the fact that he never really went there. I asked why he had never gone or felt the need to go,

> Sandra: I'm not sure. He's been with me, but never of his own accord. I don't know if he spoke about it in connection to me getting more issues [bad side effects from her contraceptive methods], that he wanted more information. He asked me if you could go there, or I said, that he could go and get information, advice, or tips. I thought it felt difficult that everything came from me. It would've been nice if he'd hear, on his own I mean, like from someone professional so that I didn't have to give information all the time. (…) It's still something that affects us both. I still think that he should have a part of it. If you have problem, that he, it impacts him too. That he should care about it too, and not just think "ah".
>
> Marie: Do you wish that he had done more or something different, to support you or be more part of it?
>
> Sandra: Nah, or maybe in the beginning that he didn't look up more things himself. But at the same time… it's really difficult because there isn't so much information and I didn't want. I don't like it when people tell me what I should do. If I feel like, he doesn't know what I'm experiencing. Reads a bit of info and then gives me tips… (…) It would've been hard if he thought that he knew, but at the same time nice if he tried more and realised earlier that this isn't normal. That "I should look this up and is there anything to do?" (…) it's difficult, there isn't a lot of information to get. There isn't so much you can read up on.

Sandra went back and forth on wanting her partner to take more initiative to learn about the issues she was struggling with due to her hormonal contraceptive method. However, only as long as he did not try to control her or override her expertise and embodied knowledge. She also acknowledged that there were wider structural issues around availability of actual information to find at the same time as being frustrated with him not going himself to talk to someone at the Youth Centre who might have more authority in explaining the severity and realness of the issues she was struggling with. Instead, all the information had to go through Sandra.

All participants who identified as cis women or nonbinary had at different points in time been concerned with their own ability to get pregnant to some extent. The other three participants identified as cis men (two as gay, and one as straight). The latter was William, who was in his early 20s and spoke to me about

his uncertainty and emotional negotiations around the extent which pregnancy prevention can be shared. Particularly, when it came to issues around abortion. William felt that it was important that it was 'her choice'. This meant that he felt that they could talk about contraceptive strategies, whether to have an abortion and his responsibilities to an extent, but in the end 'it's her choice' and thus not really in his control.

> William: But I also feel that it's easy for me to talk about it who will never have to have an abortion. I mean, I think, *ah yeah, you just do it.*
>
> Marie: It would feel like an easy choice.
>
> William: It would feel easy for me. I hope and believe that the person I'm with also think it's an easy choice. But it's nothing I can demand. And I don't know if, how difficult it is… to have an abortion. Haven't experienced it. And mainly, I never will know. I will never experience it even if I'm part of it. I guess it's the same thing if you wanna have kids. *Easy*. But it's not up to me to carry that burden. Parasite. [Marie: Parasite?] Or? (*looks quizzically at me*)
>
> Marie: Yes, or technically speaking. Or there's another word. What the name? I'm not so good at… when two organisms have a mutual exchange. [William: Symbiosis?] But I don't know if that's true (*both laugh*) a symbiotic relationship. But have you ever thought, in a pregnancy scare, if it did end up…
>
> William: If it happened with my girlfriend now then we're both towards abortion, so it's cool. But there is always a fear, a sort of feeling, *but imagine if she changes her mind when she's pregnant and thinks it's too difficult?* I guess it's also a control thing. That I don't have 100% control. And it's good that I don't… what my girlfriend chooses to do.

In discussions and arguments around why more male-centred long-acting reversible contraceptives are needed, the issue of men's reproductive control is often raised as one of the benefits. In the current Swedish sexual-reproductive system, beyond condoms and vasectomies, there is little to nothing that people with penises can use themselves to prevent pregnancies. At the same time, there is a strong discourse and ideal of women's right to choose (whether to have an abortion) that has clearly and successfully grown and developed over the past decades in many national contexts, including Sweden.

It is evidently difficult to reason your way to a clear emotional stance in an unequal system with compounding inequalities that affect people differently. Instead, you try to feel your way around it, which participants did, and in so doing one can see the everyday, ongoing, relational emotional reflexivity they practiced, and the various degrees of emotion work they did in trying to make sense of what they feel, have felt, and feel they should feel or think. It can be an exhausting, confusing and ambivalent endeavour where, using Pim's choice of words, it is difficult to identify the 'heroes' or 'villains' of the stories easily and straightforwardly.

In the beginning of our second interview, I asked Pim how it had felt reflecting around these issues in the first interview and afterwards.

> I mean it becomes sensitive when it's about how people deal with sexual… it becomes personal in the soul. I'm less sure/certain when I'm with people with penises. More youth-like. I have sex with condoms, but it's much more common here than there. Ok. It becomes a bit like self-reflection. Putting myself under the spotlight: *so, why are you doing it so?* Been a bit like, reflecting inwardly. A bit self-critical. It's always sensitive to be so self-critical. You often want to be the hero or the victim always. I mean we have our own responsibility, a responsibility that can be heavy to carry/bear. (…) The responsibility can be scary. It was a bit like this type of feeling. Now I can't be the hero or the victim… stuff have affected me, but you have to take responsibility for this, forgive or take responsibility. A lot of thoughts around it. Since I go often to get tested I take responsibility. Figured out that I must involve my partners with penises more. "What do you think about this?". It's really lovely to have sex, but you have to take responsibility for the risks. And so far, I've clearly taken the risks. They've taken risks too, but have they been aware? A lot of thoughts came. (Pim)

In a discourse – like that of the notion of sharing the work – that primarily puts emphasis on couples' and individuals' responsibility and moral obligation to do so, it is unsurprisingly that individuals existing within that discourse look for where to place blame and responsibility.

Even when acknowledging the structural and societal conditions, like Pim, they continuously returned to the individual's blame and responsibility, reproducing the image of a dichotomous situation where there is only: 'forgive or take responsibility'. Across all interviews, and in wider societal discourse found elsewhere in Swedish society, there is a strong tendency towards internalised self-blame and responsibilizing. Like for Pim, it is not unusual that people who can

get pregnant (such as women or non-binary people in heterosexual relationships) feel that you can and should do more, such as involving partners with penises more, and that it is always and only up to you as an individual. People doing the work of contracepting, moving across this sexual and reproductive landscape, seem to yearn for epistemic feelings of certainty and clarity: of feeling certain about their beliefs and knowledge of the world. But that is difficult, and these undirected ambivalent feelings can create a lot of stress, emotional pain, and anxiety, in a context of issues that cannot be solved solely or even primarily at the individual couple level. This, in my view, is another unrecognised type of invisible work that women and people that can get pregnant must continue to manage.

Conclusion

In exploring practices and experiences of sharing the work of contracepting in long-term sexual relationships, I found some similar dynamics to that between friends, specifically around sharing elements of the epistemic work required of contracepting: exploring, experimenting, and talking about possible contraceptive strategies. However, the different relational contexts matter, shaping the meaning of talk as something that is intertwined with the use of said contraceptive strategies when it is within a long-term sexual relationship. Talk in this context thus served additional instrumental functions. Another difference between friends and long-term sexual relationships was the role of gender in shaping the relational dynamics, experiences, and practices of sharing the work of contracepting, especially regarding pregnancy prevention.

Beyond epistemic work, participants also raised ways of sharing other elements of contracepting. While some participants had experience of finding ways to share the more practical, physical, or logistical elements of both pregnancy and STI prevention, it is still clear that there are limits to what partners can share in couples where pregnancy prevention is a concern. There are also tensions in the notion of a partner of someone who can get pregnant taking a more active role in the arrangements of their contracepting. This raises questions around reproductive and bodily autonomy and control.

The need to share the work of contracepting continues to be an influential theme in the stories of my participants and Swedish society at large. Yet, in unpacking practices and feelings around trying to navigate how to share this work,

we find that it is easier said than done. As I have shown in this chapter, the work, sometimes experienced as a burden, associated with contracepting is often not shareable at the individual level. For example, looking at pregnancy prevention, there are currently no male birth control methods readily available (beyond condoms and vasectomies). This raises the question of how meaningful ideals around sharing the work in some contexts truly is and which elements of the work of contracepting that can be shared in more long-term sexual relationships. One might also want to consider that the work of contracepting does not always emerge as a burden but a benefit: for either managing or controlling periods and gender identity or maintaining control over your sexual and reproductive body.

In this chapter, I have illustrated how the work of contracepting is something that is done both privately and publicly and involves a lot of emotion work including *feeling your way* around the notion, ideal, and practice of sharing the work of contracepting. In doing so, I have highlighted the immense amounts of ambivalence, frustration, anger, disappointment, and uncertainty that sometimes emerge and remain unresolved, as the cause of the contraceptive struggle cannot be truly found or solved in the private, interpersonal relational context but only at the wider structural level. As such, I would like to conclude by considering how one can reframe the question of improving experiences and abilities to do the work contracepting as a collective, societal, and structural concern and conversation. This conversation I believe should not only, or even primarily, be about the individual couple sharing responsibility considering the wider context in which the work of contracepting is made possible or impossible. The call to action here is for each of us as researchers to explore what other questions we could ask, and which other actors need to take more responsibility for the structural conditions around contracepting.

Chapter 7. The work of becoming informed about contracepting

In the previous chapter, I raised the importance of reframing understandings of sharing the work of contracepting to highlight the wider structural context in which this work is made challenging. In this chapter and the next, I try to contribute to such a perspective shift. This chapter will specifically highlight the complexity inherent in the work young people must do to *become informed* about contraceptives.

Contemporary contraceptive counselling fundamentally draws from an ethos of individuals making informed contraceptive choices. One group that has often been singled out as particularly needing intervention and education to make these informed decisions is young people, especially young girls and often in connection to reducing teen pregnancies and abortion rates. While striving to enable young sexual-reproductive actors to make informed contraceptive choices is an understandable desire, the question remains of what being informed means and entails in practice for young people engaging in the work of contracepting. In exploring the stories of participants navigating the Swedish contraceptive landscape, this chapter examines the work involved in receiving, accessing, understanding, and making sense of – or in other words negotiating – different forms of knowledge around contraceptives, the body, sex, and health.

Like Strauss and colleagues highlight in relation to the concept of patient work (Strauss et al. 1982; Corbin and Strauss 1985), I am interested in treating young sexual and reproductive actors in more agential terms. I believe that is it worthwhile to understand the work of contracepting as a form of patient work, one where much (if not most) of the work is located and done outside of the official medical spaces of contraceptive counselling offices or sexual health clinics. As with long-term healthcare patients, the work of contracepting, whether directly

or indirectly, involves having to navigate healthcare and medical systems, actors, and discourses, and take on an active role and responsibility in one's care.

Taking a patient work perspective also helps critically engage with the discourse as well as practice of *being* versus *becoming* informed. Being informed invokes the idea or process of someone imparting knowledge and information onto or into you, such as being informed by a midwife or doctor. This echoes more conventional views of the patient's role. To be informed connotes a linear journey of learning, going from not being informed to being given information and having it. On the other hand, I would suggest that becoming informed highlights a more ongoing, processual, and, ultimately, relational image of the knowledge production experience of contracepting. Depending on our conceptual choices, different realities are revealed of what it means to engage in the epistemic work of contracepting, who is doing and can do this work, and what is or can be involved in it. What we can cast light on varies depending on the conceptual choice. While there were some experiences that reflected the archetypical idea of being informed, the vast majority of participants' stories highlighted their ongoing work of becoming informed about contracepting.

In this chapter, I will trace the peculiarities of participants' experiences and practices of doing the epistemic work of becoming informed about contracepting. First, I will illustrate some of the practices and experiences of doing work of finding, producing, and receiving information about contraception. Second, I will discuss what goes into making sense and meaning of said contraceptive information, as well as what goes into navigating various sources and perspectives. Finally, before concluding, I will highlight the complexity, uncertainty and trust involved in accessing, getting, comparing, assessing, valuing, and negotiating different forms of contraceptive knowledge and information.

1. The work of finding, producing, and receiving information around contraception

Depending on the material conditions and embodied matters of the health concern or illness in question, patient work can involve various things. I understand the key conceptual point of patient work, however, as being about highlighting the nuanced roles that patients play in their own care and treatment.

In practice, patients are not passive, but active, and they engage and take action both within and beyond healthcare institutions. When it comes to contracepting, most of the work of the patient is done outside of healthcare spaces. A young person may go to a healthcare professional to receive and discuss information about contraceptive strategies, or to implement a contraceptive method such as inserting a coil or having a physical examination for potential STIs. Yet, the relative time these encounters take up is small compared to the work young people do outside of these settings, including the extensive epistemic work they do.

Reading up on and researching contraceptives independently

A central element of this epistemic work, and of becoming informed about contraceptives, as described by my participants in their stories of contracepting in Sweden, was being your own researcher. One of the first responses to how participants first came across or learned about contraception was usually, 'I googled around a lot'. Anna liked the Youth Centre website for learning about contraceptives, as did Miriam who explained,

> You had to look [for information] on your own. I went on the internet. When I was 13, hung around on the internet and that which would become social media. The Youth Centre had a really good website online. I was probably lucky that that information existed… I was maybe a bit "uppsökande" [proactive, likely to seek out]. Maybe because I had an aspect of my sexual identity that I felt that I needed to handle. Maybe it's natural that I sought myself to the Youth Centres. That conversation did not feel safe to bring up in school, with the adults. (Miriam)

Miriam explained that she independently sought out information around sex and sexuality, suggesting it might be due to her desire to explore her budding queer identity and because other adult actors did not feel comfortable or safe to go to. Nova, who partly grew up living outside of Sweden, also mentioned how she had to 'figure out stuff on your own', or with friends. She did not have a school counsellor or Youth Centre, so she felt that it was more difficult to access information. Nova, alongside Hugo, shared that they learned a lot through reading children's magazine "KP - Kamratposten" [The Friend-Post]. Nicole similarly explained that they 'had to look up stuff themselves' or read information leaflets that were sent in the mail.

As such, the way many young people learned was by themselves searching for information and reading around online on different websites, magazines, leaflets or similar. Another commonality was the practice of intensifying the learning and researching whenever someone first started using, or more critically reflecting on, contraceptive methods. Pim recounted that they learned a bit in biology about contraceptive methods, but it was mainly when they 'started questioning their coil, that I started to look up what existed. I read more about pessaries. It's been a lot of finding out for yourself'.

This created the sense of having to be your own contraceptive or sexual and reproductive health expert, which for Sally was something she found pretty exhausting and that she explained she had gotten rather sick of. After struggling to get help for issues related to using the coil, she told me that she was feeling quite despondent,

> (…) I had to wait so long. Someone must do something. I was "uppgiven" [tired/demoralised] by all the googling. There was not much you can do. I joined this Facebook group of folks having had [Vulvar] Vestibulitis[28] for over 20 years. *Great, this will be the rest of my life.* I had a lot of problems. What if I do something and make worse? (…) I feel like I don't have the energy anymore. This group, very active on Facebook. It solves a lot of things. There isn't much you can do. You can change your diet, relaxation exercises, physiotherapy. I'll save myself the time spent on going to the Youth Centre. Was just there to be able to cycle. It feels difficult, like traumatising. Feels better. It doesn't affect me so much. I'm trying to find other knowledge. (Sally)

Sally highlights the amount of time and energy, including emotional and mental, that can go into researching and trying to find information about a particular contraceptive method or its side effects. It is work that can be hard, confusing, and emotionally trying, sometimes without ever finding clear or satisfying answers or solutions.

Her story also highlights another dimension of what it can mean to be your own researcher, namely, the work of seeking out alternative sources of information. Sometimes this involved finding particular experts outside the conventional healthcare system, getting a second opinion, or seeking "alternative" knowledges and information. Having someone to bounce ideas with or talk

[28] Vulvar vestibulitis is a condition in which one experiences mild to serious pain around the vulva (the opening to the vagina).

through information, options and alternatives was clearly valued. Seeking out other sources of information and points of views could also be, in some young people's experiences, an important strategy for challenging medical authority, when, for example, struggling with side effects and not feeling happy with the initial care and counselling given. In talking about her experience with the coil, Sandra shared that it worked well, but that it lowered her libido and gave her more sensitive mucous membranes (the vaginal soft tissue). Eventually, she ended up experiencing pain during intercourse. In recounting this, Sandra lamented,

> How could I let it go that far and not admit it to myself? I let it go so far that I got Vaginismus[29]. (…) It has been going on for several years. It has been a hassle. I started going to a sexologist, and a midwife, no, gynaecologist. I had a super short visit and they [gynaecologist] prescribed a numbing cream. I was like, "ok, why should I use this in order to have intercourse?". What a sick world we live in. I never went and got it [the prescription]. Her recommendation was to push a lot on the spot that hurts. The sexologist said instead, "such stupid advice". (Sandra)

Whilst still blaming herself for the Vaginismus she developed as result of the side effects of using a hormonal coil, Sandra questioned the response of the gynaecologist she went to see for this condition. Sandra reflected with anger and frustration on their suggestion that she use a numbing cream to dull the pain from penetrative sex. Specifically, that they would prioritise her continuing to have potentially painful penetrative sex over exploring how Sandra could have sex that is pleasurable, either by treatment of the underlying condition or considering non-penetrative sex. I see this as a particularly egregious example of the coital imperative (Jackson 1984), an expression meant to capture the naturalisation of sex as 'penetration of the vagina by the penis' and other kinds of sexual practices are either 'preliminary' or 'optional extras, or substitutes when the 'real thing' is for some reason not available' (Jackson 1984, 44). In the end Sandra ended up choosing not to pick up the prescription she received, which I see as a way of resisting medical authority through non-compliance (Emke 1992). She also sought out alternative advice from a sexologist, and in so doing leveraging parallel authorities within the healthcare system. This is just one way in which individuals exercise agency and try to navigate and resist oppressive structures.

[29] Vaginismus is when the vagina suddenly tightens up when you try to insert something, like a tampon, or when you try to have penetrative sex.

Another example of seeking out different sources of knowledge came from Helena, who had been told by healthcare workers in Sweden that the coil could not be responsible for giving her a chronic yeast infection. While visiting Russia, where her parents migrated to Sweden from, she visited another gynaecologist who contradicted them, telling Helena that yeast infections were 'known side effects' from the coil as it can develop on the 'threads, and then you can't ever really get rid of it'. Both examples included encounters and receiving advice from healthcare professionals – those set up to inform you – giving either false or at the very least contradictory advice. In such a context, young people – taught that they are ultimately responsible for their own health – learn that they must do their own research and even second-guess medical advice.

When young people struggle to get help with contraceptive issues in conventional healthcare settings, many look for information and solutions elsewhere. Sometimes this involved asking questions in Facebook group, like Helena or Sally, or reading on online forums, like Miriam. For others, like Nicole and Nova, alternative knowledges and information came through being involved online or offline in different non-governmental or activist organisations. Nicole mentioned that they followed different people on social media that they knew worked at RFSU and that they tried to keep themselves up to date by reading materials they share. For Edith, YouTube ended up being of particular importance when she was younger, which made it easier to talk to friends and others about contraceptive and sex-related topics.

Becoming a medical expert and learning by doing

A second important element of the work of becoming informed involved needing to be or become a medical knower and expert. Throughout the interviews, I was constantly struck by how much knowledge some participants had about the more intricate workings of different methods – information that I often did not know myself. Pim, for example, spoke about researching in depth about the specific types of hormones that different contraceptive methods contained before choosing which to use. Others, like Sally, ended up learning a lot through her embodied experience with different gynaecological issues. She explained that by virtue of having struggled with the coil, she ended up learning a lot about the reproductive system.

But the participant who exemplified this the most was Helena, who recounted doing a great deal of medical work throughout her life, partly because of past health struggles and partly because of general interest in medicine and biology. In our first interview, we discussed the different side effects she had experienced on different contraceptive methods, and I asked who she spoke to about them. She explained that she has spoken a lot with healthcare professionals but never felt like she got adequate answers or engagement. When she was on the copper coil, she recounted being told that it had no side effects. The copper coil is classified not as a drug but a medical technical product in Sweden, which means that the standard for research and testing is not the same as for contraceptives classified as pharmaceuticals. With this in mind, Helena sought out a group online who had similar experiences to her with side effects while on the copper coil, and she noted that 'I don't know if I can medically explain why my panic anxiety increased but it was very clear that it was because of it'.

Helena discussed having done in-depth research on how contraceptive methods work, how you go about reporting side effects, and how both the hormonal system and menstrual cycle work. She ascribed this extensive epistemic work being possible due to being 'pretty medically interested'. She was not studying to become a medical professional but recounted having gotten a good foundation in biology in high school which facilitated her continued learning. She even shared that she read about studies on side effects that 'weren't really made for the general public' like academic studies and articles. She additionally described herself as 'pretty mathematically interested', prompting her to question reported statistics around different contraceptive methods. She explained,

> (…) it is also interesting to me to check how they measure effectiveness and what this actually involves. (…) I think, something in me is saying something about The Swedish Medical Products Agency and that most do not report side effects. If that is the case, then the statistics based on us as users and not studies based on people for the purposes of a study. If it actually is the case, then the statistics is based on them and not out there on everyone in reality. (Helena)

Understanding the efficacy of contraceptive methods, and how to ensure highest possible efficacy, is, as Helena raises, not straightforward and depends on a variety of factors like how often you have sex, what sex you have, and much more. It also highlights the rather complicated nature of interpreting and using statistics around likelihood of side effects and such.

With this understanding in mind, Helena described feeling a need to take a lot of responsibility for her own health issues – of having to become their own doctor. After experiencing issues with 'panic anxiety' with on the copper coil, Helena went to the doctors several times, who emphasised that the contraceptive method had nothing to do with it. In the end, still struggling with symptoms she believed were due to her contraceptive method, the initiative to try to remove the coil came from Helena herself. These experiences made Helena feel quite alone in trying to figure out the side effects and issues she was experiences. Something she contrasted with how it was when she broke her arm quite badly or struggled with eating disorders.

> (…) I didn't go home and feel the same hopelessness like with this. It has been a sort of attitude that "we're gonna help you as much as possible, and you're gonna get treatment until your well. Or rehab. And if it doesn't get well, then we're here to support you." I haven't felt that kind of back-up/support with these questions… (…) I have felt so exposed, so alone. (Helena)

The experience of navigating healthcare systems is shaped by a range of intersecting factors, including the type of healthcare issue you are struggling with. Women's pain and discomfort has long been misunderstood, misdiagnosed, and dismissed (Werner and Malterud 2003; Schäfer et al. 2016) particularly within the context of sexuality, reproduction, and gynaecological issues (Oudshoorn 1999; Denny 2004; Chadwick 2021). Experiences and meanings of pain related to sex, pregnancy, or similar has thus been shown to be highly gendered, and also racialised (Weisse et al. 2003; Rich 2016; Owens 2017; Fannin 2019). Helena struggled with being taken seriously in the healthcare context when it came to her issues with the coil. However, it is possible that her whiteness, previous medical experiences, and knowledge of the scientific field better enabled or resourced her to navigate and challenge this system. I can only speculate based on my study, but previous research has highlighted the intersecting role of racism and sexism in contraceptive counselling and reproductive coercion (Roberts 2000; Gomez and Wapman 2017; Littlejohn 2021).

Another element of needing to become your own medical expert is the experimental work and learning by doing participants engaged in, much like an experimental scientist. The process of learning something new is usually not linear or clear. Often the learning process curves back on itself, with no clear beginnings

or endings. As such, learning about contracepting for participants often meant simply trying their best, practicing, failing, and trying again.

This was a common narrative when it came to condoms, highlighting knowledge production as something deeply embodied and affective that goes beyond book-learning. Nova shared how she felt that she 'never used to be the one to put on the condom in a sexual act but that she learned [while involved in a particular university group] about how to put on a condom'. With time, she explained that she ended up feeling 'empowered, to have condoms and use them', eventually even becoming very pro-condoms. Again, we also notice the importance of friends or peers in doing different elements of the work of contracepting, which Hugo also underlined when it came to him learning about condom size being about girth rather than length, and in learning about sex more broadly speaking. For him much learning came thanks to a wider community as well as ongoing 'trial and error. I have done dumb stuff too… I don't know what I don't know. This thing with condoms, I didn't learn until the past two years. It was something I didn't know that I didn't know.'

It was not only in the context of condoms that participants learned through learning by doing, or trial and error. Trial and error also seemed to signify many young people's experiences of looking for more long-acting contraceptive strategies, especially when it came to hormonal ones. Helena walked me through her own process of trying different methods, considering different side effects and what might work best for her. Additionally, depending on the sex one is having, this work can also include learning about what to do when something 'goes wrong', like a condom breaking.

> William: The condom broke once in [country], she was from Ireland[30] or England. She became really worried afterwards. But we solved it. But even there, I am more comfortable. I became more worried for her, if you take Ireland as an example, where you are not as [inaudible] when it comes to dealing with a pregnancy.
>
> Marie: If she would want to keep?
>
> William: Yes, it is a problem on a completely different level than a broken condom level. But it was solved. We bought the morning after pill, I read up and calmed her. "It's safer than the condom". No, it's not, but it's not good that the condom

[30] Ireland has had a particularly long-standing and severe restriction on abortion rights, with abortions being illegal in all cases except to save the life of the pregnant person until 2018.

> broke, but it isn't a problem for us getting pregnant. We checked out the menstrual cycle and such. And it was when she would be most likely to get pregnant, so that isn't good. But it went well in the end.

Needing to improvise on the fly, learn as you go because you cannot always predict the situations you might face, often seems to come with the territory of contracepting. So, when the condom broke, which perhaps neither William nor his sexual partner had experienced before, they were faced with a situation of needing to find a solution there and then. It reminds me of the pedagogical mantra I was taught in high school, where we were told that we were 'learning how to learn'. I think that is relevant to reflect on in thinking how to best resource young people in contracepting, to acknowledge that their research and learning process will be an ongoing and reactive one, as there is no way to learn everything you might need to know in advance.

Being informed by epistemic authorities: reflexivity and resistance

In the previous two sub-sections I have highlighted the work that participating young people sometimes engaged in, to both find and produce knowledge about contraceptives, usually beyond the contraceptive counselling meeting or doctor's visit. Of course, as has been briefly discussed, young participants did also engage in epistemic work and experienced being informed by epistemic authorities in the medical sphere. In this final sub-section, I want to focus on these experiences, and specifically illustrate practices of reflexivity and resistance of participants receiving information in medical contexts (especially Youth Centres).

The power dynamics within healthcare and medical settings between patient and provider is historically already an uneven one, compounded by misogyny, heteronormativity, homophobia, transphobia, racism, and ableism. For young people, this is further shaped by power inequalities based on age, between the child or young lay person, and adult professional. For a few participants, encountering medical, epistemic authorities had been sources of distressing experiences and disempowerment, especially when they were younger. Sandra shared,

> Once I was with a male gynaecologist, and then it was much more direct and not so much chat. I didn't want to admit that it was difficult, but now when I have gotten older, I have probably more easily been able to say… to admit to oneself. It

> wasn't supposed to be distressing. To admit that it was is to admit that you have been subjected to something you do not like. (Sandra)

Like Sandra, other participants also had healthcare experiences that left them feeling disempowered, or – as in the case of Pim – having experienced prejudice based on sexuality, gender, and gender identity. Pim had gone to Youth Centres in several bigger and smaller towns in Sweden. In the town they grew up in the north of Sweden, the Youth Centre staff were very 'conservative', even promoting abstinence when Pim went at 15 to discuss contraceptives, making them feel like it was inappropriate to have 'that much sex' as someone they gendered as a girl. In moving and visiting other clinics, Pim continued to feel like staff had been either judgemental or baffled by Pim having sex with several people. They felt that many midwives were not as 'up to date' regarding poly relationships, polyamory, and diverse gender identities. Though not saying it in so many words, Pim hinted at conversations where midwives implicitly or explicitly had made them feel as if their relationship to gender, gender identity, sexuality and sexual identity was an issue: a 'problem' to be 'fixed' to fit into dualistic normative understandings around gender and sexuality.

Participants were reflexive about these encounters, seldom uncritically accepting or rejecting different claims by different epistemic authorities. One of these critical reflections included the dominance of heteronormative information- and knowledge-production regimes in healthcare and especially Youth Centres. This was something that Anna, Pim, Helena and Edith particularly reflected on in relation to feeling like they were never taught or spoken to about lesbian sexual practices. In Pim's case, they recounted, 'In my little town [where Pim grew up] there was no pan, bi, lesbian… you were straight. You had to explore yourself'. The sense that the Youth Centre assumed straightness prompted a call for a less heteronormative approach in encountering young people. Helena wished that there were more 'open questions' that did not assume what their sexuality or identity was.

Drawing attention to the continuing cisnormativity of being informed about contracepting in healthcare settings, Nicole pointed out the importance of gender inclusivity in contraceptive conversations, because there are of course 'trans men that have a pussy' and might need pregnancy-preventing contraceptive methods. Several participants noted the gendered and heteronormative organisation of contraceptive knowledge-making and information practices. That is, how girls and boys from an early age are taught very different things and expected to be

differently informed. As Hugo shared, 'I grew up in the countryside, sex was only about condoms. At least for boys. I would have liked to know about girls. I don't understand why we were separated [in early sexual education]. they had probably wanted to learn about ours too.'

In addition to reflecting on and resisting the authority and claims of healthcare professionals they encountered based on perceived heteronormativity, homophobia, and transphobia, some participants also reflected on power dynamics related to age. Miriam, for example, explained that at the GP she felt more like she has 'been treated more like an adult person' compared to the Youth Centre.

> (…) Here [the GP] it's a bit more, *I go here for this thing and then I go home*. Not as much shaming, or that they want to educate you, which, on the one hand is good with information about contraceptives. (…) Now in hindsight, [it's] good that they check in on how you're doing. It's the last gateway before you're 18. (Miriam)

Miriam acknowledges the logic from the institutional Youth Centre' point of view of seizing any presented opportunity to intervene and educate children and young people when they encounter them. However, she also notes the adverse impact it can have, where a young person may feel alienated and derailed by other matters the midwife sees as important.

This was in fact the case for Edith, who explained that it sometimes felt like the staff at Youth Centres 'were not really listening' or taking her concerns around hormonal contraceptives seriously, but rather dismissed them as incorrect or irrelevant.

> At the hospital I felt better treated. It felt a bit more serious. Because the Youth Centre is for youth, the atmosphere is a bit berating. You feel a bit… a bit combined with shame to sit there and talk to them. Not all. But sometimes with nurses/midwives. That they can get a bit, "aah". I encounter many that… don't know better. I'm not completely unsympathetic. But I think it's a bit unfortunate/sad that I've gotten that attitude. A bit that feeling. (…) It's difficult to counter/refute that when it's a general mood – a judging aura. Maybe you have your own little stigma. *Here I'll be judged.* But I think a little. It has been that atmosphere a bit, just among the midwives at the Youth Centre. (Edith)

During both our first and second interview, Edith spoke fondly of experiences of going to a non-Youth Centre midwife or gynaecologist, where she felt treated like a 'rational adult'. Edith explained how she felt that this was more like a meeting between two equals, two adults. In contrast, she felt a more 'maternal' dynamic from Youth Centre midwives, where she felt like she was seen as a child with little knowledge or experience, despite her feeling that 'she has plenty of experiences and knows a fair bit'. She also explained that the tone of the conversation at the hospital was more relaxed and straightforward, compared to the Youth Centre, where she felt there can be a tendency to assume that talking about sex, contraceptives and similar themes was difficult and uncomfortable – which itself created a tense atmosphere.

This resonated with William's perspective and feelings around the relationship and tension between seriousness and lightness (or 'silliness', using William's term) when adults encounter and engage with children or young people about sex. In schools, there seems to be an underlying understanding and relational dynamic in which children need to be treated with seriousness. While adults in the healthcare context and in discussing sex, on the other hand, can be met on more of an equal footing with a less solemn tone. William's reflection echoes long-standing societal discourses and views of children and sexuality, in which sex is considered too risky to treat as anything other than a serious, or even dangerous, activity.

Experiences of being informed by epistemic authorities were not exclusively stories of disempowerment, particularly when it came Youth Centres. Gabriella, Anna, and Nicole all recounted and reflected on what made such encounters positive and comfortable, citing striking a good balance between feeling professional and competent while also being warm, inviting and less clinical. Nicole explained that they had pleasant memories of the staff they met at the Youth Centre: 'like, they listened. And answered my questions, I thought. Didn't question/dispute or yes. It was… they were really great'. Noteworthy in Nicole's reasoning, however, is the awareness that you might need to defend yourself and your experiences, as they might be called into question or disbelieved, hinting at the wider structure of inequality that they exist in and navigate. Whether participants came out of Youth Centres and hospitals with positive or negative experiences, their stories consistently reflected the work put into critically engaging with the knowledge claims of these epistemic actors.

2. Making sense and meaning of contraceptive information

Becoming informed about contraceptives and contracepting involves in-depth work around finding, producing, and receiving information and knowledge – often independently, but also in relation to actors such as contraceptive counsellors. In addition to this, it importantly also requires work of making sense and meaning of said contraceptive information: of understanding, evaluating, and processing different forms and sources of information.

Navigating the viewpoints and opinions of yourself and others

> I have mostly spoken to midwives, and my friends have mostly used the pill. I had heard about the coil, mum said that was best, as well as the midwife. (Sally)

An inevitable element of becoming informed about contraception (considering all the different spaces, ways, and sources of contraceptive knowledge and information one can encounter) is the necessity and work of needing to compare, analyse and make sense of different information, viewpoints, and sources of knowledge. Epistemic work that can be confusing and ambivalent, and ultimately is deeply relational.

Throughout their lives young people encounter all sorts of information, ideas, discourses, narratives, feelings, and viewpoints of what the best or worst, appropriate, or inappropriate contraceptive methods are, from friends, sexual partners, family, school, the media, healthcare, and beyond. All things that need to be processed and made sense of by young people, something that requires, amongst other things, reflexivity and emotion work. It can also raise questions of whose advice or views one should follow and why, especially when different sources contradict each other. Edith, for example, explained how her mother had discouraged her from using the pill,

> She says that "I don't think you should take the pill. I don't like it but if you do". She wouldn't stop me. It's always been freedom with responsibility. Trusting that I know what's what. She understands somewhere that I know more theoretically, even if she's had more life experience. She lets me do my own thing… [but] she is afraid something will happen to me [using the pill]. (Edith)

When you hear from different people and sources, it can be difficult to know how to make sense of them. Much like having to remember to take a pill every day and remember, as Gabriella puts it, it is 'a lot of responsibility for like a 14- or 15-year-old'. Considering this complexity, some participants explained how they relied on and found relief and comfort in familiarity, choosing something that others around you already use or have used. Gabriella, explained,

> I think that if mum would have used more than one contraceptive method that I would never have tested – she had the pessary and it felt a bit like: *no one has that, right?* (…) But I think it really matters pretty strongly what contraceptive methods have been used around you, and who advocates for… maybe it doesn't become as scary. (Gabriella)

Another way to make sense of using methods one is familiar with through intimate others is the possibility of not just going to them for advice but being able to be in it together. To feel a bond and connection, a shared experience, or even as a way of doing intimacy. Many long-term contracepting strategies are something one per definition carries and embodies independently. No one else can co-wear a coil or implant. However, when others use the same type of strategy, it can be a way to feel less isolated and have a sounding board to compare experiences of side effects. Thus, while navigating other people's viewpoints on contraceptives can add confusion, involving others can also be a strategy for clarity.

Finally, in addition to needing to navigate the perspectives of other people, making sense and meaning of contraceptive side effects can also involve navigating your own differing perspectives, identities, and self-images. Sandra shared experiences of suffering from bad side effects from hormonal contraception, explaining,

> (…) It was difficult from the beginning when the libido starting decreasing. Maybe that's why I got all this problem, pain from having intercourse… that I didn't want to acknowledge/admit. That part of me was important for who I was. I've always been interested in sexual politics, sex positivity views. It has been important to really live out my sexuality. When it disappeared… I didn't know how to relate to. I had a thought, *ironic, working with sex, having studied sexology, but I don't have any sex myself.* A gap there. But that's what it looks like right now. It's not as difficult identity wise. I have probably let that go. (Sandra)

In Sandra's case, her not understanding the side effects she was suffering from may not have come from a lack of factual knowing but instead, as she now sees it, from it not fitting with her sense of self, self-image, and self-identity. From this, we can see how contraceptive information is additionally processed through the different stories of the self, adding further complexity to the epistemic work of contracepting.

Scientific literacy, scientific rationalism, and triangulation

As part of their work to make sense and meaning of different forms of contraceptive information, I also found participants employing strategies which echo more explicit scientific methodologies. These further highlight the necessity of being quite scientifically literate in doing the epistemic work of contracepting. Helena reflected specifically on the importance of understanding statistics to be able to understand contraceptive efficacy, in terms of how safe different methods are. Discussing condom efficacy in particular, Helena reflected on how people overestimate them due to not considering the human factors involved, and the importance of distinguishing efficacy in theory (that is, perfect use) and in practice (that is, typical use). Becoming informed about contraception and having an interest in learning specific issues are intimately connected. As Hugo put it in relation to whether he ever worried much about STIs, 'it has taken a long time before I learned what it means. Like chlamydia. If you're not medically interested, then it's nothing you learn'.

As Helena had raised, one also needs to be quite medically, biologically, physiologically literate to actually understand what is happening in the body when using some contraceptive technologies. Even just knowing how hormonal contraceptives work and what they physiologically do is extremely complex.

> (…) we spoke about the hormonal coil have the lowest dosage [of hormones], one mini pill a month. But that goes straight into the bloodstream. It's not a fair comparison! You'd have to check the concentration in the blood. So, I can't say that it's good… I don't know if it's something like that. That's what they told me when I got the hormonal coil. But apparently it wasn't the case, maybe the dosage, but not the effect. It can still shut down ovulation, so it can't be super low dose. We spoke about that, how I would've appreciated if they informed about what they *do* in the body. (Helena)

I admit that I had never thought about it in this way, but having Helena's argument and explanation, it makes a lot of sense. In fact, I remember being told the exact same thing by midwives before getting the hormonal coil inserted, that it is 'locally acting' which made me think that its impact was limited only to the uterus in which it physically existed.

In reflecting on my interviews, I noted a persistent favouring of rational medical scientific knowledge amongst participants. Helena explained this through the lens of valuing empirical evidence. She argued that it is important that something is proven scientifically when explaining her scepticism of fertility awareness and those on the internet promoting different fertility awareness practices.

> I rely on research when the empirics is large. Something that works for a great number [of people]. Maybe there isn't research now (…) When it comes to pharmaceuticals then I feel that I trust the science we have behind stuff. Of course, you can go in on details, like *how have they done this and that*… but in general terms, I trust an educated staff and those that have researched more, that tell me "there is not association between eating sugar and having fungal infections" than some lady on the internet that is just "Stop eating sugar!". (Helena)

Another way the influence of scientific methodology shone through in some participants' stories was through their practices of triangulation. Participants usually did not uncritically or blindly trust other people's experiences, but rather often described triangulating information from different people, taking actors' subjectivities and positionalities into account in often nuanced ways.

> Marie: So if it can be verified, heard from different spaces, then it feels more trustworthy?
>
> Sally: Yes. Like, personal experience. I think there is a bit of balance, that Youth Centres are supposed to tone down that they are not so dangerous, while personal experiences make it sounds like it is horrible. So, somewhere in between.
>
> Marie: So, to balance a bit where people are coming from, what they want, experiences…
>
> Sally: A person that has one experience, but if three or four. If one friend, and a friend's friend has it, then start "maybe ok". You can have it confirmed. Like with the implant. You can experience bleedings for a while, but I bled for like 100 days. It is confirmed with the Youth Centre that it is a side effect.

Sally reflected both on the importance of keeping in mind individual lay people's interests and subjectivities, as well as that of institutional actors like Youth Centres, when it comes to evaluating side effects. She also illustrated this epistemic complexity through her reflexive response to my question on what she thinks a trustworthy fact is, and where she thinks you can find trustworthy knowledge about contraceptive methods.

> (…) If you go the Youth Centre, I reckon that is, that feels like a safe source of how contraceptive methods work. They can be a bit stingy with [sharing about] side effects. Can still feel, if you go on and check on FASS[31] and read their list of side effects. But still. With all pharmaceuticals, not all that get them. It's very personal. I don't have a source that is, where everything that's on it is 100% correct. The more you hear from different angles, the more you can confirm. It's been a mix of basic knowledge, at the Youth Centre for example, but… them, it's so varied between midwives. Some have felt like they're telling you how it is [the truth], that it is in accordance with the experiences I've heard from other points. (…) It's difficult to say whether the Youth Centre is a safe source. A good start, where you get basic knowledges. You find out more, through personal experiences. From [online] groups or friends. Then you get, you add all together. If you only go on Flashback or Familjeliv[32], maybe you shouldn't use as a primary [source], but still an aspect. (Sally)

Triangulation as a method in this context, includes work of considering many different sources of information and evaluating them based on their specific context in terms of power and motivations. I also understand the relatively widespread use of such a method as reflecting a perception among participants that all potential information sources are in some way flawed and limited.

Sometimes young people expressed feeling that they needed to take the input or viewpoints from friends or family in particular with "a pinch of salt". Yet our most intimate relationships are still often those that we feel most able to trust. As such, while favouring and advocating for the importance of natural scientific knowledge, Mehmed maintained that it matters that information about sex and contraceptives comes from people you know and trust: '[f]rom teachers, doctors, nurses whatever is good, but it's always better when it's fed more with people you

[31] Swedish Drug Index

[32] Flashback is a Swedish online discussion forum. Familjeliv describes itself as a Swedish online forum, particularly regarding issue such as family life, parenthood, pregnancy, and children.

trust'. This highlights that the relationship one has with the source of contraceptive knowledge and expertise is essential for how you will receive, feel, trust, and take on information.

Being source-critical: evaluating the biases and interests of others

An important pedagogical goal in Swedish primary and secondary education is teaching students to be source-critical, that is, to identify the credibility of different sources of knowledge and assess them. An element that also emerged from participants' stories as an important part of the epistemic work of becoming informed about contraception was the need to navigate the agendas of different actors, and to identify and evaluate the interests and biases of different institutions and sources of knowledge.

One such source of information that participants critically engaged with was the internet. All participants shared stories of learning about sex, contraception, and similar issues through the internet. In fact, for many this was a primary space for becoming informed about contraception alongside friends, who also served as co-explores and companions in navigating information online. At the same time, participants reflected on the challenges of determining the quality of information found online. Nicole, for example, spoke about the issue of porn online – a medium where one seldom sees contracepting strategies employed – for providing unrealistic ideas of sex and a place where you can 'learn the wrong things'. In fact, previous studies have found 'patterns of minimal condom use in heterosexual [porn] films and moderate-to-high condom use in MSM [men who have sex with men porn] films' (Wagner and Cabosky 2018, 423). Nicole reasoned,

> There are porn movies today with a good story, that are not so unrealistic. But you shouldn't go to porn to learn about sex. I think you give way too much, what is it called, access to, the internet. To some extent. You can find all this information. When it comes to sex you should go to the right sources and not porn sites. (Nicole)

Besides porn sites, several participants also discussed being aware of how, for example, influencers or specific social media groups can be very partisan or a space where 'ignorant people' (Nicole) sometimes write. Sally, while finding great comfort in a specific Facebook group when it came to experiences of chronic yeast

infections and vaginal pain during sex, also expressed that she sometimes takes what is shared there with a 'pinch of salt, there's a lot of self-medication'.

Similarly, Helena explained how she had been somewhat interested in fertility awareness but found some of these influencers 'too extreme', while she found those advocating for hormonal contraceptive methods too prescriptive. For her, she explained, the idea of needing to keep such close track of your body and health was not helpful because of past experiences with anorexia. Nova also shared that she avoids googling around about methods as she can become scared by the fact that 'you can like always find: "you can die!"'. These examples also raise another important facet in work of assessing and being source critical about contraceptive information: namely, the emotion and identity work of considering the impact information can have on yourself and your wellbeing.

In addition to critically engaging with sources on the internet, participants also described doing so with parents and friends as sources of information. Growing up as children and young people we are impacted by the views around us, including our parents or parental figures. This includes their fears, worries, opinions, and sense of what is most important when it comes to children, sexuality, health, and contraception. But that does not mean that children passively or uncritically absorb or reject the lessons passed on by parents. While growing up, children often grow up seeing and understanding their parents or parental figures as epistemic authorities (Liu 2023), like they know everything. Yet, especially in our teens and as we age, this unrealistic expectation of parents can often start to shift and become nuanced. In so doing, like other sources of knowledge, young people reflected a great deal about the credibility of parents as sources on information on contraception, STIs and sex, a topic within which parents lose some of their status as epistemic authorities.

Several participants expressed feeling that their parents were not so well informed or knowledgeable when it came to modern contraceptives, and that as a result they were hesitant to ask for their advice or input. Gabriella, for example, shared that her mother only had personal experience of using pessaries, which she firmly rejected and felt was definitely not an option for her. Edith even shared that she was 'a bit happy that she [her mother] didn't speak to me because then I probably would've gotten a lot of inaccurate information' about contraceptive methods and the risks around STIs.

> There was this one time my mum told me, like this, if it was when I was going away on my Interrail [a pan-European train pass], when she told me like, she

> wanted, "just don't have oral sex with men, because you can get cancer from that". (*giggles*) and I was like, "Eh, right". But what? Technically, she's right. Because you can get HPV from it and then you can get throat cancer but it's really like fucking unusual. (…) But like, but that is, oh. But "mum, this is something you have read and just blown up in your head". (Edith)

Another participant that also felt that her mother was not so well-informed when it came to contraceptives was Helena. Like Edith, she reflected on whether parents really should be relied on for providing contraceptive information, arguing that it may not be fair to expect parents to be experts on this topic. She argued, '[p]urely, knowledge-wise, parents aren't responsible for knowing everything. They are just humans. So, I think that the primary responsibility for teaching and informing are those that educate and healthcare' (Helena).

This returns us to Youth Centres and the broader healthcare system – sources of knowledge and information that participating young people often also utilised. Understood as experts and privileged knowers on one hand, they were also constructed more critically by participants based on a more nuanced view of their scientific expertise, keeping systemic power dynamics in mind. Helena for example, while maintaining that healthcare actors have a primary responsibility to inform about contraceptives, also reflected more critically on the current state of contraceptive counselling as a source of knowledge. She was frustrated by the lack of options and suggested that 'maybe there is not so much knowledge among doctors, like there is nothing better to provide. No better alternatives, so there might be a lack of knowledge'.

While there were expressions of trust and belief in scientific rationalism and medical knowledge, there was simultaneously a hesitation and ambivalence about whether or to what extent you can trust different experts and institutions. Helena, for example, explained that she 'really really trusts those that have educated themselves to this', yet she also saw 'obvious flaws' in the system. Sandra questioned how much older doctors actually know about contemporary contraceptive methods, feeling that there might be a lack of knowledge among some healthcare staff when it comes to contraception, reproduction and sexuality-related issues. She wished that the everyone 'working with medicine had that competency. Like some minimum level of knowledge would have been desirable'.

In other instances, participants reflected on the subjectivity and bias as well as the difference of priorities that can exist between themselves and healthcare providers. Pim recounted their journey with contraceptive methods temporally,

including different experiences of getting contraceptive counselling at Youth Centres.

> Then it became the pill with sugar [placebo pills] to control the periods. But I did not want periods (…) She [the midwife at the Youth Centre] couldn't relate to gender identity, asked if I felt like a "trans-man". I tried to explain that I had an open approach to gender and gender identity and don't feel good when I'm gendered. Gendered with love is ok. But she couldn't understand that. Sometimes I feel like styling my hair towards the norm of men and bind my breasts. And in such a period, I feel… my gender feeling if I have periods, I don't feel good. Then I become very anti my own body. It's become so strongly connected to womanhood, childbearing. She thought that we first had to control the period flows while I felt that I shouldn't have periods (…) And then the midwife promoted the hormonal coil. I was unsure whether I wanted to try it for 5 years. (Pim)

For Pim, gender identity and being able to not have periods was incredibly important while the notion of controlling the level of period flows seemed to be the midwife's concern. Other participants also recounted experiences of feeling pushed by midwives towards hormonal contraceptive methods and the methods healthcare providers thought was the best option. '[T[he midwife seems so darn, so darn pushy that I should I have the coil. If it was that I wanted as few hormones as possible. I did feel a bit cornered (…) they pushed quite a lot for the coil' (Edith).

Another way in which healthcare or Youth Centres staff's subjectivities and non-neutrality was critically assessed by participants was in relation the problem construction of abortions. Abortion numbers in Sweden have long been discursively constructed as puzzlingly high and something that needs to be reduced. Several participants harshly questioned this notion.

> (…) It's always, "we need to reduce the numbers of abortion, we need to reduce the numbers of abortion!" But why? Why do we need it? Do you want folks to keep pregnancies they do not want or what? Why is it so important on a societal level? That debate always comes up. "We have to reduce the numbers of abortion", "Now the abortion numbers are rising". But maybe it's like, more, because more people want to get an education? Is it so incredibly important that they go down? It's an indirect signal. Where I probably have gotten the idea that it's not okay. Like how they speak about it. "We have to reduce the numbers, we don't want people to have abortions. Everyone shall use contraceptives. You cannot just happen to get pregnant. It's irresponsible when there's 25 different methods to choose from". *Well, yes, then you can try them yourself!* (Helena)

Helena maintained that there is nothing inherently problematic about the number of abortions currently being had in Sweden. Yet, the issue of abortions has become incredibly politicised. Sally reasoned that midwives think unwanted pregnancies are more serious that STIs because,

> Sally: (…) abortion is a political thing. Sexually transmitted illnesses are illnesses. We will be able to cure everything. Pregnancy is more a question of morality.
>
> Marie: Yes, because no one chooses to continue having, or it's not the same thing, choosing to continue having an STI rather than having an abortion or not.
>
> Sally: Bigger impact [Marie: abortion?] Yes, on oneself. It isn't really a choice to walk around and have chlamydia. But having children or not [is].

The meaning of pregnancy and abortion is, as Sally notes, highly politicised and culturally and historically specific, more so than most other contraceptive strategies. Medical and healthcare staff are not exempt from these political influences and will hold personal-political views that can contrast with that of lay young people, including some of my participants. This further highlights the reality that the knowledge produced around contraceptive technologies and methods – not only by lay people but also epistemic authorities such as scientists and researchers – is situated knowledge shaped by societal norms and ideologies. Speaking to Sally reflects that young people recognise this as part of critically engaging with the knowledge claims of these epistemic authorities.

Another way in which participants reflected on and critically considered healthcare institutions' presentation of information related to the idea that these institutions do not want to "scare off" young people from contraception, which could lead them to hide or minimise side effects that seem scary. Participants shared that they had this in mind when receiving and encountering official contraceptive information. Returning to my conversation with Helena about her feeling this way,

> (…) I believe that this thing with them not fully informing or showing all things has something to do with how their education is built in a way and spoken about in a way, and "that we want people to use contraceptive methods. If we don't scare folks, then we'll have higher use". I'm not one who has a negative attitude to contraceptive methods. They are incredibly revolutionary… A really good invention. And I want that people will use them as much as possible. Maybe you

> should press that instead. How good it is as an invention. Not to exclude the negative. I can feel now, the only positive thing they say, "you can avoid your period". Yes, it's not positive for everyone. "You can decrease period pains". Yes, all don't have that. "Less PMS". Yes, all people don't have that. In my case the cycle doesn't bother me. But side effects bother me. (Helena)

The tension felt between priorities and sense-making of individual contraceptive counsellors compared to young people and users is not a straightforward matter of malintent or an individual pushy midwife. As Helena notes, the issue is far more structural and systemic and relates to the wider praxis of contraceptive counselling, healthcare policy and societal discourse around sexual and reproductive health and wellbeing. While Helena expressed seeing the logic behind strategically leaving out, sidestepping or minimising certain negative side effects of contraceptive methods, she still reiterates her desire to be fully informed. It also highlights the relational, emotion, and epistemic work involved in understanding what you are being told and why, and the need to assess whether and in which way this is or feels like a reliable, trustworthy source.

3. Managing uncertainty and the work of trusting

While participants acknowledged the breadth of contraceptive information available to them, more information does not always equal an easier research task. Researching and seeking out more information can sometimes highlight contradictory narratives and further unknowns. In this section, I want to underscore the immense amount of uncertainty that participants had to manage in becoming informed about contraceptives, and the important role that trust plays in this epistemic work.

Distinguishing side effects: what is real and what is just me?

One aspect of becoming informed and making sense of potential side effects is how it can bring up rather existential questions: what has the impact of a certain method been on my body and self, and within that, what is the method's 'fault and what is me' or something else? This is something that Nova, Sandra, Pim,

Helena and Edith all had experienced in different ways. Nova, for example, explained,

> (…) It has affected me in that way, that I feel it physically, but also psychologically. It has affected my mood. I've had the hormonal coil for two and half or three years. But I don't know what it's like without the coil. It's easy to blame a coil. I'm sick of it, and not getting periods. Maybe you are just feeling bad? (…) (Nova)

Sandra expressed similar more existential quandaries in our second meeting, when I asked if she had thought about or reflected on something in particular since we last met,

> Sandra: Yes, but one thing. I have thought about this last week, and it's a bit connected to when I'm going to remove my coil. I've had the coil for so long. How will it be without it? It has lowered my libido, but I've also had it for so long. Other stuff that affects, but I won't know what is because of the coil and what is other stuff, and what is just me… I have thought about that a bit. If something has changed for me. Things can happen in five years. Will I experience periods and pleasure in the same way as five years ago? Then I was newly in love and younger.
>
> Marie: Are you worried it has dampened or changed for pleasure, for sex/libido?
>
> Sandra: Mmh… yes, it would have felt sad if I removed the coil and didn't feel a positive effect. It would've felt a bit sad and impractical since me and my partner wants to have children. It feels like an important part of that project (*laughs*)
>
> Marie: Either it's: the coil, how I am, or something else. Do you wish it was one of them?
>
> Sandra: … I guess I hope… that it isn't just, me in general that I don't have as much libido as before. I guess it's also since I inserted the coil and noticed the effect on libido – have taken it to avoid period pains and periods in general. And if those things are measured against each other: then I would choose to not have periods, any day. But now when I'm thinking towards the future, it's falls more into perspective. (Sandra)

For both Nova and Sandra, their experiences of considering or deciding to remove their hormonal coil after having had it for years raised very serious concerns and questions about their identity, sense of self, health, sexuality and pleasure. For

Nova it raised whether her different experiences of struggling with mood and mental health was directly related to the coil, and thus something that would be improved by removing the coil, or something that was simply her or the result of other factors.

The uncertainty of these embodied experiences can be taxing, and can itself cause emotional, mental, and physical distress as well as be a logistical and practical issue. It is an ontological insecurity in which being able to figure out the reality of the situation is difficult, sometimes impossible. One can never truly go back to a state in which one had not used a particular method. Time goes on, you live your life and have a variety of experiences that could impact your mental, physical, emotional, sexual, and reproductive health and well-being. This involves experiences and factors that impact, compound, and relate to each other in complex, often unknowable ways. As such, in Sandra's case, the hormonal coil, libido, pain, periods, pleasure, time, sexual identity and more make up a complex relational assemblage that cannot be picked apart.

Another example of the uncertainty and difficulty of making sense of embodied experiences while using different – particularly hormonal – contraceptives is its relationship and effect on other medications or health issues. Pim, for example, decided to go off hormonal methods and rely on safe periods to be able to investigate what elements of their experiences came from contraceptive side effects and what elements were related to neurodivergence and Pim's ADHD. Another similar example came from Edith, who explained,

> I think it was clearer to me before, when I wasn't using any other substances or pills, the more reasons there can be. It's easier if I am living my life like I was do but start taking the pill and get pimples. Then it is probably the pills. But then I have, around the time when I started taking the pills, I also started taking anti-depressants permanently and then it is difficult to know what is what. (Edith)

Another more general example complicating the nexus of what is the side effects, me or something else, brought up by Helena in our final meeting was how it can be difficult to understand side effects from contraception (or other medicines) as a teenager with a body in a rapid stage of change. She contrasted her experience of only starting with hormonal contraceptives relatively late compared to her 'hetero friends'. Instead, she describes having 'lived for eight years [with her] menstrual cycle and body without contraceptives. It made it pretty easy to notice side effects. Like this is *actually* reducing my libido'.

In outlining and unpacking participants' work of finding and making sense of different forms and sources of knowledge, I have shown the myriad of practical, epistemic, relational, and emotional dimensions this can involve. Participants reflected in great depth on this complicated information landscape, as well as how they have tried to navigate it and go about becoming as informed as possible. In doing so, they exhibited great self-awareness and self-reflexivity, and awareness of different normative systems that have shaped their journeys and experiences.

Trusting yourself and choosing to trust

Behind these encounters and relationships of dis/trust and dis/belief, lies a relational context arguably even more important to consider. That is, the relationship young people have with themselves, and whether you feel that you can trust yourself, your embodied experiences, and your feelings. Doing the work of contracepting, especially with methods that impact your body in more uncertain terms, can be a fairly severe existential issue. It requires self-awareness, self-knowledge, and self-monitoring – which are not easy tasks. Like Helena already mentioned, she was quite glad that she did not have to think about hormonal contraceptives when she was very young. Because, as she put it, 'if I had gotten something when I was like 15 then I probably wouldn't have questioned things so much'.

Trusting yourself when it comes to figuring out illnesses, side effects, or other embodied health concerns can be a great source of confusion and uncertainty, which can be deeply distressing. The Covid-19 pandemic complicated the matter even further, adding additional complexity and uncertainty to the mix. Edith explained, 'I still trust myself enough, like *this is a tension headache, this is nausea because I haven't eaten, this is…* but it adds another point of stress because it's Corona. (…). It takes a lot of your mental capacity' (Edith). Many people can at this point probably relate to the stress and mental drain that worrying about and constantly monitoring yourself for potential symptoms entails. It can take up an immense amount of time and energy, and can, in the worst scenarios, result in a relationship of distrust and second guessing your embodied sensations, feelings, and experiences.

This ambivalent dynamic that young people often found themselves in was highlighted not only the different dynamics of dis/trust that contracepting can involve, but also the work of trusting and of choosing to trust something or

someone as a deliberate strategy. Understandably, some young people ended up speaking in terms of choosing to trust either the method, healthcare, the science, or themselves to overcome the enigma of never completely being able to find concrete, objective answers, or solutions to their contraceptive situations.

For both Anna and Nova this resulted in expressed choices to trust their contraceptive method. Both were using the hormonal coil at the time, and perhaps compounded by their physical inaccessibility expressed that they choose to trust that it 'is doing its job' (Anna). Nova explained her choice to trust the coil with some more context. After experiencing several pregnancy scares and worrying about not getting periods while on the coil, Nova explained that she 'eventually developed trust in the coil' but that is has been a 'as a sort of psychological thing to get through'.

Of all participants, Nova spoke the most about choices of trusting, and how she deliberately chose to trust midwives and the healthcare sector. She expanded and contextualised her experience with the hormonal coil and the ways it had impacted her physically and psychologically,

> (…) I've had the hormonal coil for two and a half years or three. You don't know what it is like without the coil. It is easy to blame a coil. I'm tired of it and of not getting periods. (…) Yes, it has affected my, but I've still liked the hormonal coil. It has been the best contraceptive method I've used so far. (…) I am thinking about whether it is really good. If it affects me. I have great trust in midwifes and gynaecologists, but maybe it's that I haven't felt that I had a choice. And it depends on what country and society you're in. Whether you trust… and that I think also affects me. If my midwife says that it is a good contraceptive method, then I will trust it. So, yes, but I can still question, but I choose to trust it. Or yes. (Nova)

I read Nova's choice to trust the advice and knowledge claims of midwives and gynaecologists as being the result of a few different factors. Firstly, a sense of being tired of constantly wondering and worrying, and wanting to stop doing so to instead find a way make peace with the contraceptive method. And, secondly, the result of a longer more positive history, relationship and experience of the healthcare system broadly speaking which made it easier for Nova to put her trust in them, and by extension, the medical device. Nova continued explaining and reflecting on this relational approach to trusting the contraceptive method,

> Nova: (…) it's super weird that you're used to taking a pill and then it's cool. It took a pretty long time before you dared trusting that this would work. Because I

have been scared of getting pregnant. But to hear, in the choice of getting a coil, from a midwife that it is a good alternative. Heard from others saying that. The woven together: a midwife and several others that I maybe feel like I have already built up a sense of trust in, then you choose to trust it. But that doesn't mean it's good.

Marie: ... do you feel like you have to actively choose to trust it?

Nova: Unconsciously, I think so. I have probably not complicated it too much in my brain. Nah. And it is probably that which has begun a bit within me. *Is this really reasonable? Is it a contraceptive method?* It is working right now, so I guess it's fine but it's not good for my body. (…) You are a bit like. It is a bit like losing control. Maybe for someone who has a great need for a lot of control. But it is nice when you have a need for control in other contexts… Healthcare – I do not have a lot of knowledge… I choose to trust. I have pretty high level of trust for healthcare staff, because I have had pretty good experiences. (…) I have had different questions about the coil, feel like I have been able to ask them. And then I am fine. When I got it inserted. *There is nothing more I can do, just lie down and be quiet.* Then I let it go. There is nothing I can do. Then I let go of control. But I realise that I need to have complete trust in to… but it is very special.

In reviewing Nova's story, it becomes clear that the achievement of trust requires work and effort and is made easier by specific relational resources such as positive relationships and encounters with midwives and healthcare. It also seems like the process of giving up or letting go of control is one that requires active emotion work. As Nova suggests, it might come easier for some to do so, but as indicated by her retelling of getting and being on the hormonal coil, it is not automatic but rather produced through habitual self-affirmations: repeated reminders that she has done all she can and that she desires emotional closure which, for Nova, requires the choice to trust.

Towards the end of our second interview, I summarised some of the reflections I had from our first meeting to check in with Nova if I captured things correctly. She felt that I summarised it well and related to the words used to describe her relationship to contraception including a certain amount of uncertainty about what she feels and thinks about them:

(…) I have probably said that several times, that I don't really know what I think or feel about contraceptives when you talk about it on a deeper level. And that life just sorts of goes on and you "köper allt" [put up with / accept it all]. Is it my

> choice, or has someone else chosen for me? Do I have the knowledge to be able to make this decision about the hormonal coil? Or do I put my body and my life [in the hands of] a midwife? But at the same time, you have to go through life somehow, you do not have the energy to overanalyse everything. (Nova)

The process of trusting is, as I think Nova's account illustrates, not an on or off switch – something that one can hundred percent feel or not feel. Thus, to trust something like a contraceptive method, can sometimes be an active choice – and not a passive action without agency, but a way to emotionally manage uncertainty, fear, and risks and is best better understood as an ongoing accomplishment.

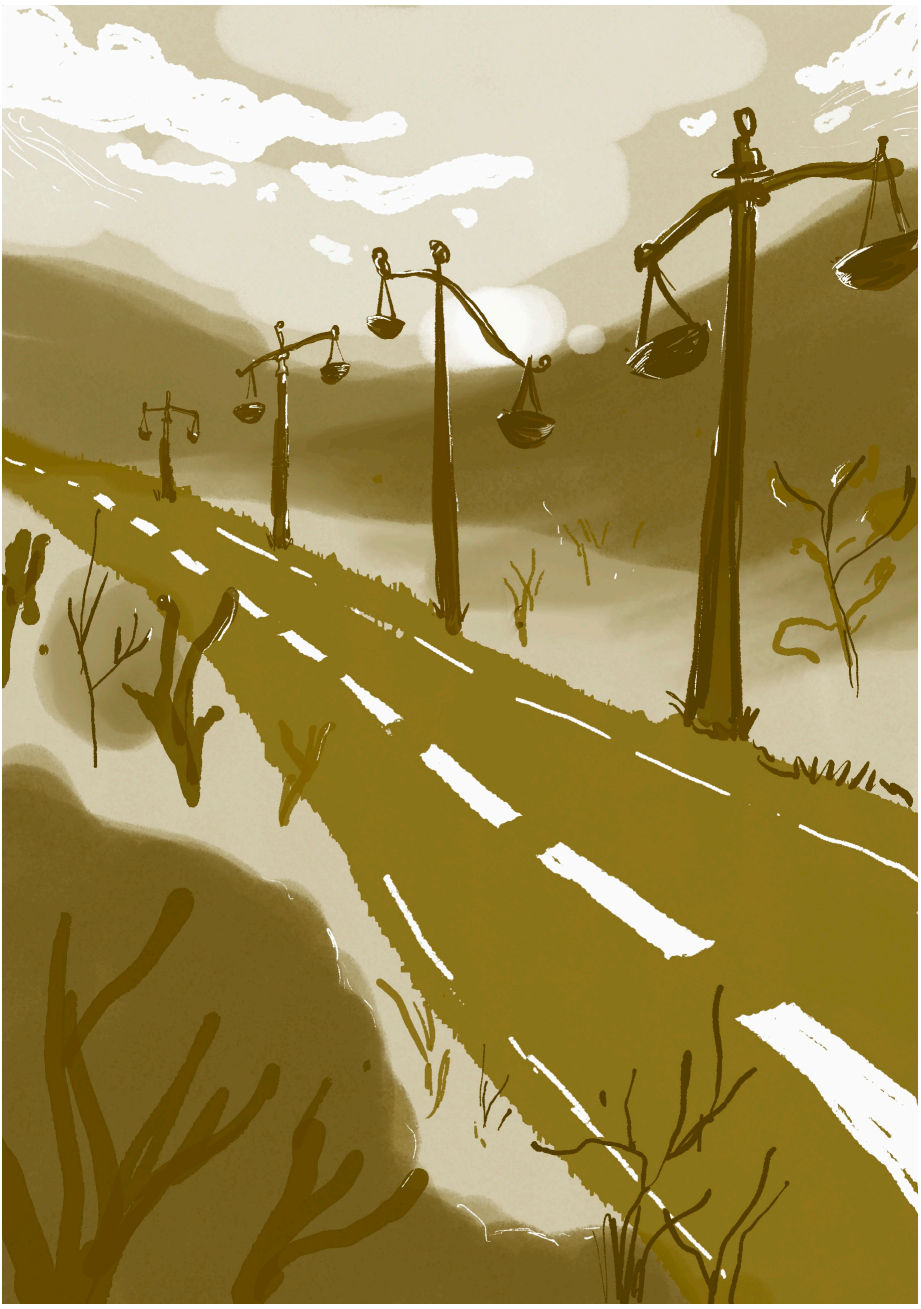
Conclusion

The work of contracepting is carried out and done in all matters of formal and informal societal spheres and spaces. Among these, the medical and healthcare sector and the individuals that work in it, still played important roles in the participants' stories around researching and evaluating contraceptive options. This to be expected considering how widespread and integrated the Youth Centre system is, as well as the specific role that midwives have in contraceptive counselling and prescribing contraception in Sweden. However, that does not mean that young people uncritically accept or reject whatever these actors suggest. In fact, as I have illustrated, participants were reflexive, critical and able to practice resistance in receiving information by medical professionals. Yet, as I have shown in this chapter, much – if not, most – of the work of becoming informed about contracepting still occurs outside of these institutional settings by individual young people independently finding and producing contraceptive information.

This epistemic work includes needing to make sense and meaning of the information young people find and encounter: navigating a range of viewpoints and opinions held by others and yourself. Some of the strategies the participants employed and favoured in doing this work mirrored conventional modes of knowledge production: scientific rationalism, scientific methodologies, source-criticism, and accounting for subjective biases. Becoming informed about contraceptives and contracepting is revealed as a complex, multifaceted endeavour that is ongoing, active, relational, and reflexive. The conventional view of the role between patient and provider does not adequately capture this process, and

concepts like patient work can help cast light on the in-depth epistemic work and problematise what it means to be meaningfully informed. As I suggested in the final section of this chapter, becoming informed about contraceptives includes the management of uncertainties (some rather existential ones at that) which can result in a strategical practice of choosing to trust either the method, healthcare, the science, or themselves.

As I noted in the introduction to this chapter, contemporary contraceptive counselling fundamentally draws from an ethos of individuals making informed contraceptive choices. However, while wanting to enable young sexual-reproductive actors to make informed contraceptive choices is understandable, the question of what it means and entails in practice to become and be informed remained – something I have explored in more depth in this chapter. However, another question also remains in relation to this ethos: namely, the meaning, practice, and experience of making contraceptive *choices*. In the final analytical chapter of this thesis, I will turn to this question and explore the work of making contraceptive choices as a young person in Sweden.



8. The work of making contracepting choices as a young person

The relationship between patient and healthcare provider, as well as the role and responsibility of the patient, is something that has changed over time. Different understandings of the role of the expert, who is an authoritative knower, and the purpose of medical and healthcare endeavours have particularly shaped the relational context of sexual and reproductive healthcare and contraceptive counselling. Within this, the powerful discourse and ethos of informed decision- and choice-making has not always been present but rather a more modern development shaping healthcare experiences.

As Sara Rushing suggests in the context of the US (though similar trends and dynamics can be seen in the Swedish context), healthcare has seen a shift from benevolent paternalism with the patient as "the good sufferer" (2020, 21) towards seeing the patient as a medical consumer and autonomous choice-maker (Sulik and Eich-Krohm 2008). It is a shift that assumes that all individuals have choice and control, creating different pressures of how to be a good patient and make good choices. In fact, Gayle A. Sulik and Astrid Eich-Krohm suggest that the '[f]undamental characteristics of the medical consumer role are *personal responsibility, proactive and prevention-conscious behavior, rationality,* and *choice*' (2008, 6).

This neoliberal model of the patient as consumer is a highly individualised one, where it is up to the patient in question to make healthcare decisions based on evidence. In many ways, the logic of this model is equivalent to contemporary models of learning, where the patient-consumer is a vessel for knowledge waiting to be filled by the medical expert knower. This is embedded in the term contraceptive counselling, or in Swedish "preventivmedelsrådgivning". The role of healthcare staff working in this field is to counsel, that is, to give advice to people seeking STI and/or pregnancy prevention options. Within this context,

the measure of a good contraceptive method is whether it suits the individual. As Edith responds when asked what she considers a good contraceptive method to be, '[w]ell, that which suits oneself'. Ultimately then, the aim of this counselling is for the patient to choose a method that suits them, their body, their needs, and their specific situation as an individual.

Yet what matters for individuals when it comes to contracepting differs depending on your relationship to a variety of complex factors – that is to say, there is no straightforwardly correct option. These factors include your relationship to or with past and historical experiences of medicalisation and healthcare, the type of sex you desire to have, the person or persons you (might) have sex with, the materiality of the methods, and more. All these experiences, perceptions, views, feelings, understandings, sense-makings, opinions, and sensations are relationally produced, formed, and shaped through what others (people, institutions, discourses) understand and believe to matter. As such, there is nothing like an objectively good or bad method but rather any method's usefulness is dependent on its relational context. In this chapter, I want to expand on these relational considerations.

As mentioned in the literature review, some scholars have started critically examining the idea of free and meaningful contraceptive choice and decision-making (Downey et al. 2017; Granzow 2007; Mann and Grzanka 2018; Littlejohn 2021). However, they are still a minority within the literature on contraceptives. To contribute to this important critical conversation, building on the previous chapter's discussion on becoming informed about contracepting, I want to explore the epistemic and relational dimensions in the work of making contraceptive choices as a young person. I want to consider that it might be more accurate to understand contraceptive choice-making as not one-off but consisting of many smaller and bigger choices both directly and indirectly related to contraceptive technologies.

First, I will show and discuss the complex, relational negotiations involved in making sense of which embodied matters matter when it comes to contraceptive methods. Second, I will discuss the sense- and meaning-making of side effects and the processes participants engaged in in choosing what type of side effect one will accept. Finally, before providing concluding reflections, I want to ultimately trouble the meaning of choice when it comes to contracepting and underscore the central role of the contraceptive imperative in participants' stories and accounts.

1. Choosing what matters to you: making sense of pain, hormones, and being natural

Based on the stories of my participants, one of the early elements (or sub-choices) in the work of making a choice of contraceptive strategy was negotiating what kind of related embodied factors matter to them. Like with any potential medical or health intervention, whether pharmaceutical- or practice-based, different contraceptive methods raise different questions. For the young people of this study, these questions largely concerned matters related to pain, hormones, and naturalness.

Meanings of pain and invasiveness: zooming in on the case of the coil

Pain and physical discomfort are understandably sensations that one may seek to avoid. Yet pain and discomfort – while embodied, affective and highly real – is also a question of meaning-making and is socially produced. This raises question around what types of pain in which embodied contexts become problematised, pathologised, or naturalised; whose pain is taken seriously, and what is understood as causing pain. These are central questions when it comes to making sense of meanings of pain and ideas of invasiveness when it comes to contraceptive methods, and where great tension and ambivalence emerge. In developing new contraceptive technologies, promoting, and informing about contraceptive methods, arguments around their invasiveness or lack thereof are often central. As I argued in my master's thesis on young people sense-making and attitudes towards emerging male contraceptives, perceptions and constructions of the painfulness and invasiveness of male and female methods are highly gendered.

In discussing with participants how they went about choosing contraceptive strategies or methods, questions of pain emerged as central and important, but not always in the same ways, highlighting the multiple meanings that the same material contraceptive technologies held. One technology that emerged in discussions repeatedly within a narrative of pain and fear was the coil.

> I got the coil inserted – it was not a good experience at all. They didn't manage to insert it. She said: "if you can survive pain for 4 minutes then you can get the hormonal coil inserted". And I was like, *yes, I can manage that*. I was not prepared to hold on. I was lying there for at least 15 minutes and was in great fucking pain.

> After a while, she didn't leave, but got up and said: "wait here, just have to leave for a moment", and I was just lying there and like, *am I dying?* (Nova)

This experience really put Nova off getting the coil again in the future when it needs to be changed. For her, the idea of having the coil for the rest of her life 'did not sound good. In and out several times? No, ugh'. Nova's experience resonated with my own of getting the coil inserted, in which I actually passed out and had to be treated with morphine pain relivers before being allowed to go home. Unfortunately, similar stories and experiences are abundant. Edith also spoke about how painful it was in the beginning and getting it inserted, as 'it is for everyone, like pain, throwing up'.

The coil is an interesting example of a technology or object containing such diverse meanings. In more official medical discourse, the coil and inserting the coil is understood as being able to cause some discomfort which stands out as being in some contrast to, for example, Nova's experience of feeling like she was 'dying', Edith's experience of being in great pain and throwing up and my own of passing out. However, while upsetting for Edith, she construed it as sort of to be expected while for Nova it came as more of a surprise and different to what had been indicated to her. This tension of what medical institutions construct as pain or discomfort versus what individuals experience is problematic, particularly when considering the historical dynamic of devaluing women's and people of colour's experiences of pain especially in the context of sexuality and reproduction. Something which has dire consequences on a larger level and for the individual's experience of medicalisation.

Of course, there are also experiences of getting the coil inserted where it only provides minor discomfort or where it was not brought up as an issue needing commenting. For others, experiences of pain and discomfort related to the coil came much later instead. For example, Pim told me how they did not like the coil as much as the implant, because they got more 'spontaneous bleedings, even heavy ones from time to time, especially after sex' and that their partner noticed the coil threads and felt that they poked them during sex. Pim explained, 'they thought it was really uncomfortable and unpleasant'. What people feel and experience as painful or discomfort must be understood in context. All bodies are different, and interventions in the body, especially somewhere as sensitive and intimate as the genitals, can be fraught. Some young people described vividly the awkward, often uncomfortable, feeling of lying in a cold, bare doctor's or midwife's office, legs

spread desperately trying to but struggling to relax before a gynaecological exam or coil insertion.

Even though the coil is inserted directly into the uterus, it is often constructed as un-invasive in medical discourse unlike, for example, the idea of a vasectomy which arguably is not inherently more physically invasive than the coil. Yet, the vasectomy – as I again found in my master's research on emerging male contraceptives (Larsson 2016) – is met by many people with an instinctive 'ouch!' and covering of the crouch with your hands, whether you have a penis or not. Perhaps unsurprisingly, the consideration of the vasectomy as a potential contraceptive method did not come up so frequently within my interview encounters. Vasectomies are often considered an older man or couple's method, for someone that is past reproductive age and will have no regrets about not being able to have children. Still when it came up, it was usually spoken of in similar terms to that of the focus groups of my master's project resonating with societal discourses on vasectomies. Mehmed, for example, felt that a vasectomy is 'very invasive, like it's so invasive'.

Perceptions of the nature of hormones - Frankenstein's monsters: unnatural, dangerous, and corrupting

The second important element in young people choosing a contraceptive strategy is their perception, feeling, and relationship to hormones, and what they understood hormones to be and do on a more ontological level. Hormones is a subject that most participants had strong feelings and opinions about. And, even more so than the coil, an object that holds such differing and varied meanings and associations. Despite the prevalence and widespread use of hormonal contraceptive methods, perceptions, and discourse around them are often filled with scepticism, fear and aversion. After 'eating birth control pills' since she was 17 or so, Sandra recounted, that things, 'didn't turn out so well. I became a hormonal monster. In hindsight, how good is it to fill a 17-year-old with a bunch of hormones? (…) It was my mother who said, "You are completely changed in personality"'. Hormones as an entity and ontological thing seem to have become somewhat of a Frankenstein's monster, something folks speak of as unnatural, dangerous, corrupting, and ultimately amoral, in interesting co-productive ways.

Miriam, for example, described how she did not like to put 'unusual stuff into her body', avoiding artificial things and comparing non-hormonal methods to

stuff that has more "natural ingredients" and clean living. For her it was very important that the things she consumed and used in her home – like cleaning materials – was "natural" and "kind" on what I took to understand as both the body and the natural environment,

> I think it is pretty scary to like all the time, some sort of, not intoxicant but it is something that affects the body, that it interacts a bit with the body's functions, or capacity (…) This is something that trickles through in different parts of my life, like with food. (…) So, it is a lot of with, that it is a bit unnatural to stuff yourself with too many hormones. Too much, what do you say, additives or artificial stuff in the body that causes it to change. Then I can understand from a gendered perspective that for many it is unnatural perhaps to take something that you do not want. Then some hormones can be really good, but I'm thinking from, that it is pretty wearing on the body to expose it to stuff that it wouldn't normally do, and I don't feel good from it. My body doesn't feel good with these divergences. (Miriam)

Hormones, in Miriam's sense-making, was discursively equated with pollution and waste, something that pollutes the body and goes against the natural state, while simultaneously acknowledging that for some these can be 'really good' when it comes to gender identity issues.

Many young people I interviewed expressed similar views and feelings towards hormonal contraceptive methods for themselves or coming from people around them. Sometimes these external views came from partners, other times from parents like in Edith's case whose mother felt that it was 'unnecessary' to stuff your body with 'lots of hormones'. Edith explained that while 'I am not like a nature-medicine-person, but I see no reason in stuffing [myself] with something unnecessarily. To fuck with my body unnecessarily'. Her mum saw hormonal contraceptives as less ideal options for Edith if she wanted to deal with her acne, and according to Edith, this seemed to be part of a larger sense of choosing to avoid hormones if and when possible. She reflected how she ended up being affected by and probably absorbing a lot of these ideas, without becoming completely averse to these methods.

For other participants, like Nova, it was their partner who 'didn't want me to expose myself to hormones unnecessarily'. Though this was not the case for William, who as a partner himself at the time to someone who considered using

hormonal contraceptives, felt quite the opposite. Instead, it was his girlfriend who was more afraid of hormones. He explained that,

> For my part, if it had been my body, then I would have been less afraid of hormones. But she has also a different feeling of wanting to have a natural body, and not change herself. And I don't have that same feeling about my body. It is difficult to know how it has affected her. Even if she feels more emotional, it can be other reasons. It is difficult for her to discern how the hormonal coil is affecting her. (William)

Throughout these narratives and stories, hormones emerged as almost a dangerous albeit sometimes necessary thing, like a necessary evil that you avoid for as long as possible.

For Mehmed, on the other hand, hormones were more clearly constructed as negative. In our second interview, we discussed ideas around what he considers good and bad contraceptive methods, in answer to my question of what he would say a bad method is, he responded, '[t]he thing that they, the woman, take is a bad method. Playing, with anyone's hormones, changing their hormonal integrity just to prevent something, something very natural, pregnancy, I think is morally wrong.' Mehmed came back to this several time in our conversation during the second interview, strongly expressing his feelings around it being amoral to ask people to take 'stuff that affects their mood'.

This was also expressed in the context of discussing possible emerging male contraceptives. I explained one recent method that they were trying to develop, where Sweden was part of the trial: a hormonal gel for men. I asked whether he thought this gel would be a good idea,

> Mehmed: I'm thinking, I think, like the male ego is too fragile. They would be like: "It'll affect my testosterone; my moods will change. I won't have beard. I'll lose hair." People would be less receptive to the idea of using. Even if, research shows that it doesn't work like that. It's not gonna affect anything like that. Maybe I have a negative image of masculinity (*chuckles*) but I think it'll be, no, it's not for me. Not really good.
>
> (…)

> Marie: So, what do you think is not acceptable side effects, especially those things you mentioned like: mainly you've been talking about mood changes, is that mainly it or other ones? "No, this should not, not that is severe."
>
> Mehmed: Mmh, I think anything that affects people's everyday life is a lot... question. Whether it is small mood changes, or changes of their voice. Although, on the other hands, I have woman friends who are okay with those, they think it's better. Go through very strong PMS. So maybe it's up to the person, but I feel like, as a partner, if I am asking someone my partner to go through this everyday life changing stress, I think it's amoral of me to ask this of them.

Anna expressed similar views: that male contraceptive methods with less hormones would be good. In discussing this potential male contraceptive gel in our first meeting, she reflected,

> I mean it is better if you aren't that affected by it. And especially, when, when you're young and it a lot of puberty. There is a lot already happening, and then to like add even more. *Aaah.* How rough. You don't want young people to experience that. No, so I'm thinking, (*chuckles*) none, no hormones or as little hormonal… impact perhaps, or maybe. So that it doesn't affect your wellbeing too much. (Anna)

Throughout both Anna's and especially Mehmed's reasoning around the risks of hormones, a narrative appears around the gendered normative construction and gendered risks associated with hormones. Mehmed discussed how the scary or worrisome element of hormonal contraceptives for men in general are likely changes related to masculinity norms (like losing your beard, loosing hair, changes to your voice, as well as mood changes). Speaking of the risk of hormones to men as the risk of becoming feminised is not new (Roberts 2003). This narrative nexus of gender, hormones and contraceptives has become so powerful that this has been a common response to new male contraceptive methods even when the methods have not even contained hormones (Larsson 2016).

Gendered risks to hormonals contraceptives and hormones were, however, also expressed in different terms by some participants. Sandra argued that it would be better if new male contraceptive methods did not contain hormones, for the risk of increased testosterone-fuelled violence and aggression,

> Yes, because hormones are potent stuff. If I got angry, then maybe it is not so good if men who already maybe are more aggressive would become even more… men that already are the cause of enough violence acts. So, with some extra bit of hormones on that. Though, on the other, maybe if they cry more, it's a good thing maybe. (Sandra)

The uncertainty of what hormones do or might cause was reoccurring, portraying hormones as something unpredictable and with potential for great power, potent stuff that might make men become even more out of control. Yet what this potent stuff involves often fell back on gendered tropes, norms and understandings.

Anna reflected extensively about femininity norms and hormonal contraceptives that really frustrated her. Unlike most other participants, Anna felt that there were other contraceptives more 'unnatural' than hormonal ones, comparing the copper coil to the hormonal one.

> Anna: (…) when I am thinking of getting the coil – cause I cannot be bothered to get the pill – and my dad was like, "you shouldn't have the copper coil (…) because copper is poison. A poisonous meta". (…) He had probably gotten that from somewhere else than biology. It made that I said that the women's clinic, "no copper". Not sure where he heard that, but I thought *that is not good.* But is it him, the individual, who has heard that, or is that copper isn't good?
>
> Marie: I have never heard that, but that is very interesting. Hormones are a bit abstract, copper we know what it is: like copper pipes.
>
> Anna: Yes, some type of metal.
>
> Marie: A bit more instinctively, like you shouldn't insert metal…
>
> Anna: Yes, exactly, while hormones are bit more natural, you are just regulating it. I am experimenting a bit with my hormones and reducing the likelihood of getting pregnant. (…)

Ultimately, most participants expressed fearful associations, experiences, and views of hormones. A fear that seems to stem from worries of losing control and being polluted. Some participants ended up choosing to stop using such methods whereas others, either for lack of options or not having these fears at the time, had continued with them.

I think it is crucial to note, however, that these associations and emotions cannot be understood as a universal story. While aware of dominant narratives around hormones, Pim felt that hormones were freeing. 'Periods are not a liberation', as they are constant reminders of a gender identity that does not always gel, while 'hormones make me free/liberate me'. Thus, for Pim, hormonal contraceptives were, unlike for their cisgendered counterparts, something highly positive and empowering, enabling them to be and feel more in control, happy, and healthy.

Your relationship to your body: is living naturally important or not?

Whether hormonal or non-hormonal, contraceptives can affect our bodies in many ways. They can feel like a relief, invasive, painful, scary, uncertain, comfortable, or liberating connected to how we relate to our bodies and different aspects of our bodies more broadly speaking. Fears and feelings around introducing 'unnatural' changes and interventions to the supposedly natural body was an important factor for some, though not all, of my participants.

William explained how it was important to his girlfriend, the 'feeling of wanting to be natural, and not changing her body' while this was of little concern to him. In discussing his relationship to the matter of condoms, the question of whether sperm in itself was positive or not, an important part of sex and pleasure, came up when discussing the notion of a male method called *The Clean Sheets Pill*[33]. William reflected,

> William: I suppose it [the ejaculation] is also a part of the sex.
>
> Marie: That is what many people thought, it is so strongly connected to sex.
>
> William: Exactly, for a one-time thing it is not… for my part. A one-night stand then the sperm has not been something positive, something you try to keep in the condom.

For William, the idea of using a male contraceptive method which would result in dry ejaculations, did not seem as such a big problem in the face of getting more

[33] The Clean Sheets Pill is a non-hormonal contraceptive that is designed to work by blocking the release of sperm while still allowing ejaculation. The project developing this method is currently stalled however due to lack of funding (Parsemus Foundation 2023).

control over his own sexuality and reproduction. Yet, for others, the presence, sensation, sight, smell, taste, and presence of sperm can be a central element of sex that would be lost.

Similarly, the need to live naturally with and in their bodies, was something that participants related to in very different ways depending on wider lived experiences. Helena, for example, explained why she did not care too much for 'natural' contraceptive strategies like fertility awareness. She did not like needing to monitor herself and her body so closely, as this brought up difficult experiences and triggers related to past eating disorders. In the final interview, we returned to this topic,

> Yes, like I don't want to live a life where I put so much focus on what is happening in my body. I want to believe that they body can solve most things, that I don't have to enter mentally and note every single little thing. So, with fertility awareness, after a while it is like you must follow these signs, in your body and your cycle. So even though it's quick, it's still this constant awareness that I feel for my personality type, is something that can easily become pretty damaging. All time keeping track of stuff. Should I then also keep track of what I am eating all the time, and if my boobs start aching before my period? I don't want to go back to a life when I write down what I eat, but that's different. Some people can do it in a healthy way. But not everyone. It's just probably not for everyone. I don't like this "pekpinne" [pointing stick] that it should be like this for everyone. And maybe everyone doesn't want to live in tune with one organ in your body all the time. For some that can be triggering if your trans or whatever, constantly keeping track of the organ you have issues with. Or if you're like me, keeping track of shit in the body like stressed you out. (Helena)

There was a tension for Helena, however, because at the same time she had struggled with hormonal methods and having stressful pregnancy scares, she still felt that she wanted to get to know her body without hormones. This resulted in her deciding at age 20 or 21, after having met her current partner, to have sex with condoms to find out what her body and periods were like. Nova expressed the same desire, experiencing discomfort over not knowing what she had put into her body for so many years after struggling with coming off of the pill: 'I started reflecting on what I had put into myself, it felt really weird'.

Your experiences with contraceptives, sex, relationships, and much more interact in complex, non-homogenous ways. Clearly, contraceptives can be and feel empowering, provide calm and ease, or give your greater insight into your

body. But, at the same time, it also able to do the complete opposite. Contraception, as such, is a fascinatingly and frustratingly dualistic phenomenon, containing so many tensions and contradictions.

> I think that the coil has given me more awareness of my body. Or contraceptives more generally, to understand what you can do with your body. But, on the other hand, you don't know what you do to your body in the long run. Yes, sorry, I was just thinking, I have a pretty inaccessible contraceptive method [the coil], I got stuck a bit in this that I would need to have an intervention, a midwife [to remove or change it] – so damn complicated. (Nova)

The uncertainties of the potential impact of different contraceptive methods can result in a lot of confusion and stress, can take a lot of mental and emotion energy and work to make sense of.

Another element that came up in relation to the meanings of being natural was raised by Anna, namely around the normative ideal that shaped that meaning. Anna reflected that it is difficult to determine what is or is not natural to the body, 'if you take it really far, to add anything at all is unnatural, that the body hasn't decided itself. Actually, then nothing is natural. Or everything is'. This made her think of the fertility/contraceptive app Natural Cycles and noted that the fact that it has natural in its name makes people impressed. She reasoned that as a method 'it is probably a more natural method, but it doesn't feel safe'. I asked whether she thought a lot about wanting a method that feels natural. She responded,

> Yes… no. I see it as an ideal, but I guess it is good too but… or? At the same time, I want as few hormones as possible… hmm, hmm, hmmm… I guess I'm thinking that as few hormones as possible is good. But why? I don't know. Yes, exactly, like this ideal, that you are supposed to be as you are and that it should work: to have as little hormone, and still be this perfect human and not get pregnant. Be a sexual creature. (…) Maybe the ideal is that you're supposed to have some sort of contraceptive method that affects you as little as possible but that still protects, to maintain the notion to be as natural a person as possible. That it's the women's job. (Anna)

Other participants also expressed feeling the societal and relational expectation that girls and women are on some sort of contraception, often hormonal ones, which – as Anna raises – can clash with other gendered ideals and expectations. The question therefore of whether living naturally in your body is important or

not is a complicated one where you might have to choose between, and fail to live up to, competing gendered ideals.

2. Choosing what you will accept: sense- and meaning-making in relation to side effects

Besides needing to reflect on and choose whether and in what way matters like pain, hormones and naturalness affect you, young people must also make sense and meaning of different side effects of contraceptive methods. As raised in the previous section, it is important to note that a side effect of a contraceptive technology is not automatically a negative or positive thing. Assessing the impact of side effects therefore becomes another step in the process of contraceptive choice-making.

Considering when a side effect becomes a problem

The way participants ended up making sense of and valuing different types of side effects, or impacts of different contraceptive methods, highlighted the importance of considering the wider relational context for young people in choosing contraceptive strategies. There were great variations in what mattered to participants, to what extent and in what way. As such, the way in which participants went about negotiating and balancing perceived pros and cons, okay and unacceptable side effects clearly differed, with different resulting choices. Yet what most, if not all, had in common was the work process of clearly considering a range of different factors in choosing between contraceptive options.

Participants varied on whether physical or psychological side effects were worse. Sandra, in thinking through what she would say a 'good contraceptive method' is, reasoned that it is one that is safe and is effective, as a bare minimum. She continued,

> (…) it would be good if it does not remove your libido… and then there's the whole environmental aspect. I know that the hormonal coil is not so great, you pee out hormone disrupting [matter] in the water. (…) An ideal contraceptive method wouldn't have negative impacts on animals and nature. Then, of course, you don't want negative side effects. You don't want to get a crazy mood… bad skin…

> increased appetite, sugar cravings… tiredness… headaches… nausea… It would be ok for a transitional period, two weeks, or a month, but then it must pass. Which is why the pill feels so impractical. (Sandra)

For Pim, and others like Edith and Mehmed, the most important consideration regarded mental health. They did not find mood swings and weight gain to be so serious, nor impacts on fertility. While 'stuff that has to do with your wellbeing, that you feel psychologically. Deadly. They can be deadly' (Pim). Another example is Sally who also felt that methods affecting hormones, especially mood and libido, were bad as well as the invasiveness of the method and how painful it was, arguing that the pills are useful because you were not reliant on someone else taking it out. This is something that Anna also mentioned as a negative aspect of the coil, the potential of feeling 'stuck' with a method, unable to stop or remove it, if needed.

In negotiating and balancing pros and cons of contraceptive methods, participants took different things into account and valued them differently. Thus, what ended up becoming a deal breaker or simply a minor nuisance to someone can differ greatly. One clear example of this was participants' relationship and emotions about menstruations, bleeding, periods, and the effect of contraception on these. Anna, while having a moment of freaking out about being stuck with the coil, still found relief in it being able to help with acne and her period pains. But she found it annoying that she ended up having weird bleedings instead, neither quite like normal periods nor like having no periods at all. Helena, on the other hand, felt that she could put up with 'some pimples and some irregular periods'. For Edith and Pim, being able to control their periods was a huge benefit. Pim, in relation to their experiences around gender identity, and Edith as this helped with her PMDD symptoms.

The construction of side effects as bad, good, minor, or devastating must be considered with people's unique histories, social positioning, and wider socio-historic context in mind. For example, the ability to see and feel a contraceptive method was something that Edith valued as she had, not long before our first interview, experienced accidentally pulling out the coil while removing her period cup. In the end, despite feeling a 'bit scarred after it fell out' Edith explained that she would probably opt for getting the hormonal coil again, as she had otherwise broadly been content with it.

However, at the time of the interview in 2020, it was not possible for Edith to get the coil re-inserted as the Youth Centres had closed because of the Covid-19

pandemic. Instead, the only method available was the pill, as this could be prescribed over the phone and picked up from a pharmacy. Edith reflected on this, feeling rather conflicted about her situation,

> It's a bit unsettling with all the side effects. I am always. I don't want something that gives me bigger boobs, that is known to cause mood swings or a lot of acne. I think it is not not cool to, more or less, become depressed in order not to get pregnant. It's a bit unfortunate. [Marie: Yes, it really is] A bit insane, I don't know if you have learnt it or so, that unprotected sex is nicer without condom. So many friends have said that it is not sexy to have sex with condoms. Becomes deal-breaker. Insane that you think it is more worth it to have acne, mood swings, increased risk of vaginal infections just because it is unsexy to put on a condom for 30 seconds. I can reflect about that. (Edith)

Edith posed a very astute social question about how we have ended up constructing such strong meanings and associations of condoms being barriers to pleasure and un-sexy, while more long-acting hormonal contraceptives with more serious potential side effects are not seen as barriers to pleasure. This raises the question of what gets constituted as un/acceptable and ab/normal side effects, and the role gender plays in this construction.

Tensions between young people and official constructions of normal side effects

A situation that several participants found themselves in, on one or more occasions, was experiencing physical or mental discomfort, pain or distress in relation to a particular contraceptive method that was either considered a "normal" side effect or not a contraceptive side effect at all. This raises the question of what becomes constructed as acceptable or real side effects, which are seen as inevitable or avoidable, how this boundary is drawn and who it is that gets to draw it. Going through the reflection tool in our second interview, Nova explained, regarding the question which methods affect her,

> Nova: Ok, affects me is next. Which methods have affected me? (…) I have felt impacted by the hormonal coil – mood, skin has gotten worse, pain in my ovaries. I have gone to the doctor, and they said it was probably the coil. And I have had cysts. (…) Yes, it has meant that I have had to go to, when I went to the women's clinic because I was in so much darn pain. But she said I should go to the GP, even

though I had called the GP who sent me there. Eventually I got to go to the GP and get an ultrasound. "It was only cysts". It is pretty odd that it was normalised, because it was freaking painful.

Marie: No, that doesn't sound normal.

Nova: No, no. I have spoken to the midwife that I'm with now and she says it's a normal consequence of the hormonal coil. But I haven't had it so, it can feel like period cramps, but it hasn't been that painful before.

It is relevant to note here, that two meanings of normal emerge that can help us understand the tension in sense-making of contraceptive side effects as expressed both by myself and Nova above, and the different medical professionals Nova described encountering. The first is normal as descriptive, in terms of frequency and commonness. The second is normal as normative, what the normal state should be: what should be the common, acceptable experience. Because, while cysts may be a common occurrence that develops in people using the hormonal coil, that is not automatically the same – which Nova in some way questions – as it being something that one must accept and put up with. Yet, the slippage between these forms of normality is frequent, and is worth being semantically clear about.

Helena, in a similar vein, discussed and argued in great depth about how contraceptive side effects tend to be constructed, treated, and valued differently compared to other medicines or medical interventions. She explained, after getting the copper coil inserted,

> Then I got crazy side effects, and I went it with and check like what alternatives there are and felt a bit like it was a plague or cholera[34] situation with everything and then I became more and more clued in on this and tried the shield with different stuff. It's only in recent years that I have thought about, because I have never had issues with my body like it is, I mean, with like my cycle or with PMS, pain. My mother hasn't either. (…) I have never had to take anything to get rid of aches or to get rid of bleedings (…) So for me it has been like, shall I (who doesn't have any reason to take a medication) take it and one day put up with side effects? But it was never anything who answered that. I mean, if you need a medication then you take, then you put up with the side effects. Like, you don't want to be ill

[34] This is a direct translation from the Swedish saying "pest eller kolera", signifying weighing up two bad options.

> but often, this is about completely healthy people. So, then I think we should have a bit of similar approach like with vaccines, for example, that common side effects and therefore healthy people taking it. (Helena)

Helena discussed her relationship to contraceptives as being more akin to that of vaccines and describes them as taking a medicine that she actually does not need (as there are other ways to avoid, for example, pregnancies by not having sex with men) which meant that she had lower tolerance for side effects. She acknowledged that contraceptives could act as medicines for some, treating periods or PMS. But as these are not issues for her, she had become very critical and questioning about using any contraceptive method that gives her side effects that interrupts her life and well-being.

Especially when it comes to hormonal contraceptives, Helena felt like you have to 'put up with a lot', compared to, for examples, vaccines. Throughout our interviews, she compared contraceptives to vaccines, and believed that they should be held to the same (higher) standard in terms of acceptable side effects. Worth noting is that vaccines do have side effects, sometimes quite significant ones, yet we give and take them. However, and here I share Helena's assessment, with vaccines there is a different view of what are acceptable or unacceptable side effects, and the side effects of vaccines are generally taken more seriously.

Alongside reflecting and discussing tensions between what participants and healthcare professionals felt or thought about so-called normal or common side effects of contraceptives compared, another more intense tension emerged in some participants' stories. Some participant described being met with denial from midwives or doctors when they were experiencing a side effect. They were told that a certain side effect was not possible, that a particular contraceptive technology could not cause said side effect.

Living in or with such uncertainty, almost ontological insecurity, can be incredibly difficult. Sally and I spoke about this in the second interview,

> Sally: I think that is that worst. Unclear side effects. Great hassle to… (*goes quiet*)

> Marie: Maybe difficult to get "gehör" [sympathy or being listened to] from healthcare, that "I think this is this thing". I can relate to that, like "I am feeling this, I feel it affects…". But how do I know that it's my coil, the pills… that does it? Many midwives said that there are no side effects. Living in the uncertainty is not so fun.

> Sally: Remove the coil, I don't know. It doesn't have to be side effects. Imagine if nothing happens when you remove it? That dilemma, I think, I mean to feel. It's a hassle to find out if it really was that.

Sally shared that she had she had struggled a lot with figuring out what to do with her contraceptives when she was feeling badly affected by them. She described how her boyfriend noticed how she was feeling bad and ended up being supportive when she decided to remove the coil. She noted that it was difficult to decide and measure how bad it must be before you feel like you can legitimately change contraceptive method.

There is no clear answer to be found when you are in such a situation, trying to decide what is a contraceptive side effect and what is something else, how long to give the new method a go, and when it is time to make a change. The advice and cautionary tales you might receive from different actors are likely to differ. Nova explained that she had been cautioned by many, mainly midwives, against using the implant because they contain a lot of hormones and can painful. But, on the other hand, she had never had friends cautioning against the implant, but rather the hormonal coil which friends would 'never be able to do', and as something that sounds 'super horrible' and painful to get inserted.

Managing a lot of known unknowns and the work of knowing yourself

Ultimately, in negotiating what matters when it comes to contraceptive strategies and potential side effects and contraceptive benefits, important questions are raised around what feels painful or invasive, what the nature of hormones are to you, how you relate to your body, and how you make sense of side effects with others and in society. These are relational negotiations with people, matter, structures, and discourses. But it is also a deeply self-reflexive negotiation and involves work of knowing and having insight into what matters to you personally. Something that involves needing to know or figure out what your body, mind and self wants, needs, or enjoys. Knowing yourself, of course, is not an easy task at any age, but perhaps especially in your youth. The task feels more like one of handling multiple, ever-changing known unknowns, rather than failing to reach the "right" knowledge.

The process of knowing yourself and knowing what matters to you can never be truly complete. Who you are, what you might need, how you function, and what

you prefer when it comes to contraceptive strategies is not static and will likely be subject to change and development. This can even be the case with seemingly straightforward questions, such as whether you are a forgetful person or not, something which is commonly asked in contraceptive counselling in conjunction with considering being on the pill or not. Pim, for example, shared that they started using the pill when they were young, but realised after some time that – due to their ADHD – they found it difficult to remember to routinely take them.

Knowing what you want and think, and being certain and assertive, is often valued as a sign of maturity and intelligence. Yet, in a world of unknowns and uncertainties, the process and project of feeling certain is arduous. In Sandra's case, this resulted in some discomfort in talking about micro experiences of contraceptives rather than sexual and reproductive politics at a macro level.

> Marie: So, have you felt that it's easier to talk about more macro [issues]?
>
> Sandra: Yes, absolutely. And it's a bit "ovant" [unusual/unaccustomed] to turn these questions on yourself, when you work with it, and I have trained in not being private. When I think about myself, not my political opinions, then I cannot answer straight up. I don't know what I think. It's "ovant". I usually reflect a lot. I usually have clear opinions. To discover a duality in one's feelings… it's a bit "ovant" to feel *I don't know* (Sandra)

Not everyone felt uncomfortable or uneasy in the same way as Sandra when it came to feeling uncertain or unclear about what they thought of a certain issue or experience. Many, however, shared her experience that it was not an automatic thing to know what you feel and think about things. This might be most clearly exemplified in the following exchange between myself and William when discussing the ambivalence of expressing your definitive views in the interview context,

> Marie: Does it feel difficult to have that (*Willliam chuckles*) "kluvenhet" [split feeling]. Maybe is the wrong word.
>
> William: No, no… I don't think about it much except for when I am interviewed… mmmhh… mmmh… No, I don't find it so difficult. It doesn't take up so much of my life, feeling "kluven" [feeling split or torn]
>
> Marie: More because of the situation that you started thinking about it?

William: Yes, absolutely. That sounds right. [Marie: "That sounds right"?] *You cannot embarrass yourself like this. Or, say something that is wrong.*

Marie: A lot about right and wrong.

William: Yeah… that is true. That's actually true.

Marie: What is it that is wrong, that you think you could say that is wrong?

William: Sometimes you say something because maybe you're just talking and then you express yourself, and then it's just, "that is sort of how I feel". Don't have good enough words to express. "It is probably right, probably". It is probably an issue with communication.

Marie: It's more difficult to find that right way to express it?

William: Exactly. Exactly. To find the right way. You start down one track, then halfway later. *What? Shouldn't we have said something different?* Instead, you continue with it.

Marie. Difficult to know what you think and feel.

William: Yes, absolutely. That is probably a part of it, that you think that you know yourself. *I can answer that, easily.* "I can answer all the questions" (*self-mockingly*) Yes.

Marie: No, it isn't everything you [William: No exactly] realise that you have reflected on, figured out what you think or feel.

William: Absolutely, it's good with these conversations. Makes you think about, figure out what you think and feel.

Feeling the pressure of needing to know yourself, to have figured out what your thoughts and feelings are about different things can complicate an already complicated and uncertain contraceptive situation. This could result in making choices that you regret or want to change but feel obligated to commit to. This is clearly problematic as it can result in young people, like Sandra, sticking with a contraceptive method that is harming them rather than changing to a different method.

While knowing yourself is incredibly difficult at any age, it might be even more confusing and difficult when you are a child, teenager and young person. Yet it is an important tool when you are in the contraceptive counselling or choice-making situation, and shapes how you advocate for yourself. As Helena explains,

> Like, after all these years I have some flesh on the bones, and I think if I would end up in a situation when like a midwife that was like "test it for another three months", then I would have been able to at least say something and have some sort of response, so that feels good. But, had I as an 18-year-old or even 15, then it wouldn't been something – then I wouldn't have questioned anything. (Helena)

Helena reasoned that she was more able to put her foot down and decide to remove the hormonal coil after experiencing difficult side effects because she was a bit older and felt more empowered and knowledgeable. She felt like she knew what she would say and argue, in contrast to what she assumed her younger self would have been able to. In a way, this was an example of Helena trusting her own embodied experiences and knowing over the advice or suggestion from the midwife about when to stop trying with a particular contraceptive method.

3. Troubling the meaning of choice in contracepting

The process of making contraceptive choices is messy, complicated, and multifaceted. It involves, as I illustrated in the previous chapter, immense work around becoming informed, or trying to become informed, as well as negotiations between different forms of knowledge and considerations of who or what are trustworthy sources of information. Yet, as you might suspect by this point, you can be as informed as you want and still feel stuck and uncertain of what choice to make, because of fundamental systemic limitations and barriers. This brings into question whether it is even meaningful to speak of choice in the first place.

Navigating the contraceptive imperative

Many participants felt the pressure to be on a modern form of contraception, pointing to a sort of contraceptive imperative where you have no excuse not to as it is seen as so accessible in Sweden. Being on contraception has arguably become

part of what it means to become sexually active in Sweden, especially as a young cis woman having sex with cis men. The participant who expressed this feeling most strongly was probably Sally.

> When you get a boyfriend, you get contraceptives. It is part of the deal. You don't want to get pregnant, [or] have an abortion. (…) It felt like a bit like you could not not have a contraceptive method. Even if it sucked. You should have it. I realised you do not have to. Then I was able to remove it. It's been an internal struggle. (…) It's still been a thing, a weird thing that you're in that age where you are supposed to have it. (Sally)

Getting on the pill when you get your period or become legally able to have sex has been a practice across national and cultural contexts (Fennell 2011; Littlejohn 2021). Moreover, this imperative to have or be on some sort of more long-term contraceptive always trumps any discomfort, pain or distress from potential side effects, as the most important thing is to be on something. This was something that Sally expressed feeling frustrated and angry about. She explained how she felt that there was a sense that contraception could not be critiqued, you could not say that they 'suck' and that any reason or choice of not using a LARC or non-condom method as a woman is constructed as irresponsible. I asked whether Sally felt in some way responsible to share her experiences of struggling with contraceptives to counter these notions,

> Sally: Yes, in a way. Because it isn't something you talk about so much. It's only because I know another friend who's had similar problems. To highlight that contraceptive methods are not always great. All women knows that contraceptives suck but you cannot say it. You have to accept it. Just like feel, it's not good. You could question a bit, to feel, that you're not alone with – it was very comforting to have a friend who didn't use contraceptive methods [beyond condoms]. Didn't think I'm crazy. Not like "oh my god, how irresponsible. She's gonna get pregnant.". She can like understand. So, even though you don't talk about so much about side effects maybe because midwives don't talk about it so much. It's ok that it doesn't work.
>
> Marie: Have you ever felt that folks questioned…?
>
> Sally: Not questioned per se, when I removed it. If you have spoken about it, then they have said, "then you can get pregnant". I have gotten a lot of affirmation for why I should keep it. "You can get pregnant. You are supposed to have the extra

> protection". That it hurts or stuff, you haven't wanted to say too much. Nobody has said, "you must take it out – you shouldn't feel like that".

Sally felt great pressure to be on some sort of long-term contraceptive method, and that not doing so was constructed as irresponsible regardless of the significance or seriousness of the issues or side effect she might be struggling with from them. In Sally's case, this became absurd, because her Vestibulitis from the coil had gotten so bad that she could not have penetrative penile-vaginal sex, that is, the reason for having the coil in the first place. Despite this being the case, she still felt a strong contraceptive imperative, frustrated that no one she encountered and shared her struggles with ever suggested she try removing the coil. She explained that she was ultimately helped by a friend of hers who was not on LARCs, as well as a Facebook group she was part of. Yet in the end she felt it was mostly thanks to her own work of learning and investigating how Vestibulitis works and the connections to the coil that eventually empowered her to remove it.

Sally was not the only participant who discussed feeling a pressure to have to use or be on some sort of long-term contraceptive method. Gabriella expressed similar feelings, but specifically reflected on it in relation to the pill: invoking the idea of a similar sort of pill imperative. She explained that, while growing up and in her youth, the pill was the only thing she knew existed,

> Gabriella: (…) If I am not remembering mistakenly, then I felt like it was the only thing that existed. When I found out that there was something called the NuvaRing then I went back to the Youth Centre… It has become unlocked, more contraceptive methods when I got older. I don't know if it's about which ones are subsidised…

In the second interview, Gabriella returned to the feeling of freedom she described when she found out that the pill was not the only contraceptive option she had:

> Marie: It seems like you have been pretty content [Gabriella: Mmh] so what would you say has been fun, or exciting or interesting with contraceptives?
>
> Gabriella: Eh. I think that… that is actually a pretty good question. I think it was pretty fun and interesting when I like realised that you did not need to be on the pill. I remember that pretty clearly. I started on the pill and this it was "skittråkigt" [fucking dull/unfortunate], and I got a lot of stress and anxiety about stuff. *Imagine if I forget to take the pill today?!*

Another way in which this contraceptive imperative was expressed or emerged in participants stories (beyond the more vague and omnipresent feeling of pressure) was in more direct experiences of being pressured by healthcare staff. Nova shared that she felt pressured to go on the pill. As did Sally, in terms of feeling like she had to be on a LARC and being met with what can only be described as anti-condom discourse, reinforcing narratives about condoms not being 'nice' as an argument for using other methods.

The imperative to be on the pill or some sort of long-term contraceptive does seem to be ubiquitous for young people in Sweden, particularly young girls and women who might be at risk of getting pregnant from the sex they are having or want to have. Critiquing contraceptives, elements of contraceptives or the wider structure around them can feel daunting and complicated. Sally explained how she eventually ended up with a different perspective and relationship to contraceptives, no longer feeling like she 'has to have them' and that she can question this norm a bit. I asked if she thought 'this norm that everyone should have contraceptives, (…) has been and is very strong?'

> Yes, a bit connected to this, that it has still been positive. Not having to feel, *now I am going to get pregnant and have to become a housewife,* because you have control. Have gotten stuck in that contraceptives are holy, a feminist symbol. It is good that they exist, but to question it, with abortion. "If you didn't have contraceptives there would be more abortions". But we have safe abortions. We didn't back in the day. There are other ways not to get pregnant. It feels like there has been such a strong norm, that it has been positive. "Do you have endo[metriosis] then it will help you!". The answer to all the problems is contraceptives. That it would be empowering. Like that. And I mean it is, it is a really good thing, but it doesn't work. I still got anxiety from the coil. It isn't so empowering to lie at home with anxiety. Women – to suffer in silence. My grandma worked at a pharmacy, has read a lot of sexology. Many women after giving birth suffer in silence. People suffer with, everything with women's healthcare. You cannot question, "because we have gotten so far". As a feminist, you cannot question, because it is something that is supposed to be good for you. A bit holy. They are trying at least. But to be able to question it, to demand more. You should be able to demand better contraceptives. And putting it on men that they should take some responsibility. (Sally)

Sally's frustration and anger about the current contraceptive landscape and culture in Sweden related to a few different things: what she sees as an inadequate system,

the systemic gendered inequalities within it, and the sense that you cannot point that out and demand better. Even in her anger she is still deeply reflexive, like all participants were, about the complexity and nuance of the situation, both historically and in present day, and conscious of the immense power and benefit of being able to control if and when you get pregnant.

Helena also spoke to this norm, and feeling like you cannot express unhappiness or complain about contraceptives methods. She was annoyed with what she saw as a common response to any complaints raised against contraceptives, '"if you are unhappy with them, then get pregnant!"', finding this to be a deeply flawed argument to make.

> (…) I think also that there is something in it that, you realise that the argument is pretty easy to fall back on. "Well, if you're discontent, then get pregnant". That would not have been said if you had a headache and like shouldn't care about other stuff. Then you can of course, if you want to look at it from that perspective, say that women's health in general is deprioritised. It scares me to have gone around for so many years with different side effects and everything else and sought so much help in that way. There is no one that really gives a proper answer and, in a way, it has been me who has solved my own problem, which is pretty nuts. (Helena)

Both Helena and Sally raised extremely crucial questions about the system in which contraceptive counselling and care functions and the way it is structured and approached. As they both discuss, and as has been argued repeatedly over the years by feminist medical sociologists, feminist STS scholars and the like (Martin 1987, 1991, 1999; Haraway 1988; Clarke 1998; Clarke and Olesen 1999; Segal et al. 2004; Inhorn et al. 2009; Ernst and Horwath 2013), the medical and healthcare system cannot be understood as a neutral, objective practice or institution. Not only in terms of permeating sexism and misogyny, but also racism, classism, ageism, ableism, homophobia, and transphobia. As such, the idea of the contraceptive imperative (or the pill or LARC imperative) must be understood within a wider social, historical, and cultural context. A context in which women have been responsible for pregnancy prevention, where some women have been encouraged to reproduce and others to not: where some people's sexual lives and practices have been deemed desirable and others deviant (Rubin 1992).

Scrambling through the contraceptive market: longing for more and better choices

The development from the pill imperative to the contraceptive (especially LARC) imperative, resulted for several young people in feelings of frustration and stuckness. Anna was frustrated and angry with hormonal methods in general,

> (…) I have had, I stopped using… the pill. But then I went over to. I mean, I am a bit angry (*chuckles*) in a way that there needs to be something better… for your biological process, if it supposed to prevent pregnancy. But also, eeeh. Or STIs, if you have sex with, if I have sex with a person with a penis. But, otherwise it is good. I have still gotten a bit annoyed that it affects me, more hormones and such in a way. It makes me a bit angry. It has been rough from… the pill to the coil. And it was horrible, so damn painful. It is a lot better with mood swings, but yes. A bit agonising. (Anna)

I remember listening to Anna recount this, and her ambivalent feelings, going from moments of anger and frustrations, to shrinking back, more defensively as if feeling the need to take of the edge off of her emphatic critique. Later in this interview, I asked whether she wanted to continue using the coil. She was surprised by my question and the notion: 'yes, I mean, that question I have never asked myself. Maybe I will continue after this one has to be taken out. Intriguing thought…'.

Many participants wished that there were more options and methods for people with penises. Anna argued, 'I would like to see that men can have a method that is not condoms' as a way to take more responsibility in heterosexual encounters. Sally shared this view, and questioned the notion that it would not be logistically possible to develop more male contraceptives: 'logistically, it feels easier for a guy, than the female reproductive system (…) it is easier to shut down. Something good for, trustworthy, that men can use and does not affect too badly. So, I don't feel like I need to put myself in early menopause'.

William, the only heterosexual man amongst the young people I met within this study, shared these sentiments. In our first interview we discussed emerging male contraceptives. William said that he easily would have been interested in this kind of method even if he were single. He explained that it would feel "extra secure", but also 'it is not that I do not trust my sexual partners but there is a feeling that when my ejaculation has left me then she can do whatever she wants.

It isn't mine. That can feel insecure. It is not up to me what happens after that. It would have been really nice not to have to feel that way'.

William explained that he would like to feel more in control over his reproduction and whether he would be part of someone getting pregnant or not. As such, he was very positive about the idea of using another more long-acting contraceptive method himself.

> William: If she chose to keep it, then I would have found that really hard. Oh yeah, even harder position if you think about, like what should you do there. Now it is more general/abstract than just me if a person has. In the end I think that it is up to my girlfriend, or the person that has the child in them. The question is what you can demand of this other person? If the person is clear about that we should abort, but the other person does not want to abort. Should there be a demand that the other one cannot? "Then you can do it yourself". Or can you demand that?
>
> Marie: What do you yourself think?
>
> William: It is a bit my opinion that I think abortion should be the standard. But that is easy for me to say. But that, I guess I have a feel that, maybe selfishly, that I make someone pregnant, and I have been clear that I do not support it, then you get to do it, but I will not support that the child is kept. Then I feel a feeling that I can, then it is not my responsibility anymore. And maybe that is not right. Maybe I will change my mind in the future. Right now, in the phase of my life that I am in, then it would really ruin. If it was a one-time hook-up and not a fixed relationship. If you are clear with it, but make sure you talk about it before, so that a child is not kept in the belief that you'll do it together. And, if you want to become a single parent, then they should be able to do that. That is nothing crazy. It is possible in the world we are living in; many people do that. More services. You can get help. But I think it is reasonable that I should not have to take responsibility for… I think.

It has been found before that some men wish that there were more options available for them when it comes to pregnancy prevention (Nguyen and Jacobsohn 2023) despite common narratives or tropes arguing that men would never take them or be responsible enough to do so (Oudshoorn 1999). The issues of responsibility, agency, and choice can feel messy and complicated. As such, I can empathise with William's situation and stress. It further highlights why it is vital for the contraceptive repertoire to increase to include methods for people with penises so that the responsibility and ability for non-condom

methods does not only fall on those able to get pregnant, and so that men and people with penises have options and more control over their own reproductive bodies and capacities.

The ethos and notion of making informed contraceptive choices comes across as understandable and fair one at first glance. However, as I hope I have shown over these last two empirical chapters, a continued emphasis on individual choice-making does not question the inequalities or gaps in the system within which that choice is being made. What makes a method good or bad and what the pros or cons are, differ for people for both structural and individual reasons.

Side effects from contraceptives, especially hormonal ones, are repeatedly produced as an individualised concern: as a matter of individual preference or compatibility, rather than systemic problems, placing the responsibility primarily on the individual rather than structural conditions or institutions. This displaces responsibility and accountability from any societal actor, like pharmaceutical companies, the healthcare sector or the state. I suggest that more attention is needed unpacking the wider contexts and capacities for contraceptive choice-making, particularly when it comes to pregnancy prevention methods.

I have argued previously (Larsson 2016) that a useful explanatory metaphor for the current contraceptive contexts for young people can be illustrated in the difference between a supermarket and a monopoly. In the current contraceptive landscape and regime, there exist a variety of contraceptive technologies for people that can get pregnant: a series of (imperfect) options to choose between. For people with penises, however, there is essentially only one: condoms. While the vasectomy exists, it is usually ever considered by older individuals and seldom suggested as an option for people making their different sexual debuts.

Elaine Lissner has also referred to the structure of women's contraceptive reality as that of a contraceptive supermarket based on 'the concept that since no method is right for everybody, a variety of methods should be available' (Lissner 1994, 53). This metaphorical supermarket is more akin to a free market where the pressure is placed on the individual consumer to make the right choice for them, rather than the onus being on the producer to provide high-quality options. Within this contraceptive supermarket, women and people who can get pregnant have a range of options to choose from created to fulfil slightly different contraceptive needs. The good individual consumer then has the task to become

informed about these options and test them until the right one is found, best suiting their needs.

The contraceptive context and regime for men and people with penises, on the other hand, is rather that of a monopoly where the pressure is placed on the producer, rather than the individual consumer. In this context, it is difficult for a new method to break into the market, so to speak, despite there being a clear need. This explanatory metaphor of the contraceptive supermarket can also be seen in participants narratives within this study. Gabriella, for example, discussed that a bad contraceptive method is one where you are rushed into a decision, not being properly informed and making the wrong ones:

> And in that case, it might be that the person chooses something that does not suit them and then that is a pretty bad contraceptive method. But I feel that all contraceptive methods that exist on the market today can be good or bad, there are those that feel good from having a routine and taking a pill every day. I don't know. So, I can imagine that there are not so many bad contraceptive methods but that a contraceptive method can be very bad for you. (Gabriella)

Regardless of whether you put onus and responsibility on the market, the individual or the system, many participants ended up in a situation where they described it as nearly impossible to make a contraceptive choice. A situation where everything feels like a bad option, but you are still attributed agency to choose and be responsible. For participants, this question often boiled down to when a method was worth it or not.

> Marie: Right now, today, is it ok – the way you want to have it – or acceptable?
>
> Sally: Yes, I do not need to worry about pregnancies too much. Not about contraceptives. But, I'm thinking, I am still pretty young, like when I am 30. I've got ten years left. You can feel a bit frustrated. I don't want the coil again, but I don't want anything else either. If you in the future want something. That you, like, *will I need to feel like shit then?* That feels a bit rough. That you know that you had maybe the best alternative and that was very bad. Yes. I become annoyed. That like, it is always on women. I am bisexual but I have only had sex with men. But maybe I will dump my boyfriend and become lesbian. This like, *what the hell should I do* way of thinking. If it is with a man, then it's screwed.

Like many of the participants in this study, I believe that people who can get pregnant should be able to demand and ask for better contraceptive alternatives that are less invasive and harmful for one's physical and mental health. As it stands, it makes sense that it continues to feel like a 'plague or cholera' situation for many young people needing pregnancy prevention methods. As Helena hopelessly proclaimed and questioned on a few different occasions during our interviews, 'is there like any option where I do not suffer?'. Ultimately, the bar for what counts as acceptable contraceptive options must be raised before it is possible to speak of meaningful contraceptive choice-making.

Conclusion

The powerful discourse and ethos of making informed contraceptive choices has not always been as present within sexual and reproductive healthcare or the Swedish contraceptive landscape as it is today. It is rather a recent notion which fundamentally shape healthcare experiences, echoing modern approaches to the role of the patient and the patient-provider relationship. In this neoliberal healthcare and medical landscape, the patient turns into a consumer and autonomous choice-maker Yet, as I have shown and argued throughout this chapter, this understanding of choice-making, especially when it comes to young people's choices of contraceptives, is highly misleading and deceiving. The process of making contracepting choices is rather a series of complex decisions both directly and indirectly related to contraceptive methods, that requires work at different epistemic, emotional, and relational levels.

By exploring the participating young people's experiences and practices with contraceptives, I have cast light on the complex, relational negotiations involved in these processes of choice-making. This includes making sense and choosing what embodied matters matter when it comes to pain, hormones, and naturalness; considering what type of side effects present a problem to you and which ones can be accepted; and, if you are someone who can get pregnant, navigating a rather powerful contraceptive imperative. What matters for individuals when it comes to contracepting differs depending on one's relationship to a variety of factors and matters, often making it less than straightforward to identify a contraceptive option that suits.

Ultimately, informed contraceptive choice-making is rather best understood as an ongoing, relational, and complex negotiation. A negotiation done by young people in relation to and with a range of actors, institutions and often competing knowledge regimes and in context where choice is structurally constrained. I want to recognise the extensive, hard work this requires of young people and echo the call and wish many participants expressed to develop and provide better contracepting options to choose from. And, crucially, to consider how to better resource and support young people in doing this work.

Chapter 9. Conclusion

In coming closer to the end of this research project, I found myself lingering on the importance of recognition. That is, the importance of not only making visible – but recognising and engaging with – the impact, complexity, and relational dynamics involved in contracepting as a young person. The concept of work has been key in this task. By exploring and analysing stories of contraceptive experiences and practices of young people in Sweden, I have started identifying and recognising what this work can involve for different people, within particular contexts, and at different times in one's lives. In doing so, I hope to have nuanced the story of contraception beyond being a matter of individual, informed rational decision-making. At this point it feels safe to say that it is not. The work of contracepting is embedded in relationships and relationalities, involves continuously becoming (rather than being) informed, and involves choices strongly curtailed and conditioned by the structures and society within which young people exist. My hope is that that the reader, like me, has gained new critical perspectives and better insight into what STI and pregnancy prevention can entail for young people, and the ongoing multifaceted work it can require.

Before looking ahead and considering future endeavours and paths, I want to pause and take stock of the findings of this thesis and reflect on lessons learned from some of the experiences and challenges encountered while conducting this study. As such, in this concluding chapter, I will start off by giving a summary of the thesis and the main findings of this research project. After this I will reflect on some of the limitations of the study. This will then be followed by discussing the wider implications and key contributions from this study, including some suggestions for future research pathways. I will then end on my final reflections and a closure from a perspective of critical optimism.

1. Taking stock: significant findings and some limitations

Throughout the chapters of this thesis there have been a range of important findings – some more specific, and others more fundamental and wider reaching. In this section I want to underscore what I see as the most crucial and significant findings while summarising the thesis, followed by some reflections on challenges and limitations.

Summarising the thesis and revisiting the research puzzle

I started this thesis by familiarizing the readers with the phenomenon of contraception more broadly– clarifying terms and providing an outline of common contraceptive methods for pregnancy and STI prevention. I painted a rough picture of the Swedish contraceptive landscape and current trends and patterns regarding contraceptive use in Sweden among young people. I also outlined my motivations for doing this research alongside the project's wider aims, as well as the research questions that have guided me throughout this endeavour. These questions focused on identifying and describing some of the *everyday practices and experiences of contracepting as young person in Sweden, what they involve*, and *what the conceptual lens of work can reveal about these practices and experiences*.

In the second chapter, I provided a review of the ways in which contraception has been researched previously. I noted that previous contraceptive studies have centred on women who can get pregnant as well as men who have sex with men, largely erasing experiences of trans and non-binary people, women who have sex with women, and men who have sex with women. Regarding young people's contracepting and sexual-reproductive lives, the dominance of narratives of risk continue, alongside persistent concerns with exploring contracepting through the singular lens of informed decision-making and choice-making. I argued that the empirical gaps in the literature are even more pronounced in Sweden, as there are extremely few studies that explore contracepting beyond the medical sphere, through more critical approaches, and as a social phenomenon that is engaged in by more than solely a limited group of women. The main sociological contributions to studying contraceptives that I instead foregrounded included

studies highlighting contracepting as feminised work and more than a physical burden; research emphasising pleasure and sexual acceptability; critical studies of medicine and health which consider different forms of knowing beyond the medical and which challenge the notion of the rational individual and the idealised responsible sexual citizens; and, critiques of the neoliberal view of contraceptive choice-making. Finally, I observed that these sociological contributions mainly refer to the US context, highlighting the need for more social and critical research in other national contexts, including Sweden.

In the third chapter, I presented the wider theoretical framework and primary conceptual tools used within this study. I explained how I investigate contracepting as ongoing doings and practices that can include both pregnancy and STI prevention. I also presented the central concept of *work*, arguing that it can help one better understand what efforts, resources, skills, and knowledges often go into trying to prevent unwanted pregnancies or STIs. Additionally, I presented the main work-based concepts that aided and shaped my analysis, namely: invisible work, household and care work, epistemic and emotion work, and patient and articulation work. Finally, I argued for the importance of understanding work contextually, relationally and through a critical lens that considers the role and function of power in the work of contracepting.

In the fourth chapter, I accounted for methodological starting points, processes, and choices of the thesis, including how these were shaped by feminist and critical methodological perspectives. I described how I designed the study to cast light on experiences and practices of contracepting, including relying on qualitative in-depth interviews and the importance of the follow-up interview. I presented how I went about recruiting participants and provided methodological reflections on the research design with a particular emphasis on the interview encounter and the recruitment process. Finally, I presented the analytical approach and process of the research, including how I generated the empirical material, identified analytical leads using a broadly thematic approach, and went about analysing stories and accounts of contracepting, influenced by narrative inquiry and critical optimism.

In the four chapters that followed, I shifted from setting the scene and presenting the theoretical and methodological framework of the thesis to its substantive chapters. Namely, the main empirical and analytical findings where I started exploring what the participating young people's experiences and practices of doing the work of contracepting involved in different relational contexts.

In the first empirical chapter (chapter five), I raised and discussed the *importance of friends* in the work of contracepting as a young person. I illustrated the crucial emotional and practical support they often provide young people, especially within the epistemic dimensions of the work of contracepting. The playfulness, non-instrumentality, collectiveness, and mutuality found in many young people's friendship relationships seem particularly important for creating an environment of support and care. Yet, despite not being normatively responsible for other young people's sexual practices, themes around responsibility towards friends still emerged: out of care but also care functioning as control. Some participants also shared stories that pointed to persisting normative boundaries, taboos, and stigmatised topics even among friends. Ultimately, I argued that young people's relationships to friends are diverse and can be helpful, comforting, caring, controlling, and much more. There is cause for optimism, without naively romanticising the power of friendship, about the role friends and friendly communities play for young people's contracepting experiences. This also raises an important reflection on the sector often overlooking this key actor in shaping young people experiences and practices, in favour of working through schools and families, which participants were much more critical of as effective contributors to their contracepting strategies.

In the second empirical chapter (chapter six), I focused on a different relational context, namely long-term sexual relationships, and explored practices and experiences of *sharing the work* of contracepting in these contexts. Some similar dynamics emerged to that between friends, specifically around sharing elements of the epistemic work of contracepting: exploring, experimenting, and talking about possible contraceptive strategies. However, talk in this relational context served additional instrumental functions compared to interactions between friends, and gender played a significant role in shaping the experiences of and possibilities for sharing the work of contracepting, especially regarding pregnancy prevention. The egalitarian ideal of sharing the burden of contracepting continues to be influential among participants as well as Swedish society at large. Yet, in unpacking practices and feelings around trying to go about sharing this work, we find that sharing the burden is easier said than done as the current contraceptive system sets significant material limitations on what elements of contracepting can be shared in real terms, especially when pregnancy prevention is a concern. As such, I found that another theme in long-term sexual relationships where pregnancy prevention was a concern was the emotion work involved in navigating

the notion, ideal, and practice of sharing the work of contracepting. With this chapter, I particularly wanted to cast light on the wider structural issues that set the boundaries for what young people in long-term sexual relationships can share: challenges that sometimes cannot be solved at the individual level.

In the third and fourth empirical chapters (chapters seven and eight), I critically engaged with the participant's work of contracepting in relation to medical and healthcare actors and discourses. In chapter seven, I specifically explored the work of *becoming informed* about contracepting. The work of contracepting is done in both formal and informal societal spheres and spaces, including medical and healthcare institutions and actors. These actors did play important roles in the participants' stories around researching and evaluating contraceptive options. In engaging with these epistemic authorities, participants were highly reflexive – sometimes resisting norms and discourses they found problematic. With that said, most of the work of becoming informed about contracepting was still found outside of the medical and healthcare setting, carried out by young people themselves. It included needing to navigate a range of viewpoints and opinions held by others and by yourself, revealing the work of becoming informed about contracepting as a complex, multifaceted endeavour that is ongoing, active, relational, and reflexive. Becoming informed about contraceptives, as the stories of the participants showed, included managing many uncertainties which the conventional view of making informed contraceptive choices does not consider. Concepts like patient work, on the other hand, can help cast light on the in-depth epistemic work involved in contracepting and problematise what it means to be meaningfully informed.

In the final empirical chapter (chapter eight), I explored and analysed the work of *making contraceptive choices* as a young person in Sweden. Contemporary contraceptive counselling fundamentally draws from an ethos of individuals making informed contraceptive choices. However, while wanting to enable young sexual-reproductive actors to do so is understandable, a fundamental question remains of what meaningful choice-making entails and to what extent it is possible in the current sexual and reproductive landscape. In this chapter, I showed that making contracepting choices is in fact a series of complex decisions both directly and indirectly related to contraceptive methods, and something that requires work at different epistemic, emotional and relational levels. I explained that what matters for individuals in making contracepting choices differs depending on one's relationship to a range of factors and matters beyond the relative

effectiveness of the contraceptive method, often making it challenging to identify a suitable contraceptive option and leaving participants with ambivalent feelings as they chose between flawed options using limited knowledge. In fact, the work of making contracepting choices was revealed as structurally constrained, highlighting the importance of considering what other questions we must ask around resourcing and support young sexual-reproductive actors in the work of contracepting.

By understanding contracepting critically and relationally, we can better understand contracepting as everyday work that often involves ongoing negotiations with matter, knowledges, discourses, narratives, people, structures and places. As the reader hopefully sees at this point, contracepting as a young person in Sweden involves a lot of negotiation and navigation of varied and complex types of interpersonal relationships and relationalities with a range of actors (both human and non-human), including others' ideas, thoughts, feelings, understandings, and beliefs about what are right/wrong, in/appropriate, un/reasonable, un/fair and ir/rational contraceptive practices in different situations. Young people find creative ways to manage this work, including relying on friends and friendly communities, as well as taking on the mantle of contraceptive researchers in their own right. However, challenges remain and there is still much scope for improvement. I look forward to continuing the conversation that I hope these findings might inspire and generate.

Reflecting on some challenges in and limits to the study

Research is a continuously evolving and changing process, particularly long-term research projects such as a PhD thesis. The shape and content of this study has been adjusted along the way, based on new learning, insights, feedback and critical engagement from colleagues, supervisors, students, participants, and others I have spoken to about my research. As with any piece of rigorous research, you do your best to address limitations and mitigate them, but some limits will inevitably remain. In this section, I want to reflect on some of these.

The first is a returning one, namely relying on the term "contraception" to speak of both pregnancy and STI prevention strategies and technologies. As I noted in the introduction, the linguistic limitation of contraception is something I have grappled with throughout. Choosing to bring together pregnancy and STI prevention in the definition of contraceptives, and thus the work of contracepting,

can be seen as risking obscuring one or even both subjects. In English, the word contraception connotes meanings of fertility, conception, and pregnancy prevention despite the word also being used to reference STI preventing methods. Thus, while I may *wish* for the work of contracepting to signify both STI and pregnancy prevention, if the signifier – the word itself – communicates something rather different, then there is clearly an issue. While I have felt that my definition feels solidly justified, choosing a word to carry the signification has been far less straightforward. After having researched, reflected, and discussed this with a wide range of colleagues, I have yet to produce what I see as a more viable or effective alternative to contraceptive in English. Fundamentally, it is difficult to break away from the linguistic hegemony of pregnancy in this sphere while still keeping the concept relevant to commonly used understandings of these practices. It might be that the meaning of contraception, like many words and concepts, ends up shifting while it travels between languages, disciplines, and fields, and eventually ends up being understood in the general imagination as something that relates to both pregnancy *and* STI prevention endeavours. Either way, I would encourage all of us interested in studying contracepting, sexual health and sexuality to continue these discussions and engagements with language.

A second aspect I want to return to and reflect on is the limitations of *work*, or rather, the limits of using work as an entry-point when studying sex, sexuality, and contracepting. I have already argued that the boundaries between work and the sphere of fun, pleasure and play is neither clear nor dichotomous. As the concept of playbour has highlighted, sometimes work can be fun and can involve play, just as fun and play can take work. In fact, contraception can be understood as one of the clearest examples of this: the work you do to enjoy the fun and pleasure of sex. With that said, the notion of the work of contracepting does centralise the non-pleasurable aspects, and other frameworks may cast light in ways that better highlights the role of pleasure in contracepting. It is not antithetical to it, but I think it requires an explicit effort to seek out discussions of pleasure as well as an explicit engagement with the notion and meaning of pleasure itself. There can be pleasure, or something akin to pleasure, in the work of contracepting. I tried to query into participant's views of what makes contraception fun or sexy and I have highlighted some of the more fun or pleasurable aspects in the empirical chapters. However, I still feel like I only really scratched the surface and that there is more to explore. I imagine that a different entry point is needed other than or alongside work to capture such facets more fully.

The third limitations I want raise is related to the scope of the study vis-à-vis recruitment. In my desire to explore and utilise *the work of contracepting* as a conceptual framework, I tried to ensure that different types of stories of young people contracepting were included as much as possible. As such, my recruitment was broad, with the only real inclusion factors being living in the area where we could meet for an interview, being aged 18-29 and having had some sort of experience with contracepting. However, by casting a very wide net and bringing in a range of experience, there is a risk of flattening and homogenising these experiences, of folding them into each other. In hindsight, I wonder whether I tried to do too much, keen to get a little bit of everything rather than homing in on a few distinct analytical categories, such as looking at how the work of contracepting is shaped (in different ways and in conjunction with other categories of difference) by gender identity, class, or race more specifically. As I discussed in the methods chapter, I encountered a challenge within my very open and broad recruitment call in that mainly white heterosexual cis women reached out to take part. This was probably unsurprising as they have been constructed, historically and in research, as the ideal and normative contraceptive user. In my methodology chapter I even reflected on this as very tangible indicator of how powerful that norm is. Future research on contracepting may want to consider this in designing studies that allow for a more nuanced exploration of specific experiences with contraceptives.

The final aspect I wanted to raise were the limitations posed by the methodological decision to conduct some of the interviews online or over the phone when Covid-19 interrupted the ongoing fieldwork. Realising that the impact of the pandemic would be long-lasting, I decided to finish my interviewing during the 2020 through a mix of outdoor as well as online and phone interviews. I am glad that the technological infrastructure afforded this option, especially when I was able to conduct interviews with video and audio. However, while I did my best to prepare for interviewing in this way, I still see a difference in quality and depth between the interviews conducted face-to-face compared to those done virtually or over the phone. Without the casual interactions and more organic relationship-building that an in-person encounter affords, achieving the same level of connection and depth is challenging. For many people conversations over the phone or video can be more mentally draining than speaking in person. My in-person interviews were often longer and more in-depth than others, and I felt that I was usually able to establish a better rapport and connection in face-to-face

interviews. Having said that, the fact that I was able to continue and complete my interviews at all in the context of the pandemic was crucial for being able to complete this thesis.

2. Looking ahead: wider implications and future research

Having summarised and highlighted some of the key findings of this thesis as well as some of the limits of the study, I now want to look ahead. I will highlight what I see as the main implications and most important contributions of this study for other researchers, as well as possible generative perspectives and pathways for future research projects.

Wider implications and key contributions of this study

The purpose of my theoretical and empirical work has been to try to make visible, recognise and engage with the activities and efforts involved in contracepting for young people. This involved treating the work of contracepting as more than one-off achievements or tasks, such as using a condom or having an IUD inserted. As a researcher, employing the concept of work has been part of the strategy to make visible and utterable activities and efforts often sidelined, unseen, or unrecognised (or not recognised enough) in academic research on sexual and reproductive health (both social scientific and medical). And through that, to enable different conversations and imaginations, and show that there is more that can be done to make the work of contracepting easier, less burdensome, more shareable, more enjoyable and fairer. Talking about the work involved in contracepting is a different way to enter the conversation around sexual and reproductive health and wellbeing, one that relies on a more open-ended understanding of the underlying problem.

As such, the main contribution and wider implication from my work for scholarly audiences is undoubtedly the theoretical and conceptual framework of this project captured in its title: *the work of contracepting*. Even before the publication of this thesis and the earlier stages of conceptualisation, my conceptual approach and way of analysing contraceptive experiences and practices resonated

widely – by receiving questions of how it could be referenced and referred to. This has been immensely encouraging. The purpose of the work of contracepting as an analytical framework is that it can, and is meant to, be employed by others, and become further developed in the process. As I have shown through its employment in this thesis, the perspective shift that it provides enables researchers to cast light on facets of contracepting experiences that were previously obscured.

A second scholarly contribution that I want to highlight is my theorising and critical view of work, which has wider implications for sociological engagement with work and labour more generally. I have taken on a broader definition of work, inspired by feminist and medical sociological theorisation around work, and argued that it is not the activity in itself but the context and experience of carrying out the activity that determines its quality as work. To repeat, an activity can be or require more or less work depending on the wider social context and the relationship between the person or persons doing the work, the nature of the work and the wider context in which the work is carried out. As such, the personal experience of doing the work is what is key and what should be our concern as researchers, policymakers, educators, and healthcare professionals. Depending on circumstances, social location and structural positioning in society in terms of intersecting privilege and oppression, one contraceptive activity might be a non-issue for someone while it is laborious, difficult, or tiring for another.

Throughout the thesis I have also made the choice of using the term *contracepting*, highlighting strategies for pregnancy and/or STI prevention as a doing that is ongoing and relational. I believe this is another important intervention in fields interesting in studying contraception, that again provides a shift in perspective. Going from having our gaze fixed firmly on the endpoint of correct, appropriate. and effective contraceptive use to an ongoing process with no fixed or predetermined start, end point or goal. This resulting use of contracept*ing* is due to my wider relational approach, which considers a variety of relational actors (including human and non-human actors) and understands relationships as the contexts for and in which young people do the work of contracepting. This relational approach is another crucial contribution to the study of contraception as a social phenomenon.

Another contribution that emerges from my relational approach is the ability to cast light on the wider structural matters besides interpersonal challenges at the individual level. As became evident with the Covid-19 pandemic, historical, cultural, and temporally specific circumstances clearly affect and shape how the

work of contracepting can be done and what it involves, significantly limiting choices. In 2020, as Youth Centres in Sweden closed down for in-person consultations, midwives were only able to prescribe the pill to young people seeking contraceptive options beyond ordering condoms for pregnancy prevention. While this is no longer the case, similar situations can occur again. What does that mean and imply for young people's ability to make contraceptive choices?

I believe that as scholars we need to contribute towards shifting the conversation as a society we currently focus on so ardently. From keeping the issue of informed contraceptive choice at the individual level to looking at the bigger picture: the spaces, contexts, and systems in which young people are demanded to make supposedly informed contraceptive choices and widen the support, recognition and resources provided to young people in doing this work. Perhaps then, we can start working towards more structural, fundamental societal change when it comes to pregnancy and STI prevention experiences. Part of this effort is taking more extensive range of matters besides relative contraceptive efficacy into account and seriously. A contraceptive method's relative efficacy is not the only factor that matters when it comes to contracepting or making choices around contracepting. In fact, in prioritising effectiveness above all else, patient-centred contraceptive counselling is ultimately undermined (Brian et al. 2020, 319).

Considering future research: generative perspectives and pathways

Building on several points raised in the previous section, I will now summarise some suggestions for further research: potential perspectives and onward paths.

Firstly, I would suggest that there is great need for research that critically engages with and analyses problem constructions in the field of contraception, or if I were to use Carol Bacchi's (2009) influential analytical framework: what is the problem represented to be here? Too often a field of research can become stuck in shared pre-set ideas of what the research problem is, which as we can see in the context of contraception, often comes from the perspective of different institutions or the state. Instead, I would welcome research endeavours that ultimately asks new questions and unpacks what the problem is. I believe one path to doing so in contraceptive research is to better centre the person, exploring what it means and involves for different communities and individuals in their own lives. This means pausing and reflecting on what one is trying to achieve and what

problem representation one's questions reflect before moving ahead to solutions. Starting from a sexual and reproductive justice framework coupled with critical qualitative methodologies can help us immensely in doing this – enabling us to question the historical and structural conditions that shape contracepting as well as contraceptive research.

The second suggestion for future research relates to the kind of perspectives one might take as starting points, or to avoid, as researchers. There is a need for structural analyses and considerations that does not only responsibilise the individual. The analyses need to actively counter pathologising, moralistic and risk-centric narratives and make space for pleasure and joy rather than shame and blame. What the work of contracepting can entail and how it is made more or less possible or difficult depends, as we have seen, on the context. Yet, we have only started to scratch the surface and more research is needed to continue casting light on contraceptive activities and experiences that thus far have been sidelined. I welcome empirical studies conducted across different contexts and demographics that can help us further investigate what the work of contracepting can involve. The analytical framework of *the work of contracepting* can help researchers to structure their analysis in these efforts.

One such specific relevant context to explore is the work of contracepting in relation to sex work. As a group already engaging with sex as work, sex workers' experiences and insights would be invaluable in further exploring this concept. I suspect there may also be similar dynamics found in societal discourse and research dynamics around sex work, particularly in the Swedish context, as that of young people's sexual lives. There is little research taking sex worker's experiences and practices seriously in Sweden (Levy and Jakobsson 2014, 594) and societal debates around sex work are fraught with moral panics and both direct or indirect stigmatising of sex work and sex workers (Levy and Jakobsson 2014; Bettio et al. 2017; Weitzer 2018; Bullock 2023; Thapar-Björkert et al. 2023). As such, I welcome research critically engaging with the structural conditions and experiences of sex workers when it comes to contracepting.

Another relevant context to explore is the particular intersection of race, racism and the work of contracepting in Sweden. As I noted in the literature review, Sweden has long been painted as a progressive utopia and "exceptional" on a range matters, including sex and contraception. Such sensationalist accounts are simplistic and one-dimensional, and obscure the oppressive historical dynamics that have shaped and continue to shape experiences and practices of

contracepting. Sweden has a long history of eugenic practices and contraceptive coercion (Broberg and Roll-Hansen 1996; Hyatt 1998; Byrman 2001). In more recent years there have been some notable cases in Sweden of medical violence and racism, especially when it comes to reproductive care. In November 2022 a debate article (Hillerberg et al. 2022) went viral which was written by 18 people from the healthcare sector and anti-racist organisations calling for end to racism in maternity care. The article prompted wider societal debates and some politicians called for increased knowledge about racism in Swedish healthcare (Anon. 2023). I want to echo these calls and the need to challenge structural racism in Swedish sexual and reproductive healthcare. I suggest that this should include qualitative studies of young racialised people's experiences of contracepting in Sweden based on an understanding of racism as everyday and institutional (Kristoffersson et al. 2021; Kristoffersson and Hamberg 2022), and compounded by gender, gender identity, class and sexuality (Mulinari and Neergaard 2017).

The final suggestion for future research that I want to mention concerns the possibility of imagining and producing different contraceptive futures that go beyond solely technophobic or technophilic accounts. As feminist STS scholars such as Donna Haraway (Haraway 1991; Markussen et al. 2000) have raised, scientific and technological developments are neither inherently good, moral and inevitable, nor bad, dangerous and scary. Contraceptive technological developments are possible and, as is the case of male contraceptives, the reason there are so few is not because of supposed scientific barriers but rather social ones. Heterosexual men have for long been silent and invisible in the contraceptive imagination. This needs to change, including monitoring and shining a light on current ongoing and future trials for new male contraceptive methods. Additionally, the need for more, or rather better, contraceptive methods remains. This includes male and female non-hormonal methods, since these are increasingly being called for by young people. Such research needs to be funded and supported across the board and, I would suggest, carried out in collaboration with social scientists.

A critically optimistic and hopeful closure

> Marie: We have spoken quite a lot about the past, and looked back, and the current situation, about what it looks like now. But, if you look ahead, how do you envision your own contraceptive future? What do you think it will look like?
>
> Nova: You hope that there will be new contraceptive methods that I can try. Like that. It feels like, even if it is pretty awesome with the current contraceptive methods it still feels a bit like, we can go to the moon! I mean, what the hell? Come on. There are some things that feel a bit old fashioned.

I started this project with ambivalent feelings around the topic of contraception. Ambivalence that you might expect remains unresolved. Yet, I do feel more critically optimistic and hopeful – maybe not only because I need it, but because the participants and young people out there need it. One of the things I asked towards the end of my interviews was what an ideal contraceptive method would look like to the participant. I asked them to dream big and think in an ideal, utopian scenario.

Often, their visions were still grounded in tangible conditions in the present. Some dreamed of methods that are less painful, that you do not need to think about every day, that rebalance more towards men or reduce the likelihood of getting an STI like a vaccine. Others dreamed a bit more creatively, like Sandra who imagined with a chuckle, 'having something in the body, like a chip that you can control from your phone when you are about to have sex would have been practical'. I enjoyed these exercises and, moving forward, I would like to continue the journey from narrating pasts and presents towards collectively imagining, and thus configuring, different contraceptive futures.

There is power in exercising one's imagination: in enabling ourselves to dream bigger and better, and imagining how things could be otherwise. This is partly what sociology has taught me and what I see as one of the strengths of our discipline. Change does take time and there is still a way to go before better or radically different contraceptive technologies exist. But we must continue to imagine and demand better, and not settle for something that is not good enough.

In the meantime, there are tangible actions one can take (besides going into research and development of new contraceptive technologies), including resourcing and supporting young people better. This takes work and effort, and creating relational contexts of care and respect free from judgment and moral

panics. Something that all of us can do (whether you are younger or older, lay person or professional) is better understand the emotional, mental, and epistemic dimensions involved in the work of contracepting, and consider how the burden of these can be lessened or shared.

Making a full circle and to return to contraceptive historian Norman Himes, I want to end by reiterating that there always seems to have been a desire to contracept, and this will continue to be the case. Yet, *how* contraception has been possible or impossible, done or carried out, and by *whom*, under what *circumstances* and with what associated *meanings* and *consequences* is something that is constantly changing and shifting – however slightly or slowly. I am critically optimistic about a future where young people's sexual lives are defined not by adult anxieties but enjoyment and care, and in which the work of contracepting is done in similar conditions.

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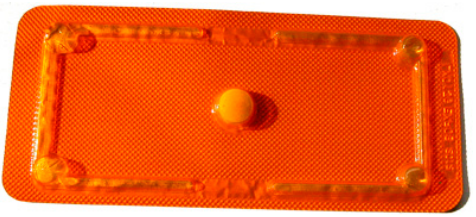
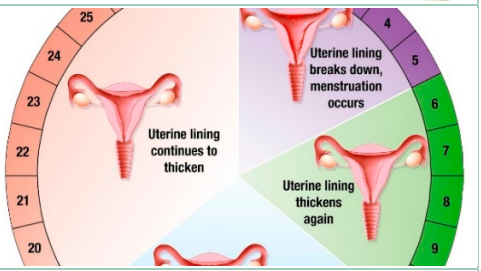
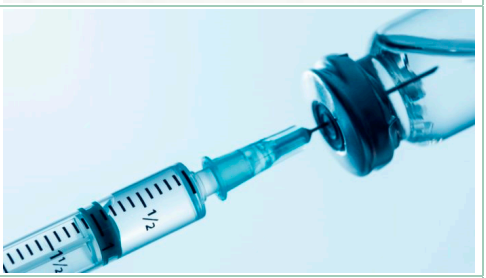
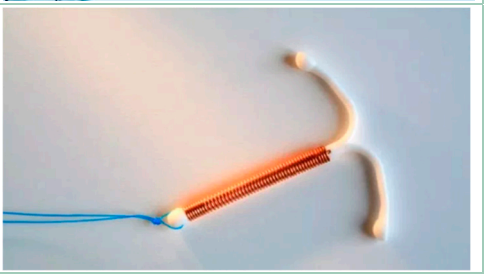
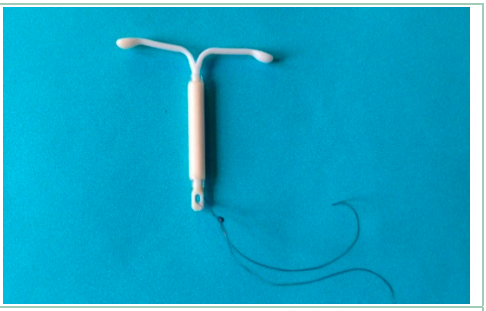
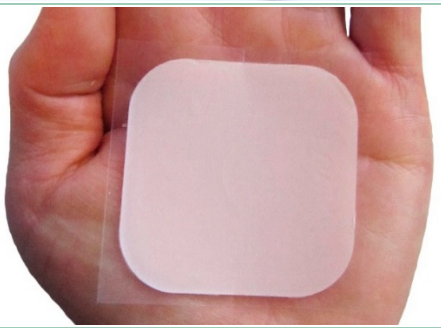
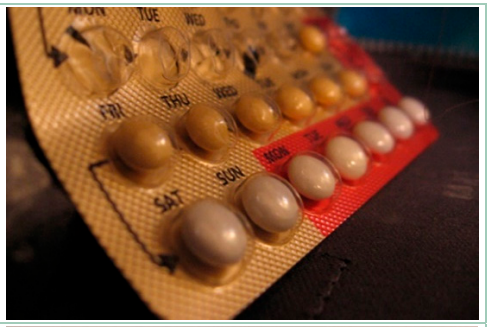
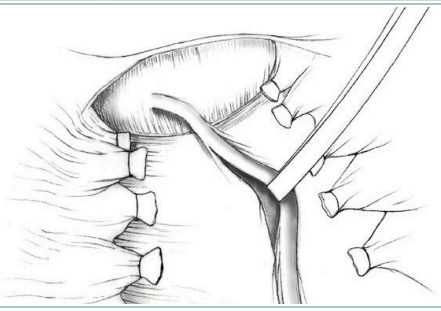
Appendices

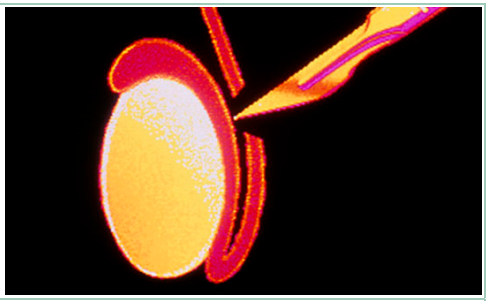
Appendix A: Some contraceptive methods and strategies for preventing pregnancies or STIs

Contraceptive method (alphabetical order)	In Swedish	Example image
Condom (penile, external)	Kondom, extern kondom	
Condom (vaginal, internal)	Vaginal kondom, femidom, intern kondom	
Dental dam	Slicklapp	

Emergency contraceptives	Akutpreventivmedel	
Fertility awareness-methods	Fertilitetsförståelse	
Implantable birth control	P-stav	
Injections	P-spruta	
Intrauterine device (IUDs) or coil, copper	Kopparspiral	

Intrauterine devices (IUDs) or coil, hormonal	Hormonspiral	
Mini-Pill (progestin only pill)	Minipiller	
Patch	P-plåster	
Pessary	Pessar	

Pill (combination pill)	P-piller	
Post-Exposure Prophylaxis (PEP)	Postexponeringsprofylax (PEP)	
Pre-Exposure Prophylaxis (PrEP)	Preexpositionsprofylax (PrEP)	
Rhythm method	Rytmmetoden, säkra perioder	
Sterilisation (hysterectomy)	Sterilisering, hysterektomi	

Sterilisation (vasectomy)	Sterilisering, vasektomi	
Vaginal ring	P-ring	

Appendix B: Interview guides (in Swedish)

B1. First interview

Möjliga följdfrågor: Kan du utveckla? Kan du berätta mer om det? Hur kändes det? Kan du ge något exempel?

Introduktionsfrågor

- Alltid bra att få en bild och idé om vem en person är och deras bakgrund när man forskar, så innan vi hoppar in på ämnet p-medel/metoder så undrar jag om du skulle berätta lite allmänt om dig själv?
- Varför kände du att du ville delta?
- Kan du berätta lite om dina erfarenheter av preventivmedel?

Tema 1: Dåtid - första erfarenheter av preventivmedel

- Sexualundervisning: hur var din erfarenhet av det?
- Vad var dina första erfarenheter av preventivmedel?
- Hur lärde du dig om preventivmedel?
- Vilka talade du med om preventivmedel? (familj, vänner, partner, lärare…)
- Finns det några ”preventivmedelsminnen” som sticker ut särskilt?

Tema 2: Nutid – preventivmedelsanvändning idag

- Hur ser din preventivmedelsanvändning ut idag?
- Hur ser du på (olika) preventivmedel idag?
- Vad har du för relation till preventivmedel idag?
- Vad känner du kring din preventivmedelsanvändning idag?
- Vilka talar du med om preventivmedel idag?

Tema 3: Framtid – preventivmedelsanvändning i framtiden

- Om du blickar framåt: hur ser din framtida preventivmedelsanvändning ut?
- Hur vill/önskar du att den framtiden såg ut?

Avslutning

1. Finns det något mer du vill berätta om?

2. Vad tänker du om intervjun?
3. Hur kändes det att prata om dessa frågor? Erfarenheter?

Om del 2 i studien

- Är du fortfarande villig att delta i studiens nästa fas och ses för en till intervju om cirka 3-4 veckor? (upp till dig om du vill skriva något däremellan, ta med denna reflektionsverktyg…)

B2. Second interview

Följdfrågor: Kan du utveckla? Kan du berätta mer om det? Hur kändes det? Kan du ge något exempel? Är det svårt att komma ihåg?

Återkopplingsfrågor

- Hur har det gått/känts/varit sen vi sist talades vid?
- Har du haft möjlighet att titta/tänka kring reflektionsverktyget?
- Kan vi gå igenom dina reflektioner tillsammans där du får berätta vad du tänkte?
- Är det någon fråga som du vill återkomma till?
- Är det något särskilt från när vi såg senast:
    - Vad förvånande dig mest?
    - Vad kommer du ihåg?
    - Hur kändes det att prata om?
    - Väckte det några särskilda tankar efteråt?

Lite mer abstrakt

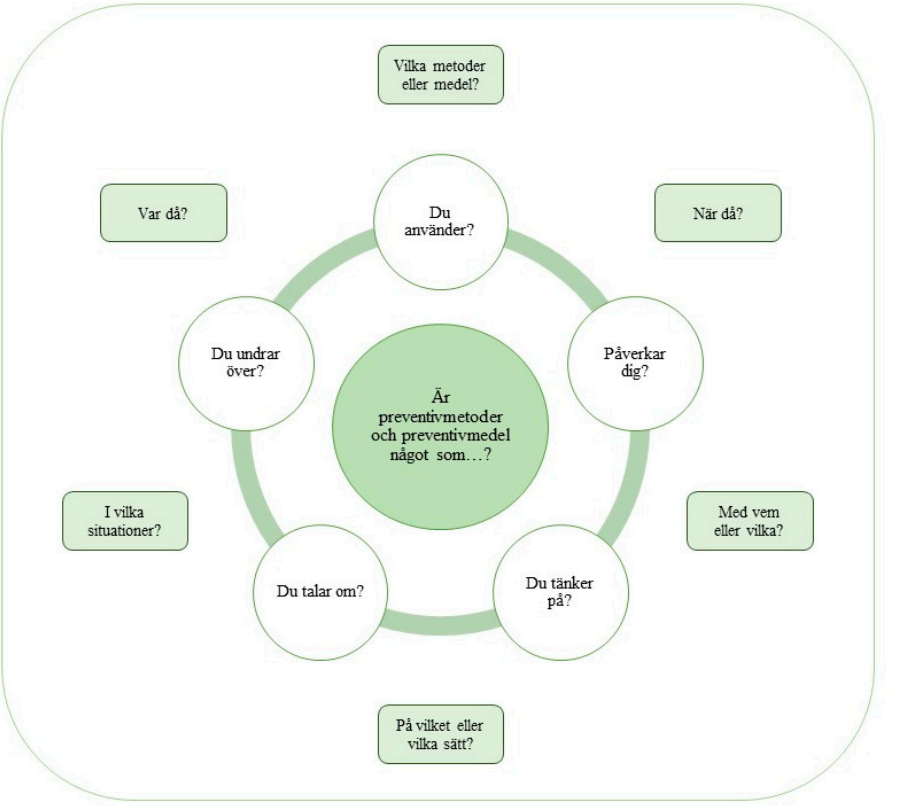
- Vad skulle du säga är ett bra preventivmedel/metod?
- Vad är ett dåligt preventivmedel/metod?
- Vem anser du ska ha eller ta ansvar för p-medel?
- Vad ser du som samhällets roll när det kommer till detta?

Avslutning

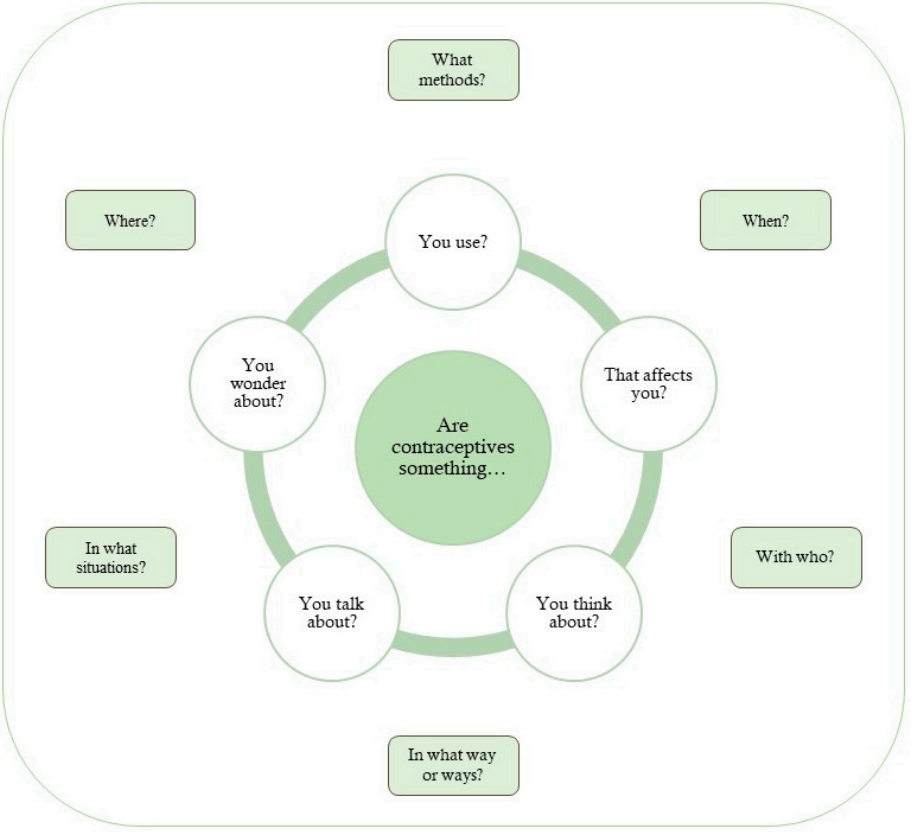
4. Finns det något mer du vill berätta om?
5. Vad tänker du om intervjun?
6. Hur kändes det att prata om dessa frågor? Erfarenheter?

Appendix C: Reflection tool

C1. In Swedish



C2. In English



Appendix D: Recruitment materials for phase I and II of recruitment

D1. Phase I (only in Swedish)

SÖKES: Intervjupersoner för forskningsprojekt om ungas erfarenheter av preventivmetoder (mot könssjukdomar och/eller graviditet)

Jag heter Marie Larsson och jag är doktorand vid Sociologiska institutionen vid Lunds universitet. Just nu söker jag efter personer (cis- och trans- kvinnor, män och icke-binära personer) mellan 18 och 25 år som har erfarenhet av att använda eller ha använt preventivmedel eller andra metoder mot könssjukdomar och/eller graviditet och som kan delta i en till två pilotintervjuer.

Dessa preventivmedel eller metoder kan till exempel vara: kondomer, p-piller, spiraler, p-stav, p-spruta, p-plåster, pessar, femidom, s.k. avbrutet samlag och ”säkra perioder”, PrEP, PEP, sterilisering eller andra metoder.

Jag är intresserad av att höra om dina erfarenheter och upplevelser av att använda preventivmetoder. Din berättelse är värdefull och kan ge ny insikt om vad preventivmedelsanvändning innebär i vardagen, och om hur olika individer och grupper upplever användning av olika preventivmetoder. Det finns för lite forskning på detta område, särskilt när det kommer till normkritiska perspektiv. Syftet med studien är därmed att öka kunskapen och förståelsen för vad det faktiskt innebär att använda preventivmetoder.

Är du intresserad av att delta? Vill du veta mer om projektet eller har du några frågor?

Kontakta då mig via mail på: marie.larsson@soc.lu.se

Du är inte på något sätt förpliktigad att delta i studien och även om du, efter ha fått mer information (muntlig såväl som skriftligt) om projektet, väljer att delta i en intervju kan du när som helst (utan att ange särskild anledning) avbryta din medverkan.

Marie Larsson
Doktorand & forskare
Mail: marie.larsson@soc.lu.se

Sara Eldén
Handledare & huvudansvarig forskare
Mail: sara.elden@soc.lu.se
Telefon: 046-222 03 46

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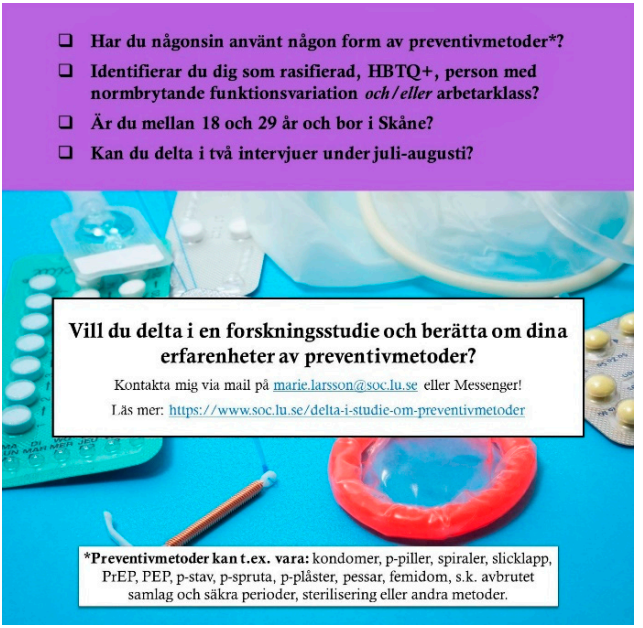
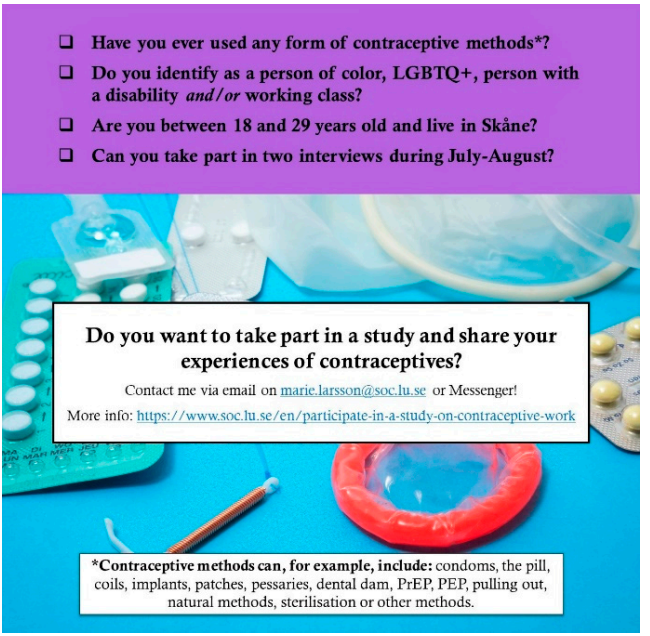
D2. Phase II (social media ad in Swedish and in English)





Appendix E: Information for participants

E1. Information for young people in Swedish

Information för forskningspersoner

Vill du delta i forskningsprojektet *Dåtid, nutid, framtid: en utforskande studie av unga vuxnas preventivmedelsarbete i Sverige*? I detta dokument hittar du information om projektet och vad det innebär att delta.

Vad är det för projekt?

Detta projekt handlar om att undersöka unga vuxnas (mellan 18-29 år) erfarenheter av att använda preventivmetoder/preventivmedel av olika slag. Tidigare forskning har primärt haft ett mediciniskt perspektiv och fokuserat på olika biverkningar av preventivmedel, samt på preventivmedelsval. Dessa studier har främst studerat ciskvinnors erfarenheter. Detta är inte tillräckligt. Jag är intresserad av att undersöka inte bara ciskvinnor utan även män, trans- och icke-binära personers erfarenheter av preventivmetoder/preventivmedel. Jag är även intresserad av att undersöka preventivmedelsanvändning som ett omfångsrikare fenomen som infattar många olika aspekter utöver den medicinska, så som att tänka kring, samtala om, planera ens preventivmedelsanvändning.

Inom projektet kommer jag att prata med unga människor och samla in berättelser om deras erfarenheter och uppfattningar kring preventivmedelsanvändning. Jag vill undersöka hur de resonerar kring och upplever sina metoder för att förhindra könssjukdomar och/eller oönskade graviditeter. Jag kommer också i en annan del av projektet samla in berättelser från de som i sin yrkesroll kommer i kontakt med unga preventivmedelsanvändare, för att få deras perspektiv på denna fråga.

Jag tillfrågar dig som är mellan 18 och 29 år och som har erfarenhet av att använda preventivmetoder/preventivmedel att delta i denna studie. Jag heter Marie Larsson och är doktorand vid Lunds universitet. Övriga medverkande forskare är: Sara Eldén (handledare) och Veronika Burcar Alm (handledare) på Lunds universitet.

Hur går studien till?

Inom studien kommer unga människor intervjuas om deras erfarenheter av att använda preventivmetoder/preventivmedel. Studiens intervjudel med unga går till som följer och är uppdelad i två delar:

1. En första intervju där forskaren samlar in berättelser och historier genom ett informellt samtal om dina erfarenheter och upplevelser av preventivmetoder/preventivmedel. Intervjun kommer att ta ca 2 timmar och spelas in med diktafon, om du samtycker.
2. En andra intervju hålls sedan, ca 2-3 veckor senare, där forskaren och forskningspersoner återkopplar kring ämnet och samtalar om eventuella nya reflektioner och tankar som kommit upp sedan den första intervjun. Intervjun kommer att ta ca 2 timmar och spelas in med diktafon, om du samtycker.

Du kan alltid välja att avstå från att svara på frågor, ta en paus i intervjun, pausa inspelningen eller avbryta ditt deltagande i studien när som helst under datasamlingsprocessen.

Vad händer med dina uppgifter?

Om du samtycker kommer intervjuerna att spelas in med diktafon och transkriberas för att sedan analyseras. Analysen kommer att publiceras i form av vetenskapliga texter (avhandling, vetenskapliga artiklar). Om det inte är möjligt att använda ljudinspelning kommer jag ta anteckningar. När intervjuerna transkriberas, analyseras och renskrivs kommer all data som kan leda till identifiering av dig att tas bort såsom namn eller andra identifierande faktorer.

Du har rätt att få tillgång till alla uppgifter vi samlar in om dig. Du har även rätt till att få en kopia av anteckningar och transkriptioner av dina intervjuer. I ett sådant fall kan du kontakta mig som genomför intervjuerna, Marie Larsson. All data kommer att förvaras på säkert sätt och sparas i 10 år, för att möjliggöra eftergranskning. Kodlistor kommer att förvaras inläst och åtskilt från insamlat datamaterial. Ingen obehörig kommer att få ta del av dina svar.

All personlig information behandlas i enlighet med EU:s dataskyddsförordning. Enligt denna har du rätt att begära tillgång till personuppgifterna som hanteras i studien, och vid behov få eventuella fel rättade. Du kan också begära att uppgifter om dig raderas.

Huvudansvarig för personuppgifter är Åsa Lundqvist, Lunds Universitet. Hon kan kontaktas via e-post på asa.lundqvist@soc.lu.se och telefon på 046-222 87 39.

Hur får du information om resultatet av studien?

Om du önskar få en kopia av publikationer i projektet är du välkommen att kontakta ansvariga för studien.

Allt deltagande är frivilligt

Du kan när som helst välja att avbryta din medverkan i studien, utan att behöva ange ett särskilt skäl.

Om du vill avbryta din medverkan kan du kontakta mig, Marie Larsson, eller huvudansvarig för studien, Sara Eldén. Våra kontaktuppgifter hittar du nedan.

Ansvariga för studien

Marie Larsson

Doktorand & forskare
Mail: marie.larsson@soc.lu.se
Mail: marie.jo.larsson@gmail.com

Sara Eldén

Handledare & huvudansvarig forskare
Mail: sara.elden@soc.lu.se
Telefon: 046-222 0346

Tveka inte att maila eller ringa oss om du har några frågor eller funderingar kring studien eller ditt medverkande!

E2. Information for young people in English

Information for research participants

Do you want to take part in the research project *Pasts, Presents, Futures: exploring young adult's contraceptive work in Sweden?* In this document you will find more information about the study and what taking part involves.

What is the project?

This project investigates young adults' (aged 18 to 29) experiences of using different contraceptive methods. Previous research has often primarily been framed within a medical context, focusing on hormonal side-effects and contraceptive decision-making. These studies have mainly looked at ciswomen's experiences, which is not enough. I am interested in exploring the experiences of using contraceptive methods not only for ciswomen but also men, trans- and nonbinary people. I am also interested in exploring contraceptive use as a broader phenomenon that includes many different aspects in beyond the medical, such as, thinking and talking about as well as planning your contraceptive use.

Within the project, I am going to interview young people and collect stories about their experiences and reflections around contraceptive use. I want to investigate how they make sense of and experience the use of different methods for preventing STIs and/or pregnancies. I will also, as a separate element of the project, collect stories from individuals who in their professional setting work with young contraceptive users in order to get their perspective on this issue.

I am asking you – who are between 18 and 29 years old and has some sort of experience of using or having used some contraceptive methods – to take part in this study. My name is Marie Larsson and I am a PhD candidate at Lund University. Other participating researchers include: Sara Eldén (supervisor) and Veronika Burcar Alm (supervisor) at Lund University.

How will the study be carried out?

In the study, young people will be interviewed about their experiences of using contraceptives. This interview part of the study consists of two parts, and will be carried out as follows:

1. A first interview where the researcher collects stories and histories through an informal conversation about your experiences and reflections on using contraceptive methods. The interview will take about 2 hours and be recorded using a Dictaphone, with your consent.

2. A second interview will be held, about 2-3 weeks later, where the researcher and research participant reconnect with the topic and talk about any potential new reflections and thoughts that have arisen since the first interview. The interview will take about 2 hours and be recorded using a Dictaphone, with your consent.

You can always choose to decline to answer a question, take a break during the interview, pause the recording or withdraw your participation from the study altogether at any time during the data collection process.

What happens to your information?

If you consent, the interviews will be recorded using a Dictaphone and transcribed for analysis. The analysis will be published in different forms of academic texts (PhD thesis, scientific

articles). If it is not possible to use the audio recording, then I will take notes. When the interviews are transcribed, analysed and typed up, all data that could lead to your identification will be removed, such as name and other identifying factors.

You have the right to access all data that we collect about you. You also have the right to receive a copy of notes and interview transcriptions. In such case, you can contact me, Marie Larsson, who is conducting the interview. All data will be safely stored and kept for 10 years, in order to be able to review the material. Coding lists will be kept locked away and separate from the data material. No unauthorised individuals will be able to access your information.

All personal information will be handled in accordance with the EU General Data Protection Regulation. According to this regulation, you have the right to request access to the personal data that is managed in the study, and if necessary, have potential mistakes corrected. You can also ask to have your personal data destroyed. The main person responsible for personal data is Åsa Lundqvist, Lund University. She can be reached via e-mail, asa.lundqvist@soc.lu.se, or phone, 046-222 87 39.

How will you be informed about the results of the study?

If you wish to receive a copy of the publications of the project, you are welcome to contact the responsible researchers for the study.

All participation is voluntary

You can, whenever you choose, withdraw from the study without needing to give a reason why. If you want to withdraw your participation, you can contact me, Marie Larsson, or the head researcher of the study, Sara Eldén. Our contact details can be found below.

Responsible researchers in the study

Marie Larsson

PhD candidate & researcher
Mail: marie.larsson@soc.lu.se
Mail: marie.jo.larsson@gmail.com

Sara Eldén

Supervisor & head researcher
Mail: sara.elden@soc.lu.se
Telefon: 046-222 0346

Do not hesitate to email or call us if you have any questions

or queries about the study or your participation in it!

Appendix F: Information about interview participants questionnaire

F1. In Swedish

Information om intervjudeltagare

OBS! Alla frågor är valfria!

Vilket år är du född?

Hur skulle du beskriva ditt genus/din könsidentitet?

Är du eller har du erfarenhet av att vara transperson?

Hur skulle du beskriva din sexuella läggning/orientering?

Hur skulle du beskriva din etniska tillhörighet/bakgrund och rasifiering?

Hur skulle du beskriva din klassbakgrund och/eller ekonomiska förhållanden?

Anser du dig själv som en person med normbrytande funktionsvariation eller funktionsnedsättning? (Om ja, beskriv gärna)

Vilken pseudonym skulle du föredra att jag använder istället för ditt riktiga namn?

Om du vill att jag ska dela min avhandling med dig när den är färdig, vad är bästa sätt att kontakta dig på (t.ex. email adress)?

Tusen tack!

F2. In English

Information about interview participants

All questions are completely voluntary!

What year were you born?

How would you describe your gender/gender identity?

Do you currently or have you ever identified as a Trans person?

How would you describe your sexual identity/orientation?

How would you describe your ethnic background and race?

How would you describe your class background?

Do you see yourself as someone with a disability? (If yes, please give some more details)

If you want me to share my thesis with you when it is done, what is the best way to get in touch with you? (e.g. email)

Many thanks!

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The Work of Contracepting

The prevention of unwanted pregnancies and sexually transmitted infections, or contracepting, is usually treated as a medical or health issue rather than a social one. As such, a lot of the everyday work that goes into contracepting remains unseen and unrecognised. Young people in particular are often spoken about rather than spoken to when it comes to their contraceptive use. This needs to change. Instead, as is suggested throughout this thesis, we need to listen more to young people and take their perspectives on contraception seriously.

The Work of Contracepting departs from the accounts and stories of thirteen young people with different gender and sexual identities living in Sweden. It casts light on the invisible everyday work that is fundamental to young people's contracepting experiences and practices. This thesis provides an important shift in perspective and new insights into the social phenomenon of contraception. Ultimately, it considers how we can better support each other in doing the work of contracepting, not only as medical professionals, educators, and policymakers, but as partners, family, and friends.

MARIE LARSSON is a social researcher interested in gender, sexuality, reproduction, emotions, intimate relationships, critical theory, feminist technoscience, and qualitative methods. She has a background in sociology, having studied and carried out research in both Scotland and Sweden.

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