

Men and Masculinities in Sexual Healthcare

Exploring Notions and Discourses among Healthcare Professionals

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“This is a place where masculinity becomes something difficult.”

Participant in focus group seven

ABSTRACT

Aim: Healthcare professionals (HCP) have been described as vital for men's experiences of sexual healthcare (SHC). However, HCPs in SHC have to a low extent been included in research on men and masculinity. The aim of this thesis was to explore HCPs' attitudes, notions and discourses on men and masculinities in the SHC context. Notions about men and masculinities were explored in Study I. How HCPs construct gendered social location in SHC was explored in Study II.

Methods: Data were gathered through seven focus group interviews (n=35) with HCPs working with men's SHC at a primary healthcare clinic and at sexual health clinics in Sweden. HCPs notions of men and masculinities were analysed using qualitative content analysis. The construction of the gendered social location in SHC was analysed using critical discourse analysis.

Results: In the analysis we identified that notions of men and masculinities were elusive and hard to grasp but easy to exemplify with normative, idealised and stereotypical masculinity. Further, men and masculinities seemed to be potentially challenging, and some types of masculinities were considered more challenging and situated further from the idealised masculinity. Experienced organisational deficiencies, lack of education and training on men's sexual health and notions of men and masculinities appeared as interrelated. Moreover, we identified that masculinity was considered as something that should be disregarded to stay gender neutral in relation to patients in SHC and that notions of masculinities were situated in a context of personal and private relationships. Romantic and sexual preferences were used to describe preferable masculinity. In the analysis of how the gendered social location in SHC was constructed we found that SHC was positioned in opposition to masculinity in society, which was described as uncondusive with SHC. Furthermore, HCPs' discourses did not reflect a shared approach to men and masculinity and HCPs seemed to lack a shared professional discourse on masculinity. We identified compensatory strategies for the lack of professional discourse. Another finding was that SHC, as an arena, was construed as predominantly feminine in descriptions of its history, practice, staff and patients. The analysis identified that masculinity was constructed as a violation of norms and as a problem that men in SHC need help with. The discourses seemed to position HCPs as agents of change with a mission to transform masculinity, and men as reluctant patients that need extra efforts.

Conclusion: The findings in this qualitative study indicate that HCPs balance private and professional notions of men and masculinities in SHC, and that the discourses on men and masculinities might lead to othering, rather than including, the diversity of men. A shared approach and professional discourse

to men and masculinities could contribute to the creation of a more consistent and knowledge-based treatment of men. To achieve this and to manage the experienced organisational and educational challenges health system interventions are needed, including training and education on men's sexual health, gender and masculinities. Future studies are needed to further explore HCPs' experiences, and in particular, how HCPs' attitudes, notions and discourses are associated with treatment seeking and satisfaction for men in need of SHC.

Keywords: Masculinity, Sexual Health, Attitude of Health Personnel, Focus Groups, Gender, Qualitative Research

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SAMMANFATTNING PÅ SVENSKA

Bakgrund: Tidigare forskning har framhållit hälso- och sjukvårdspersonal (HSP) som betydelsefull för mäns upplevelse av vård för sexuella hälsoproblem. Trots detta har HSP i liten utsträckning varit föremål för forskning om män och maskuliniteter. Syftet med denna licentiatavhandling var att utforska hälso- och sjukvårdspersonalens attityder, föreställningar och diskurser om män och maskuliniteter i relation till vård vid sexuella hälsoproblem. Föreställningar om män och maskuliniteter utforskades i studie I. Hur HSP konstruerar genusbaserad social lokalisering inom vården vid sexuella hälsoproblem utforskades i studie II.

Metoder: Data samlades in genom sju fokusgruppsintervjuer (n=35) med HSP som arbetar med mäns sexuella hälsa på en vårdcentral och på mottagningar som erbjuder vård för sexuella hälsoproblem i Sverige. Personalens föreställningar om män och maskuliniteter analyserades med kvalitativ innehållsanalys. Konstruktionen av genusbaserad social lokalisering analyserades med kritisk diskursanalys.

Resultat: I analysen identifierade vi att maskulinitet som begrepp och fenomen var undflyende och svår att förstå men enkel att exemplifiera utifrån normativa, idealiserad och stereotypa föreställningar om maskulinitet. Maskulinitet verkade vara potentiellt utmanande, och vissa typer av maskuliniteter ansågs vara mer utmanande och mer avlägsna från den idealiserade maskuliniteten. Hur män och maskuliniteter uppfattades verkade hänga samman med upplevda organisatoriska brister och bristande utbildning om mäns sexuella hälsa. Dessutom identifierade vi att HSP strävade efter att vara genusneutrala i relation till patienter och maskulinitet ansågs därför vara något som borde bortses ifrån. HSPs föreställningar om maskuliniteter var inbäddade i personliga och privata relationer och romantiska och sexuella preferenser användes för att beskriva den maskulinitet som HSP föredrog. I analysen av hur genusbaserad social lokalisering konstruerades fann vi att vården för sexuella hälsoproblem ställdes i opposition till maskulinitet i samhället. Maskulinitetsnormer i samhället beskrevs av HSP som missgynnsamma för kliniskt arbete med sexuell hälsa. HSP verkade sakna ett gemensamt förhållningssätt till män och maskulinitet och en gemensam professionell diskurs om maskulinitet. Diskurser är språk betraktat som kunskaps- eller meningssystem och kommunikation som en social process som kan skapa, dela eller påverka förståelse och kunskap, oberoende av talarens intention. Vi identifierade att HSP hanterade avsaknaden av en professionell diskurs med olika diskursiva strategier. Ett annat fynd var att vården för sexuella hälsoproblem, som arena, tolkades som övervägande feminin i beskrivningar av dess historia, praktik, personal och patienter. I analysen

identifierade vi också att maskulinitet konstruerades som ett normbrott och som ett problem som män som söker vård för sexuella hälsoproblem behöver hjälp med. Diskurserna framställde personalen som förändringsagenter med uppdraget att förändra maskulinitet, och män som motvilliga patienter som kräver extra ansträngningar.

Slutsatser: Resultaten i denna kvalitativa studie pekar på att HSP försöker balanserar privata och professionella föreställningar om män och maskuliniteter och att deras diskurser riskerar att andrafiera män, det vill säga framställa män som främmande, snarare än inkludera mångfalden av män. Ett gemensamt förhållningssätt och professionell diskurs skulle kunna bidra till att skapa ett mer konsekvent och kunskapsbaserat bemötande av män. Resultaten visade också att HSP upplevde organisatoriska och utbildningsmässiga utmaningar. För att hantera dessa upplevda utmaningar finns det behov av utvecklingsarbete inom hälso- och sjukvården och av utbildning om mäns sexuella hälsa, genus och maskulinitet. Det behövs fler studier som undersöker HSPs erfarenheter, i synnerhet hur personalens attityder, föreställningar och diskurser relaterar till mäns vårdsökande och upplevelser av vård för sexuell hälsa.

LIST OF PAPERS

This licentiate thesis is based on the following two studies, referred to in the text by their Roman numerals.

- I. Persson, T, Löve, J, Tengelin, E, Hensing, G. Notions About Men and Masculinities Among Health Care Professionals Working With Men's Sexual Health: A Focus Group Study. *Am J Mens Health*. 2022 May-June;16(3):15579883221101274.
- II. Persson, T, Löve, J, Tengelin, E, Hensing, G. Healthcare Professionals' Discourses on Men and Masculinities in Sexual Healthcare: A Focus Group Study. Submitted manuscript.

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ABBREVIATIONS

CDA	Critical discourse analysis
HCP	Healthcare professional
MSM	Men who have sex with men
PHCC	Primary healthcare clinic
SHC	Sexual healthcare
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection

1 INTRODUCTION

1.1 SHORT BACKGROUND

Sexual health is defined by the World Health Organisation as “*a state of physical, emotional, mental and social well-being in relation to sexuality*” (1). This implies that sexual health is multifaceted and that it cannot be reduced to an absence of sexual dysfunction or of ill-health. It also implies that sexual health is closely related to physical and mental health (2-4). The awareness of men’s need for sexual healthcare (SHC) is increasing globally and in Europe (5-7). Even though men seem willing to talk to healthcare professionals (HCPs) about sexual health issues (8, 9), men use SHC to a low extent (7, 10-14). It has been suggested that access to SHC for men is not proportional to their needs (15) and that SHC is not designed for men (16). Related to this are the attitudes and knowledge of HCPs, which can be crucial to how men utilise and experience SHC (17).

1.1.1 MEN’S SEXUAL HEALTH AND UTILISATION OF SEXUAL HEALTHCARE

Sexual health has historically (15) and traditionally (7, 18) been considered a women’s issue, tied to women’s reproductive health (19). There is an increasing recognition that men need SHC, both to promote gender equality by supporting women’s rights and access to SHC (20, 21), and for men’s own sake (22, 23). This SHC includes information, counselling and testing related to sexually transmitted infections (STIs), prevention of unwanted pregnancies, support relating to sexual relationships, information about sexual development and support and services related to sexualised violence (15, 24, 25). It also includes treatment and care of conditions that specifically affect men’s sexual health, e.g. premature ejaculation, erectile dysfunction and late-onset hypogonadism (26, 27).

There is a general lack of systematic information about men’s sexual health in Europe (6) and few surveys are directed at men’s need of SHC. A study on sexual health and care-seeking among adults aged 40–80 years in Northern Europe (including Sweden) reported that only 31% of men with sexual problems sought SHC (28). An American national survey, covering men’s use of SHC, concluded that there were unmet SHC needs for men who have sex with women, especially for men with risk-taking sexual behaviours (7). A population-based survey in Sweden (29) identified that 86.7% of men who reported having problems with their sex life, sexuality or sexual health did not

seek help from healthcare bodies. Of those who sought help, 42.1% reported being partially helped and 23.3% reported not being helped at all. The survey also stated that physical problems and health issues increase with age. It has been argued that the SHC needs of men who have sex with men (MSM) are not being met (30) and that HCPs need to become more aware about the situation and needs of MSM (31).

Men's low use of SHC has been studied and discussed in terms of external and internal factors. An important aspect to consider is the heterogeneity of men and that factors may vary between groups of men (32). For example, young men report stress, denial, fear of stigma, loss of social status, embarrassment, disrespect from HCPs and not knowing where or how to access SHC (32, 33). Older men report views and beliefs about sexual health in society, embarrassment, discrimination, HCPs' lack of knowledge and training and the relationship with HCPs (34). Transgender men report difficulties with the availability of competent care, distress, the characteristics of the SHC setting and the relationship and role of HCPs (35). Even though factors vary between groups, a commonality in these examples is that interactions with HCPs were perceived as a factor in men's use of SHC. A scoping review of men's sexual and reproductive healthcare in the Nordic countries concluded that HCPs' knowledge and attitudes are crucial to their ability to provide healthcare and to men's experiences of SHC (17).

Internationally and in Sweden there is an emerging recognition that sexual health and reproductive health are linked and dependent on the realisation of sexual and reproductive rights (20). The concept of sexual and reproductive health and rights (SRHR) implies that all four components need to be considered in services, interventions and measures which aim to enhance these two areas.

1.1.2 SEXUAL HEALTHCARE IN SWEDEN

Universal access to healthcare is considered a public responsibility in Sweden (36). The healthcare system is primarily funded through general taxes, and patient fees are subsidised (37). Healthcare is separated into primary care, specialist outpatient care and inpatient care. Primary care is responsible for providing all medical assessment and treatment, nursing, preventive work and rehabilitation that does not require special medical or technical resources (36), including general practice, child and maternity health and youth clinics. Primary care units, such as primary healthcare centres (PHCC), do not act as gate keepers to specialised care and patients are free to contact specialists by self-referral (38). Healthcare in Sweden is decentralised. Each region and regional council is responsible for the public healthcare system and for

providing healthcare, including SHC, according to need, within its respective geographical area. The principle of care according to need is regulated in the Swedish Healthcare Act of 2017, which states that:

“The goal of health care is good health and care on equal terms for the entire population. Care must be given with respect for the equal value of all human beings and for the dignity of the individual human being. Those who have the greatest need for health and medical care must be given priority for care.” (36)

According to Sweden’s national strategy for SRHR, Swedish laws assert that the regional councils’ responsibility:

“[...] includes ensuring access to equal and accessible health-promoting, preventive and remedial measures in the area of sexual and reproductive health for all. This also includes targeted and target-group-specific initiatives.” (39)

Care according to need implies that healthcare must be organised so that those who have the greatest need are given priority access to care (40). To identify care needs, knowledge of current and intended conditions is needed. The realisation of care according to need presupposes the availability of treatments and the understanding that needs can be graded.

Sweden has been described as comparatively gender equal, ranking first in the EU’s Gender Equality Index (41) and fifth in the Global Gender Gap Index (42). Gender equality is part of the Swedish “progressive” self-image (43), and a large proportion of Swedish men engage in parenting and domestic tasks (44). However, despite a comparatively equal gender balance in the workforce, the degree of gender segregation at a societal level is high. Occupations, education and organisations are divided along traditional lines of masculinity and femininity (45), and gender stereotypes are prevalent, regarding association between men and masculinity (46). Sweden has a tradition of sexual health promotion aimed at young people, including mandatory sexual health education at schools and the availability of youth clinics, which distribute free condoms and offer free contraceptive services, and free testing for and treatment of STIs (47, 48). According to a national survey, approximately 11% of those who seek care at youth clinics are men (49). All women have access to sexual and reproductive healthcare at medical and gynaecological clinics, maternal care is free and midwives have a unique and central role in providing sexual and reproductive healthcare to women in Sweden (50, 51). According to a national report about men and equality, men

are requesting more clinics and better opportunities to seek help and gain information about sexual health (52). Efforts are being made to improve access to SHC for men, and a few new clinics are opening, mostly in inner-city areas. Most of these are aimed at younger men (18-30 years old). However, adult men's SHC in Sweden has been described as scarce regarding the availability of clinics specialising in men's SHC, and knowledge of men's sexual health is limited among HCPs (17, 53). Andrology, the medical speciality that deals with men's sexual and reproductive health, is not officially defined by the National Board of Health and Welfare in Sweden or recognised as a medical speciality. The organisation of the healthcare system, the lack of a holistic approach to men's sexual health and the low priority given to men's sexual health have all been identified as barriers within the healthcare system for men's SHC in Nordic countries, including Sweden (17). As primary care is first-line healthcare, it plays an important role in men's access to SHC. But men's SHC in Swedish primary care has been described as being in "*everybody's interest but no one's assigned responsibility*" (54). The availability of formal education and further training for HCPs is low (17, 53). In a comparison between the National Prescribed Drug Register in Sweden, the National Patient Register in Sweden, and international studies, Pousette (53) stated that there are probably severe underdiagnoses and undertreatment of andrological conditions in Sweden. If, as previous studies suggest, there is a lack of medical knowledge and organisational prerequisites considering men's SHC, then this raises questions about how men's SHC can be assessed according to need.

1.2 THEORETICAL APPROACHES

1.2.1 SEX AND GENDER

Sex and gender are interrelated concepts, and both sex and gender influence health (55, 56). In medical and health research, the concepts can be ambiguous (57) and are sometimes conflated (58, 59). It has been argued that there is a need to approach sex and gender from a holistic perspective, and that both, neither, or one or the other may be relevant for exposure and health outcome (55, 59). Sex usually refers to the biological construction of the body, whether defined by anatomy, hormones, or chromosomes, but should not be understood as a binary definition of two exclusive categories, male and female, but rather as a spectrum including intersex variations and subjective identification (58, 60). Gender can be defined as psychosocial-cultural constructs of men, women, non-binary and transgendered persons (61) or as structures of social relations and practices that produce performative distinctions between bodies, based on reproduction (61, 62).

This thesis uses a social constructionist perspective on gender. This approach assumes that gender and gender norms are socially constructed concepts of masculinity and femininity (61-63). In this sense gender is adopted from culture rather than being a role or biologically determined (64), and varies and shifts across time and context, in interaction with other social and political positions, experiences, and identities (65, 66). Stated another way, gender is not a static position or something that resides in a person but rather something that is done, performed, or demonstrated repeatedly in interactions with others (64). This does not mean a denial of physical bodies, but rather that bodies are involved in social practices and structures that create, reshape and define how gender is manifested in and in relation to physical bodies (63).

1.2.2 GENDER AND HEALTHCARE

Gender and gender norms influence health and well-being (67, 68), including sexual health (20). Gender norms in society can be reproduced or reinforced in healthcare systems, which may contribute to gender-based inequalities in health (69). Gender norms in SHC have been described as affecting patients' perception of SHC as gendered (17). Gender bias in medicine and healthcare can negatively impact interaction between patients and HCPs, attitudes of HCPs, clinical decision-making, the design of research and the mediation of medical knowledge (70-73). It has been suggested that healthcare functions as an institution that has the power to determine what is considered healthy behaviour in society (74) and that institutionalised social structures in healthcare can create and reproduce gendered health inequalities (64).

The practice and knowledge of medicine and the healthcare institution have been described as andronormative (75). The concept implies that men and masculinity are constructed as normal or neutral in medicine and healthcare at the expense of women and femininity, and that femininity needs to be deliberately emphasised to be perceived at all. Empirical studies have supported this (76-78). However, some areas of healthcare have been described as designed for women (79). One such area is SHC (7, 9, 16).

Health service research describes, analyses and evaluates the structure, management, economy, organisation, and results of the healthcare system (80, 81). In studies of how healthcare risks create or maintain gendered health inequalities, it is important to examine HCPs. HCPs may play a role in how inequalities arise and are perpetuated (82), since they are key players in facilitating or limiting conditions for patients, based on patients' gender (83).

1.2.3 GENDER DISCOURSES, GENDER NORMS AND GENDER NOTIONS

One of the ways gender is performed is through gender discourses (84). Notions of masculinity and femininity are constructed discursively, i.e. through how we speak, produce symbols and texts, and present ourselves, including our gender identity (84). Gender discourses may construct, maintain, or change gender norms as well as reflect personal notions of gender. An analysis of gender discourses in healthcare and medicine identified that a dominant discourse was “*the gender-specific body*” (85). This discourse was based on other discourses which equated sex with gender, nullified gender by stressing biological differences between male and female bodies, reduced sex to singular aspects of biology (e.g. genitals, hormones, chromosomes or genes) and fragmented bodies into components.

Gender norms are often unspoken rules or expectations on how a person should be, behave and think within a certain context based on their ascribed gender, i.e. gender norms regulate acceptable and preferred attributes and behaviours in specific contexts based on what gender a person is assumed to have (86, 87). Gender norms are upheld and reinforced through various social institutions such as families, schools, labour markets, and healthcare (88). At an individual level, gender norms are internalised through socialisation and upbringing, and conforming to gender norms may have implications for an individual’s health, since behaving in accordance with certain gender norms can be associated with differences in health exposure and outcome (87). Gender norms have been described as particularly persistent, and deviations may incur sanctions from the surrounding community (86). However, changes in policies, legal reforms and individuals’ actions can change or influence which social norms prevail within an institution (62, 89).

In this thesis the term gender notions are defined as conceptions, ideas, beliefs and impressions related to gender, including views on masculinity and femininity.

1.2.4 MEN AND MASCULINITIES

In this thesis the term “man” refers either to someone who can pass as, i.e. be regarded as, a biological male person or as someone whom the participants in Studies I and II identified as or described as male or a man. “Masculinity” refers to the social practices that a person needs to perform in order to pass as a man or be regarded as masculine, but also to the structures that construct and reproduce men’s power over women and transgender people in society, as well as some men’s power over other men (63, 90).

In critical masculinity research, it is suggested that there is not one uniform or common masculinity in all societies and cultures, but many. However, there are always dominant culturally defined ideals of masculinity, the so-called hegemonic masculinity that all men (and everyone else) relate to (63, 90). These cultural ideals can vary and shift between contexts and over time. Hegemonic masculinity or hegemonic discourses are discourses that successfully reproduce power. In large parts of the Western world, including Sweden, hegemonic discourses place expectations on men to be heterosexual, white, robust, independent, physically competent, and emotionally restrictive (91-93). It should be noted that men who conform to hegemonic ideals are not necessarily the most powerful men in society (90).

In addition to hegemonic masculinity, other masculine positions have been suggested (94). Complacent masculinity refers to an assumed majority of men who strive for but do not themselves live up to hegemonic ideals, but who nevertheless receive benefits and privileges from maintaining masculine dominance in society. Subordinate masculinity is a position against which hegemonic masculinity is defined, and which consists of men whose position is excluded from these privileges. Subordinate masculinity is usually exemplified by homosexual men's subordination to heterosexual men (63). Marginalised masculinity describes a lack of qualities that make it possible to conform with hegemonic masculinities, for example, the experience of men of colour in many Western societies (63).

Masculinity has also been described as a social location (95). From this perspective, masculinity is a position that men, women and others can embody by performing masculine practices and masculine attributes in social situations, including institutional practices in healthcare. The position is created and defined in relation to other gender positions such as femininity and un-masculinity, but also in relation to other factors such as age, physical place, sexuality, class, ability and ethnicity (90).

1.2.5 MASCULINITY AND HEALTH

Masculinity has been used as one explanation for the so-called male-female health-survival paradox (64, 91), i.e. that women have a higher life expectancy than men, despite men, globally (96) and in the Nordic countries (97), having fewer disabilities and reporting lower levels of mental and physical illness. The paradox has been associated with men's sexual and reproductive health (27), and masculinity has been described as an internal barrier to men's health seeking (98). Conforming with masculinity includes adopting beliefs and behaviours that increase health and safety risks and avoiding behaviours that promote and preserve health and longevity (99, 100). This includes sexual risk-

taking, including the number of sexual partners, substance use, and attitudes to condom use, to testing for HIV and STIs, and to treatment of HIV (101-103). Stoicism, tolerance of pain and illness, and reluctance to admit needing professional help or support have been described as ways of performing or preserving masculinity (76, 104), which relate to health seeking. It has been suggested that men are more positive about seeking healthcare when health issues may impact traditional masculine performance, such as the ability to work or perform sexually (105). A study in England with high-income men showed that seeking healthcare can be interpreted as performing masculinity by regarding it as taking responsibility, problem solving and taking control (106).

Gendered differences in health literacy have been interpreted in terms of the social construction of masculinity (107), including men's ability to recognise symptoms (108). However, there is a knowledge gap regarding how men's health literacy relates to structural health inequalities (109); for example, how masculinity relates to men having shorter interactions with HCPs and receiving less medical information than women from HCPs (110).

1.3 THE STUDY RATIONALE

Gender biased attitudes and attitudes based on idealised or stereotypical gender norms among HCPs may influence the care provided (70, 75, 111). It has been argued that HCPs can mediate or counteract gendered structures in healthcare (82). Normative assumptions about men in SHC can be important for how men's SHC needs are assessed and treated (112), and patients who have previously experienced prejudiced or normative attitudes from HCPs are less likely to seek care in the future (113). Considering all this and the importance men place on HCPs' attitudes in relation to how they experience SHC (17), it is crucial to understand what notions HCPs have of men and masculinity and how gendered social locations, in terms of men and masculinity, are discursively constructed by HCPs in SHC.

Exploring HCPs' notions of men and masculinities in SHC, and how HCPs construct the gendered social locations of masculinity in SHC, can be an important step in understanding potential gender inequalities in SHC. It may also be important for understanding whether HCPs' notions and discourses influence the creation of barriers that counteract care according to need. The studies in this thesis set out to explore and understand how men and masculinities in SHC are perceived and constructed by HCPs.

2 AIM

The overall aim of this thesis was to explore healthcare professionals' attitudes, notions and discourses of men and masculinities in the sexual healthcare context.

The aim was addressed in two studies with the following objectives:

- I. to explore notions about men and masculinities among HCPs working with men's sexual health in Sweden; specifically, how HCPs think about and describe men and different forms of masculinity from a professional standpoint, and what HCPs perceive to be masculine and un-masculine traits and behaviours.
- II. to explore how HCPs construct gendered social location in SHC, specifically in terms of masculinity and masculinity seen as situated in relationships.

3 METHODS

3.1 RESEARCH DESIGN

The research in this thesis was based on the explorative qualitative epistemological approach, which aims to “*provide an understanding of social behaviour by exploring people’s account of social life*” (114). Both Study I and Study II were designed as qualitative focus group studies. The focus group interview method was chosen because it is suitable for collecting different perspectives on a subject area (115), filling in gaps in understanding, producing complex, nuanced and even contradictory perspectives on the subject (116). The focus groups method is a form of group interview which explicitly uses interaction between participants in a process to clarify and explore views and experiences that would be difficult in a one-on-one interview (117). The method has been described as “*an effective technique for exploring the attitudes and needs of staff*” in healthcare research (118). Focus groups are suitable for exploring potentially sensitive subjects related to health and healthcare, since participants who share experiences are more likely to confide in researchers and elaborate on sensitive topics than they would be in individual interviews (119). The focus group can capture social and group norms and diverse and shared experiences, and bring out information that would not normally come out in individual interviews (119).

In Study I, to explore and capture HCPs’ complex notions of men and masculinity in SHC, qualitative content analysis was chosen (120, 121). This method permits varied levels of abstraction and interpretation of manifest content (an interpretation of the visible and obvious content in a text) and latent content (an interpretation of the underlying meanings in the text) (121). Qualitative content analysis was deemed suitable, as the data were expected to differ in depth and variation.

In Study II, to explore how HCPs construct gendered social location in SHC, a discourse analysis method was chosen. Discourses are language, i.e. text and speech, regarded as “speech acts” or as communicated “systems of meaning”. Discourse analysis examines how experiences, shared understanding and social realities are constructed and shaped through language, irrespective of the speakers’ intention (122). An important aspect of analysing discourses is to investigate interdiscursivity: namely, how a discourse relates to other discourses. The methodological approach we chose was inspired by critical discourse analysis (CDA); specifically, the three-dimensional model described by Fairclough (123). CDA investigates how interpersonal communication

constructs and maintains power, social practice, structures, and knowledge, as well as shaping experiences and identities in relation to settings (123).

3.2 DATA COLLECTION

3.2.1 SETTING

The data in Study I and Study II were collected at clinics which provided SHC for men. Six of the clinics were located in Västra Götaland County, in western Sweden, an area with 49 municipalities and 1.7 million inhabitants receiving care from the regional council (Region Västra Götaland). One of the clinics was located in Stockholm County, in the east of Sweden, an area with 26 municipalities and 2.4 million inhabitants receiving care from the regional council (Region Stockholm). The clinics were selected based on the location and focus of the clinics, to get a broad representation of catchment areas and types of clinics. The following types of clinics were included: PHCC, venereology clinic, youth clinic, reproductive clinic, and men's sexual health clinic. The clinics had the following catchment areas: inner-city, suburb, smaller town, and rural area.

3.2.2 RECRUITMENT AND SAMPLING

In both studies a variation in clinical experience of working with men's sexual health was aimed for. To obtain this, HCPs with varied occupational categories from PHCCs and clinics specialising in men's sexual and reproductive health were invited.

Recruitment was done at clinic level, to facilitate natural conversation and self-disclosure, based on the assumption that participants would be more comfortable talking and sharing within groups who work together. The inclusion criteria were: clinical experience of working with men's sexual health. All HCPs who met the criteria at the clinics were invited to participate together.

The clinics were recruited through the SRHR network in Region Västra Götaland, an inter-organisational network for strategic coordination and development of SRHR in the regional healthcare and public health sector. The network consisted of four geographically sub-divided networks. Information about the studies was sent out in the network's newsletter and by e-mail to key stakeholders in the network, asking them to pass the information on to representatives from sexual and reproductive health clinics and PHCCs within their geographical area.

Nine clinics expressed interest in participating in the study, but three had to withdraw due to time issues. None of the remaining six were PHCCs. Since PHCCs are one of the main providers of adult men's SHC, it was important to include at least one PHCC, so 30 PHCCs suggested by the Research and Development primary healthcare in Region Västra Götaland were contacted and asked to participate. Several expressed interest, but none of those had the availability to participate within the timeframe. A new letter was sent through the SRHR network, resulting in one PHCC choosing to participate.

In all, 35 individuals participated in the studies, ranging from 29 to 71 years old. The occupational categories represented were assistant nurse, assistant physician, counsellor/social worker, general practitioner, midwife, nurse, and psychologist. Sixty-eight-point-six per cent (n=24) of participants were women and 31.4% (n=11) were men.

3.2.3 THE FOCUS GROUP INTERVIEW

Data were collected using audio-recorded focus group interviews. Seven focus groups, with four to six participants each, were conducted at participants' places of work, in rooms that would ensure privacy. Each interview lasted approximately 90 minutes. The interviews were moderated by the first author of Studies I and II (TP) and co-moderated by four different public health researchers. Two of the co-moderators had extensive experience with the focus group method, two had clinical backgrounds and one had experience of sexual health research. The co-moderators' tasks were to identify gaps and contradictions during the interviews, but also to explore lines of reasoning that the moderator might overlook. The co-moderators had no involvement in the study apart from data collection. Notes were taken by both moderator and co-moderators. The moderator monitored group interactions and initiated the interview using a guide (see Appendix). Key questions were:

- Tell us about the men who come here seeking sexual healthcare
- What is it like to meet men seeking sexual healthcare?
- What is masculinity to you?
- What is your perception of the men that come here?
- Are there qualities that you consider to be masculine or un-masculine?

To gain further details, examples, and explanations, and to enable and stimulate the conversation within the group, probes and follow-up questions were used. Examples of probes included:

- Can you give examples?
- Do you all agree with this?
- What do the rest of you think about this?

The interview guide was pilot tested in two focus groups at clinics that provide SHC for men. This is recommended so that questions can be revised or adjusted and to ensure that the interviews are well-organised and produce valuable data (124). The pilot interviews consisted of four and five participants. The audio recordings from the pilot interviews were transcribed and analysed to see if the questions generated relevant data. The questions were not changed, but the order in which they were asked was. Probes were adjusted to ensure further participation from all participants. Data from the pilot interviews were not included in either study.

Audio recordings from the focus group interviews were transcribed by a professional transcription firm. All transcripts were closely read, scrutinised, and adjusted for any errors by the first author of Studies I and II before the texts were analysed.

3.3 DATA ANALYSIS

3.3.1 QUALITATIVE CONTENT ANALYSIS (STUDY I)

In Study I the data were analysed using inductive qualitative content analysis, as described by Graneheim and Lundman (120, 121). The analysis interpreted both manifest content, i.e. the visible and obvious content of the text, and latent content, i.e. the underlying meanings of the text. To obtain an overall sense of the content, the analysis started with an immersion in the data. This was done by reading and re-reading the texts. At this stage each focus group was treated as a separate unit of analysis. The data were then imported into qualitative analysis software (NVivo 11.3.1) and closely examined to determine how they related to the aim and research questions of the study. Words and sections that related to the aim and questions were extracted as meaning units. The meaning units were then condensed and labelled with a code. The next step of the analysis involved searching for patterns, similarities and relationships between codes. Sub-themes were formed by aggregating similar and related codes into higher orders of abstraction. The sub-themes were then organised into preliminary themes that unified the content of the sub-themes.

After formulating three descriptive themes (121), i.e. themes that reflected the explicit content in the data, a theme of meaning was identified (121), i.e. a theme that captured the implicit content. This was done by identifying common

patterns in the descriptive themes, sub-themes and meaning units. The analysis up to this stage was conducted by the first author of Study I (TP) and one of the co-authors of Study I (ET). ET, who had had no prior involvement in the study, could approach the data from a new and open perspective.

Finally, the codes, sub-themes and themes were reviewed and refined within the author group until consensus was reached about the content and naming of the themes. This was an iterative process that involved challenging preliminary findings by revisiting data and notes from the focus groups.

3.3.2 DISCOURSE ANALYSIS (STUDY II)

The data in Study II were analysed using discourse analysis, inspired by CDA, specifically the three-dimensional model described by Fairclough (123). Using the three-dimensional model (Figure 1), the data were analysed in three stages. At each stage, codes were identified as sections of texts that related to the study's aim and research questions.

The first stage analysed the text level. Key words and phrases were identified, which showed how the speakers' attitudes, opinions, and values were constructed.

The second stage analysed discursive practices, i.e. how words and phrases were used in sentences to create change. This included analysing how topics were interpreted and discussed, how values and attitudes were expressed, and how the participants positioned themselves as subjects. It involved an analysis of interdiscursivity, group dynamics, and the organisational cultures.

At the third stage, the text was analysed at the norm level. This included looking at the text in a wider societal, ideological, and political context. At this stage the analysis looked at language as power and identified how discourses were used to construct social relations and practices.

Lastly, codes from all three stages were aggregated in broad themes that illustrated how the three dimensions were interrelated, i.e. how key words and phrases were used in sentences, and how these sentences were used to construct, shape, or question attitudes, norms, traditions and ideologies within the groups, the organisations, and society.



Figure 1. Fairclough's three-dimensional model for CDA.

To mitigate potential preconceptions, and to ensure reliability and transparency (125), coding was initially done independently by the first author of Study II and a co-author (ET). Before codes were aggregated into themes, TP's and ET's codes were compared and reviewed. Finally, the themes and the analyses were revised and refined within the author group.

3.4 ETHICAL CONSIDERATIONS

The studies included in the thesis were approved by the Regional Ethical Review Board in Gothenburg, Sweden (registration number 543-14). Both studies used the same data. As data were collected from HCPs who were interviewed in their professional capacity, the data collection was assessed to have a lower level of ethical risk than interviews with patients or clients. All participation was voluntary, and participants gave oral and written informed consent and were informed that they could withdraw from the study at any time. The interviews were transcribed by a professional transcription service. Names and other detailed information about the participants and the clinics they worked at have been anonymised to ensure confidentiality. Participants were asked not to mention names or other information during the interview that could reveal the identity of patients.

Even if quotes have been selected so that they cannot be traced to individual participants or clinics, it may be that participants can recognise themselves in the published quotes and that they may feel that the quote does not represent

their intention or portray them or their clinics in a favourable way. I have striven to be true to the aims of the studies and the results from the analyses even when this could be potentially uncomfortable.

4 SUMMARY OF RESULTS

This chapter provides a summary of the results in Studies I and II as well as describing how the studies relate to each other. Study I was an exploration of HCPs' notions of men and masculinities in SHC. Two of the findings in Study I were surprising and are in need of further exploration. These were that HCPs perceived masculinity as a potentially problematic social place, or social location, in SHC, and that HCPs' notions of masculinities were situated in participants' personal and private relationships, e.g. romantic, kinship, or sexual relationships, whether these were real or hypothetical. In Study II the construction of the gendered social location of masculinity in SHC was explored, particularly in relation to masculinity seen as situated in relationships.

In total 35 HCPs from seven clinics participated in focus group interviews that were analysed in both studies. A summary of participant characteristics and the distribution of the catchment areas of the clinics can be found in Table 1. Detailed results can be found in Studies I and II.

Table 1. Summary of population characteristics and catchment areas.

Characteristic	n
No. of participants	35
Gender, n (%)	
Female	24 (68.6%)
Male	11 (31.4%)
Age range	29–71 years
Profession, n (%)	
Assistant physician	1 (2.86%)
Counsellor/social worker	5 (14.29%)
General practitioner	3 (8.57%)
Midwife	12 (34.29%)
Nurse	7 (20%)
Nursing assistant	3 (8.57%)
Psychologist	4 (11.43%)
Type of clinic, n	
Primary healthcare clinic	1
Venereological clinic	1
Youth clinic	3
Reproductive clinic	1
Men's sexual health clinic	1
Catchment areas, n	
Inner-city	2
Suburbs	2
Smaller towns	2
Rural area	1

4.1 NOTIONS ABOUT MEN AND MASCULINITIES (STUDY I)

The rationale for Study I was that HCPs' notions about gender may relate to the provision of care, and if care-seeking men are met by HCPs holding idealised or stereotypical notions of masculinities in SHC, this could reinforce barriers to adequate care. Therefore, it was important to understand what these notions entail.

The study aimed to explore notions about men and masculinities among HCPs working with men's sexual health in Sweden; specifically, how HCPs think about and describe men and different forms of masculinity from a professional standpoint, and what HCPs perceive to be masculine and un-masculine traits and behaviours.

Qualitative content analysis of the focus group interviews yielded three descriptive themes and one theme of meaning. The three descriptive themes were:

Contradictory masculinity – elusive but clear. HCPs' notions of masculinity as a phenomenon or as a concept were elusive, i.e. difficult to describe or formulate, whereas traits, behaviours and qualities considered masculine (e.g. being secure, being strong, not showing weakness, being robust and active) and un-masculine (e.g. being camp, being feminine, wanting to be pampered, being too involved in a pregnancy, being fake, being gender queer, being indecisive, being a bad father, not keeping your word, or being giggly) were easily exemplified. These examples reflected normative and stereotypical notions of masculinity.

Sexual healthcare is a social place where men and masculinity can be challenging. Masculinity was perceived as challenging and potentially problematic for HCPs in SHC and for men seeking SHC. Certain expressions of masculinity were considered especially problematic (these included rude, domineering, belittling and provoking behaviours) and certain identities difficult to interact with or relate to (for example rural, older, upper-class, and non-Swedish men). Masculinity was perceived as challenging professionalism in HCPs, and male patients were associated with unwanted sexual tensions. Men seeking SHC were viewed as doing something outside of masculine norms on several levels. Having sexual issues, seeking help, and communicating about sexual issues were all viewed as performing un-masculinity. HCPs considered that their views on men in SHC and masculinity

in SHC were influenced by lacking organisational prerequisites and lacking education and training on men's sexual health and masculinity.

Regarding masculinity as irrelevant – a difficult ambition to achieve. Participants considered gender neutrality to be a professional ambition in SHC. They strove to regard men seeking SHC as patients, humans, individuals or as gender-neutral rather than as men or masculine. However, private and personal notions of men and masculinity were thought by HCPs to affect their professional demeanour in interactions with men seeking SHC.

The theme of meaning was:

Notions of masculinity are relationally situated. HCPs' understandings and views of masculinity were embedded or placed in the context of real or hypothetical personal and private relationships with men. Experiences and preferences in familial, romantic and sexual relationships were used to define HCPs' notions of masculinity and of preferable masculinities in the SHC context.

4.2 DISCOURSES ON MEN AND MASCULINITIES (STUDY II)

Men experience SHC as stressful, heteronormative, potentially sexualised, "tailored for women" and as an experience that makes them feel vulnerable, and HCPs view masculinity as relationally situated and SHC as a social place where men and masculinity can be challenging. The rationale for Study II was to understand how the social location of masculinity was constructed and how HCPs' discourses on men and masculinity related to the construction.

The aim was to explore how HCPs construct gendered social location in SHC, specifically in terms of masculinity and masculinity seen as situated in relationships.

CDA analysis of focus group interviews identified that HCPs' discourses constructed gendered social location in four discursive ways:

By problematising and opposing masculinity in society. Masculinity in society was constructed as inconducive to SHC and as an underlying problem for many men's sexual health issues. HCPs lacked a professional discourse on masculinity and a shared approach to men seeking SHC, apart from the oppositional or critical discourse on masculinity in society.

Through discursive strategies where a professional discourse on men and masculinity is lacking. The lack of a professional discourse was handled by connecting, recontextualising and re-negotiating existing discourses; for instance, validating private attitudes towards masculinity by referencing clinical experiences of men, negotiating the prerogative of interpretation by citing closeness to men and experience of men as patients, or presenting private attitudes as unprofessional but aligned with the oppositional discourse on masculinity in society.

By constructing SHC as a feminine arena where masculinity is a visible norm violation. The SHC profession and the SHC arena were constructed as feminine. SHC was considered to be primarily aimed at, made up of and designed for women. Femininity was portrayed as a socialised ideal and masculinity as a violation of feminine norms. The waiting room was used as a discursive arena to construct masculinity as a visible violation of norms.

By constructing men as reluctant patients and formulating a mission to change masculinity. HCPs interdiscursively linked their discourses on men and masculinity with organisational discourses and institutional expectations of a need to report an increase in the proportion of men seeking SHC. HCPs expressed mixed attitudes, being positive towards men seeking SHC, while men were portrayed as challenging, requiring extra effort from HCPs, and receiving undue praise for seeking SHC. These discourses constructed men as reluctant patients. Masculinity was constructed as problematic for men in need of SHC, and HCPs were construed as agents of change with a professional mission to transform masculinity in patients and society.

5 DISCUSSION

The findings of this thesis contribute to the understanding of HCPs' attitudes, notions and discourse on men and masculinities in SHC. The findings in Study I identified that HCPs balanced personal and professional notions of masculinity and viewed masculinity as ambiguous and potentially problematic in SHC. Furthermore, their understanding was situated in a context of personal, private, and sometimes sexualised relations. HCPs also strived to be gender-neutral in their approach to patients, by regarding men and masculinity as irrelevant. Study II identified how HCPs' discourses positioned SHC in opposition to masculinity in society and that HCPs used discursive solutions to the lack of a shared professional approach to and the lack of a shared professional discourse regarding men and masculinity in SHC. Men were constructed as reluctant patients, SHC as a feminine arena, and masculinity as a norm violation that HCPs aimed to change.

In this chapter the focus will be on how the findings relate to each other and on discussing the findings in relation to other research. This chapter will also critically evaluate the strengths and limitations of the studies.

5.1 RELATIONALLY SITUATED AND NORMATIVE NOTIONS OF MASCULINITY AND THE RISK OF "OTHERING" MEN

One of the main findings in Study I was that HCPs' notions of masculinity were situated or embedded in a context of personal and private relationships. This included romantic and sexual relationships as well as family relations. HCPs' notions about masculinity were in part sexualised and preferable masculine traits; characteristics and behaviours were based on preferences in real and hypothetical intimate relationships. This finding was further investigated in Study II, where we found that personal and relational understandings of masculinity were validated in a professional context by referring to clinical experiences of men. Study II also found that personal closeness to and experiences of men were used to negotiate the prerogative of interpretation about masculinity and men in SHC. A related finding from Study I was that masculinity in SHC was perceived from a primarily heteronormative perspective. This was implicit in descriptions of unwanted sexual tensions between female HCPs and male patients, in discussions about gender differences in routines regarding physical examinations, and in the difficulties experienced in combining notions of masculinity with homosexuality. A

Canadian study of men's experiences of HIV/STI testing found that normative assumptions about patients related to differences in risk assessment, as non-heterosexual men were positioned as being at risk and deviant whereas heterosexual men were assumed to have low risk (112). It has been suggested that heteronormativity may lead to discrimination towards patients who seek SHC in Sweden, and that patient-centred care combined with re-organisation of primary care can be ways to reduce this (126, cf. 127). It has been argued that professional boundaries are especially important in SHC due to the potentially sensitive nature of the subject (128, 129). HCPs' examples of masculine and un-masculine traits, qualities and behaviours largely reflected normative or stereotypical notions of masculinity, and HCPs felt that their notions of masculinity could leak through what they called the professional "*armour*" (Study I). Men who sought SHC were thought of as doing something outside masculinity norms (Study I). HCPs' portrayal of men in SHC as performing un-masculinity can be related to andronormativity in healthcare (75) and to masculinity norms in society. These norms create expectations for men to be emotionally restrictive, robust, and to avoid seeking help or care (63, 64). This could also relate to the somewhat negative image of men and masculinity in SHC that HCPs present in the studies.

In Study II we argued that HCPs' discourses may risk positioning men and masculinity in SHC as the "other" in relation to the construction of masculinity as a violation of norms in SHC, which was constructed as a feminine arena. Othering, i.e. constructing a group of patients as different, can have negative implications for clinical interactions (130, 131). Findings in this thesis indicate that HCPs lack a shared professional approach to masculinity in SHC, and that there is a risk that personal notions and attitudes to masculinity may affect interactions with men seeking SHC. Given that studies have shown that men regard HCPs' attitudes as crucial to the experience of SHC (17), there is a risk that HCPs' discourses based on individual preferences regarding masculinity could play a role in how men experience SHC. However, there is a lack of observational research on how HCPs' notions and discourses are enacted in interactions with men seeking SHC. It has been argued that both sex and gender should be fundamental components in healthcare and medical education (132). Based on the findings in Studies I and II, there seems to be a need for further education regarding gender awareness and a professionalisation of the understanding of gender as a social and cultural construct, as a complement to a biological understanding of sex.

5.2 EDUCATIONAL AND ORGANISATIONAL CONDITIONS FOR PROVIDING MEN'S SHC

In Study I we found that HCPs who lacked training and education on men's sexual health and masculinity related this to how they viewed and experienced working with men's sexual health, including their attitudes to men as patients. In Study II HCPs stated that inadequacies in their professional training and education were the reason for not having a shared approach to men seeking SHC or a shared professional discourse on masculinity. Similar findings were made in a focus group study with Swedish primary care midwives, where a lack of knowledge about andrology was reported to cause insecurities regarding working with men's sexual health (54). Gender inequality in healthcare can partly be explained by implicit biases and social norms that may affect interactions with patients (133-135). In healthcare, implicit biases can be understood as notions which are taken for granted, based on stereotypes (that relate to HCPs' attitudes to patients, assessments of patients' needs, and clinical decision-making). Although reviews of the effects of implicit bias on clinical decision-making and health disparities show mixed results (136), implicit biases have been shown to correlate with lower quality of care (72, 137). It has been suggested that HCPs' social norms and implicit biases are partly socialised or influenced during training and education (134). The findings in this thesis suggest that neither the academic education nor the clinical training of the participating HCPs had prepared them for working with men's SHC, and point to a potential bias in the education system.

Implicit biases can exist at organisational and institutional levels (86). In Study I we found that HCPs experience structural barriers to working with men's SHC. These included a lack of organisational support from management, existing competences being undervalued, and requests for further training being denied. Some participants also reported that their medical records did not accept men's social security numbers (in Sweden social security numbers are gendered). From an organisational standpoint, including the availability of and access to SHC clinics, men's conditions were described as "*a black hole*" and HCPs conditions for working with men's SHC as "*a twilight zone*". It has been argued that the healthcare system needs to change the gendered approach regarding men's access to SHC (17). HCPs in Study II negotiated their own positions in relation to organisational and institutional expectations that sexual health clinics should report a larger proportion of men. These negotiations constructed men as reluctant patients who demand extra effort from HCPs, and constructed HCPs as positive to men as patients, while also problematising giving men who seek SHC undue praise for doing so. Previous studies have

indicated that the HCPs in Sweden are unclear about whose responsibility it is to provide SHC for men (54), and that defects in organisational design, including insufficient goals and guidelines, contribute to uncertainties about addressing sexual health in primary care (126). A focus group study with occupational therapy students in Sweden found that the students wanted managerial support and clinical guidelines regarding sexual health and thought that organisation and management problems were potential barriers to including sexual health in clinical practice (128). Having sufficient organisational resources has been linked with HCPs experiencing a balance between demands and prerequisites as well as manageability (138). The fact that HCPs experience organisational requests or institutional demands for SHC clinics to report a larger proportion of men, while also experiencing structural barriers for providing that care, could lead to these requests or demands being perceived as incongruous with existing conditions. Experiencing organisational constraints in healthcare has been associated with feeling ethical stress (139). Considering also that HCPs stated that formal training and education had not prepared them for working with men's sexual health, and that this related to how HCPs view men and masculinity in SHC, it is likely that all these factors directly affect HCPs' self-perceived ability to offer adequate care for men seeking SHC.

5.3 ATTITUDES TO ADDRESSING MEN'S SEXUAL HEALTH

We identified that HCPs perceived masculinity as potentially problematic in SHC (Study I) and that working with men's SHC was associated with unwanted sexual tensions. Masculinity in SHC was associated with challenging behaviours and experiences, e.g. aggression, belittling and domineering. HCPs discursively constructed men as reluctant patients who require extra effort in SHC (Study II). Despite this, HCPs described themselves as being positive to men seeking SHC. A study with nurses in Swedish primary care associated men's sexual health with treatable physical or medical issues (primarily related to diabetes) (126). These were regarded as easier than women's sexual health issues, which were associated with problems with relationships or psychological problems, which the nurses did not consider their task. This is in line with findings that suggest that healthcare lacks a holistic approach to men's sexual health (17). We identified that HCPs viewed men's sexual health as mechanical or technical (Study I) and discursively reduced men's sexual health and masculinity to physical aspects such as genitals (Study II). However, addressing sexual health can be sensitive for HCPs regardless of patients' gender. Several factors have been reported as

important for HCPs' attitudes to talking about sexual health. These include situational factors, the clinical context, beliefs about and attitudes towards patients, social norms, personal attitudes, and knowledge about sexual health (126, 140-143). In an American study of HCPs' attitudes to sexual health in primary care, addressing sexual health was described as opening "*a can of worms*" (144), due to time constraints, limitations in expertise and that the subject was perceived to be complex and sensitive. Studies have found that men expect or prefer HCPs to initiate conversations about sexual health issues (145-148). An American review identified a gap between HCPs and patients regarding who should address sexual health (149). A study with 88 Swedish nurses identified that 90% understood that disease and treatment could affect patients' sexuality, 80% did not discuss sexual health with patients, and 60% did not feel confident in their ability to do so (150). Perceptions of masculinity as potentially problematic in SHC, combined with discursively constructing men as reluctant patients, may contribute to HCPs not addressing men's sexual health or only addressing physical aspects. However, this must be studied further in future studies. As was suggested previously, further education on gender is needed, and such education should be supplemented with education about sexuality and sexual health. This training should not focus only on factual lectures on biological aspects of sexual health but also on cultural, social and psychological aspects, including training on how to handle sensitive topics in communication and meetings with patients.

5.4 HCPs' PERCEPTION OF MASCULINITY AS A BARRIER TO SHC

The finding that men were discursively constructed as reluctant patients in SHC (Study II) is similar to the view of men in relation to their use of primary healthcare (151). We found that HCPs portrayed men as unaware of their SHC needs and as unsocialised in the SHC context (Study II). Masculinity was perceived as a potential barrier to seeking SHC (Study I) and a potential underlying problem for men's sexual health issues (Study II). It has been argued (152) that men are being portrayed as victims of their own masculinity, and that it is unhelpful to blame or to "*re-educate*" men to be better patients and better at seeking healthcare when the conditions for men's healthcare seeking are not sufficiently explored; for example, if there is no access to HCPs with sufficient training to assess and treat the healthcare needs of men, and if available healthcare services are not designed to meet men's needs (152). We found that HCPs in SHC constructed themselves as agents of change with a mission to transform masculinity (Study II). We also found that HCPs stated that men who sought SHC would, apart from receiving help with the reason

for their encounter, also receive help with their masculinity (Study I). This help was aimed at improving men's help-seeking and ability to communicate about sexual health. These findings show that HCPs perceive men's willingness to seek SHC and their awareness of and ability to talk about their SHC needs as related to their adherence to masculinity. The findings also indicate that HCPs approach masculinity as an internal barrier to men's SHC. If this approach is used as the main explanation for the low proportion of men who seek SHC, then this could limit HCPs' ability to critically examine their own role and the role of the healthcare system in limiting or enhancing the availability and acceptability of men's SHC.

5.5 GENDER NEUTRALITY

In Study I we found that having a gender-neutral professional demeanour and approach to patients in SHC was perceived as a professional ambition. This approach included disregarding patients' gender and perceiving masculinity as irrelevant in SHC. This result was similar to one of the strategies HCPs used in Study II to compensate for a lack of a professional discourse on men and masculinity in SHC. This strategy involved stating that men who sought SHC were not men but patients, gender-neutral, or individuals. We also found that gender neutrality was not always possible to achieve, that private notions of men and masculinity would leak in during interactions with patients (Study I), and that HCPs who used gender neutrality as a discursive strategy also described acting on gendered assumptions in interactions with patients (Study II). It has been argued that denying the impact of gender by claiming gender neutrality in healthcare can be a "*particularly powerful way of doing gender*" (75), as doing so risks dismissing or obscuring gender-related inequalities. HCPs' gender neutrality ambition and discourse can be interpreted as gender blindness, which is a form of gender bias that disregards the potential importance of gender in healthcare (70, 153, 154). The blindness approach to gender or to other social categories (e.g. skin colour) de-emphasises categorisation of individuals by social groups, based on assumptions that ignoring social categories will reduce inequalities. However, the blindness approach has been criticised for obfuscating power structures and has been called "impossible" (154). HCPs' gender-neutral approach can also be interpreted as an unwillingness to disfavour patients based on their gender or to make generalised assumptions about patients, in line with person-centred care. However, in person-centred care, an individual should be understood as embedded in their social, situational and relational context, including their gender (155).

5.6 THE HETEROGENEITY OF MEN AND MASCULINITY IN SHC

Our choice to focus on men and masculinities was in part a practical choice, based on what was perceived as feasible within the time frame of the thesis. It was also based on a genuine interest and on perceived gaps in previous research. That said, it is important to consider that neither the category “men” nor “masculinity” are homogeneous. The concept of multiple masculinities (63) was described in the theoretical approach section in this thesis. It has been argued that masculinity can be used as a lens to understand how different men’s identities, behaviours and health relate to each other (156), and that examining gender can be a starting point in exploring how social locations intersect (157). As stated, the primary focus in Studies I and II was on men and masculinity; however, we found that other social locations were important for HCPs’ notions, attitudes and discourses on men and masculinity in SHC. In Study I we identified that HCPs’ notions of men in SHC varied based on men’s age, ethnicity, and social class. These social locations shaped HCPs’ notions of preferred masculinities in men seeking SHC, as they related to the HCPs’ perception of which men were easy or difficult to communicate with, to interact with, to relate to, and which men had a “correct” view, i.e. shared the HCPs’ views, on sexuality and gender equality. In Study II we found that the HCPs’ lack of a professional discourse and shared approach to men seeking SHC was particularly clear in descriptions of men outside HCPs’ notions of normative masculinity, e.g. transmen and non-heterosexual men. Taken together, these findings indicate potential biases towards certain intersections of men and masculinity in SHC that should be explored further in future research and considered in the design of future initiatives to improve men’s access to SHC.

5.7 CONSIDERING SHC AS A PLACE

SHC was discursively constructed as a feminine arena (Study II). Studies with young Swedish men have reported that they viewed SHC as “*a place for women*” (158) and that they wanted more “*male-friendly*” clinics (159) – this included clinics staffed by male HCPs – and not to have to seek SHC at the same time as women. We found that clinics that exclusively work with men’s SHC were described as separatist rooms (Study II), i.e. as safe spaces for men. It has been suggested that places need to be considered as part of the approach to understanding health inequalities (160, 161), and that the relationship between spaces, places and people should be viewed as having a “*reinforcing*” and “*reciprocal*” relationship (162). This approach includes considering the

power relationships in places (162), as exemplified by a Canadian study of palliative care which demonstrated how structural vulnerabilities and access to care can be enhanced in the intersection between hospitals and clinics, as places, and patients' social power (163). In Study I we reported that SHC was perceived by HCPs as a place where masculinity becomes potentially difficult, and in Study II, we argued that it can be important to consider how the waiting room in SHC clinics and gender expressions intersect, as this intersection risks making masculine bodies a visible violation of feminine norms in SHC. From a neo-materialistic perspective, it has been reasoned that health inequality can be understood in terms of emergent entities which form in interaction between people and "non-human actors", in this case between men, masculinity and the place of SHC (161). Using this perspective, masculinity in SHC or gendered-bodies-in-the-waiting room could be considered emergent entities that could be examined in future research to try to capture how social structures and healthcare seeking interrelate.

5.8 SUMMATION OF RESULTS DISCUSSION

As was mentioned in the introduction, men seem to seek SHC to a low extent (7, 10-14), SHC does not seem to be designed for men (15, 16), and men's health-related behaviours, including avoidance of seeking SHC, have been attributed to masculinity (99-103). The relationships between care needs, access to care and care-seeking are complex and can depend on a variety of factors (164). There have been several investigations of men's health seeking regarding SHC and healthcare more generally (23, 33, 165-168). An integrative review of men's health seeking and men's engagement with general practice revealed structural barriers, including poor availability and challenges to accessibility, and internal barriers, including fear, embarrassment and masculinity (151). It also revealed that men perceived healthcare as providing treatments rather than prevention and that the relationship with their GPs influenced whether they sought help. The findings discussed in this chapter suggest that HCPs experience barriers to providing men's SHC. HCPs report limitations in organisational conditions. Findings suggest a need for a professionalisation in HCPs' understanding of gender in SHC, to avoid the risk of gender blindness and having to rely on private and personal notions of men and masculinities. It also suggests that HCPs need further education and training on men's sexual health, including how to handle sensitive subjects in communication with patients. Education and training are especially important, as HCPs state that the lack of training related to how they view men and masculinities and how they perceive working with men's sexual health. In sum, this thesis suggests that the findings presented here are vital to consider in

relation to men's SHC seeking, as HCPs' notions, attitudes and discourses can be of great importance to men's utilisation and experiences of SHC.

5.9 METHODOLOGICAL CONSIDERATIONS

In qualitative research the researcher is the instrument that investigates social realities using data that contain multiple meanings (169, 170), which can be interpreted in multiple ways (121). As a cisgender man working strategically with SRHR, I was aware when I designed the research project and moderated the focus groups that I had to try to set aside my own experiences and preconceptions and approach the design and interviews from a researcher's perspective (171). For me this meant adopting a curious attitude and diligently questioning my interpretations and understanding of what the participants were telling me. Designing and conducting the research together with tutors, co-moderators, a co-analyst and co-authors assisted greatly in this, as their experiences, identities and skills meant that their approaches differed from mine. This helped me to see assumptions I was making and notions I had that I had not been aware of prior to this research project. An example of this was that initially in the analysis process, I placed too much emphasis on findings which I deemed potentially relevant for strategic development efforts.

The subjectivity of qualitative research can be perceived in medical research contexts as a weakness or a bias (172). However, it has also been reasoned that qualitative research can make significant contributions to "*the creation, application and delivery of healthcare interventions and service provision*" (173), and that it can provide understanding of the context and meaning, and enable the implementation, of quantitative research in medicine and health service research (173, 174).

Masculinity is a complex phenomenon. Understanding all aspects of masculinity in relation to SHC cannot be fully achieved in focus group studies with HCPs. However, this thesis has identified how the participating HCPs perceived men and masculinities in SHC from their professional standpoint and how the gendered social location of masculinity in SHC was constructed in terms of HCPs' discourses.

5.9.1 CONSENSUS AND HIERARCHIES OF OPINION IN FOCUS GROUP INTERVIEWS

What distinguishes focus group interviews from other forms of interview is the interaction between the participants. This is a strength of the method but also something that a moderator needs to be aware of, as interviews involve a

degree of social performance (117). Focus group interviews can be subject to having one or more participants dominating the interview or having hierarchies of opinions (117). To mitigate this, probes and follow-up questions were used, and phrased to further include and encourage divergent opinions and experiences. Despite this, some participants may have felt that they could not express themselves as freely as others. One possible example of this was that participants who identified as men used embodied discourses to a lesser extent while talking about patients (Study II). This could be explained by differences in gendered discourses, or it could be interpreted as men finding it difficult to represent an embodied masculinity in relation to the discursive construction of SHC as a feminine arena. It could also be explained by the fact that fewer men participated in the interviews.

5.9.2 RE-ANALYSING DATA

The same data were used in both studies. This meant that data from Study I were re-analysed for Study II using a new method and asking different questions of the data. It has been argued that re-using qualitative data can strengthen the “*methodological robustness*” and increase the depth and breadth of the insights gained from the data (175). Re-analysing existing data has been suggested when exploring potentially sensitive subjects in health research (176), and we knew from Study I that the subject of masculinities was partly perceived as private. However, when conducting a secondary analysis of qualitative data, it is important to be aware of the degree to which the data fit the aim of the research (177). In both studies the focus was on HCPs and their relation to men and masculinities in SHC. The first study can be said to have explored the “what” and the second the “how”. Study I explored what HCPs’ notions of men and masculinities were, and Study II explored how HCPs constructed the gendered social location in terms of masculinities in SHC. A challenge was to try to find the right balance between disregarding interpretations and conclusions made during the first analysis when we performed the second, and understanding how the results for both studies related to each other. We tried to achieve this by asking ourselves throughout the second analysis process whether the findings were based on the data or on the findings from Study I. Another thing that assisted in this was that the analysis methods differed markedly, which meant that the data could be approached from completely different perspectives in Studies I and II.

5.9.3 TRUSTWORTHINESS

It has been argued that there are no unified or universal criteria for judging validity or quality in qualitative research, and that judging the quality lies in the subjective perspective of the reader (178). This, however, should not

prevent researchers from trying to audit or appraise their own work. It is the researcher's job to help the reader answer the question, "*Can the findings be trusted?*" (179). There are several definitions of trustworthiness. According to Graneheim and Lundman (120), the concept of trustworthiness in qualitative research refers to *credibility*, *dependability*, and *transferability*.

Credibility refers to the collection and analysis of data in relation to the purpose of the study, i.e. do the participants have experiences related to the aim and research questions and are they able to talk about them, does the method of collecting data generate relevant information, and does the analysis suit the aim of the research? Based on the aims of Studies I and II, it was clear that data would be collected from HCPs working with men's SHC, since only they possessed relevant knowledge and experience and were able to talk about this. In the method section I have explained why qualitative content analysis, CDA and focus group interviews were deemed suitable and relevant to the aims and research questions. Another important aspect of credibility is whether the amount of data is sufficient. The amount of data needed depends on the complexity of the focus or topic of the research. The recommended number of focus group interviews needed for homogeneous groups is between four and five, since homogeneity in focus groups contributes to facilitating the ease and smoothness of the conversation (119). In this thesis the participants in each focus group could be described as homogeneous, as they were all HCPs working with men's SHC at the same clinic. However, for complex topics, more interviews can be needed (119). As the complexity of the study topics was unknown, we chose to conduct seven interviews, as well as two pilot interviews. The pilot interviews examined whether the chosen method and the interview guide would generate relevant data to answer the aims of the studies. Credibility also deals with similarities within and differences between themes (120). One way of illustrating this is by choosing representative quotes. In Study I, example quotes were presented in the text and in a table related to sub-themes and themes. In Study II, each line of reasoning within each theme was exemplified with illustrative quotes, either in the form of longer quotes or in the form of key words and phrases.

Dependability concerns consistency in data collection (120) over time. Data for the studies in this thesis were collected over a period of nine months. If data are collected over a long period of time, changes in study design, based on insights gained during the data collection, may alter how questions are asked and probes are used during interviews. To mitigate this, an interview guide was used (see Appendix) during the focus groups which not only specified questions and probes but also included an introductory script that detailed the purpose and procedure of the interviews and described why the participants

had been asked to participate (i.e. in their professional capacity as HCPs working with men's SHC). The script was read aloud at the onset of each interview. The data analysis was not started until all data were collected.

Transferability refers to the degree to which findings can be transferred to other settings and groups (120). Transferability may be suggested by the authors but is in reality judged by the reader. Factors that are important for judging transferability include how the context, data collection and analysis are described, and how details about the study population are presented. As the author of this thesis, I suggest that the findings presented here are transferable to settings with similar healthcare systems and gender dynamics, in Scandinavia and elsewhere. This is not to say that the findings represent the notions and discourses of all HCPs who provide SHC to men, but they illustrate that HCPs who lack education on men's sexual health and gender awareness may rely on private, biased, or stereotypical notions of men and masculinity in SHC. They also illustrate how local discourses, interdiscursively linked with institutional and societal discourse on men and masculinity, construct gendered social location in SHC.

5.9.4 DIFFERENTIATION BETWEEN SEXUAL AND REPRODUCTIVE HEALTHCARE

Some participants in Studies I and II worked at clinics that were specifically aimed at providing SHC for men; others worked with men's health from broader perspectives, including working with men's reproductive health. As sexual and reproductive health are linked, interdependent, or even in some respects integrated (20), it was difficult to ascertain whether some of the findings, either in full or in part, also relate to men's reproductive health. In the information provided to participants before and during the interviews, it was made clear that our interest lay in men's SHC. However, we did not define sexual health or SHC either before or during the interviews, and participants self-selected to participate based on having experiences of working clinically with men's sexual health. In the analysis of both studies, we tried to exclude data which only related to men's health more generally when we could not see the bearing it had on men's SHC and when it related only to men's reproductive health. However, as reproductive and sexual health are, at least in part, integrated, it is likely that the findings presented in this thesis about HCPs' notions and discourses on men and masculinity in SHC are relevant for men's reproductive healthcare also.

5.9.5 CHALLENGES WITH TRANSLATION

In both qualitative content analysis and CDA, nuances in language and translation are important (121, 123). Analysing Swedish texts and translating the results into English presented challenges. For instance, the words “manlig”, “manlighet” and “maskulinitet” can mostly be used interchangeably in Swedish, whereas the corresponding words in English, “manly”, “manliness” and “masculinity”, are not interchangeable to the same extent, as manly and manliness both denote a more normative notion of masculinity than “manlig” and “manlighet” mostly does in Swedish. In the instances where the modality of words might differ, we had to closely scrutinise the context of the words in the texts to determine whether the participants’ use of the words “manlig” or “manlighet” should be translated as manly, manliness or masculinity. The same was true for the words “kvinnlig”, “kvinnligt” and “feminint” and how they relate to “womanliness”, “womanly” and “femininity”. Another challenge was the word “ju” which is an adverb or subjunction and roughly means “of course”, “as you know”, “as you can understand”, “actually”, “indeed”, “certainly” or “as everyone knows”. Participants used the word “ju” to ascertain or affirm that statements were self-evident, true for them, true for everyone, or to signal either that the listeners knew and agreed with what the speaker was saying or that the speaker wanted support and agreement from the listeners. To accurately convey these nuances was challenging. For example, a statement such as:

“Så att det finns ju ändå vissa krav på att man skall vara manlig, hos vissa män själva. För det upplevs som manligt att alltid vilja ha sex.”

could be translated as:

“So actually, there exist certain demands to be masculine, in certain men themselves. Because it is perceived as masculine to always want sex.”, or

“So as you know, there exist certain demands to be manly, in certain men themselves. Because it is perceived as manly to always want sex.”, or

“So don’t you agree that there exist certain demands to be masculine, in certain men themselves? Because it is perceived as manly to always want sex.”

In sentences where the tone of the statement or modality was unclear, we translated “ju” as “actually” and used masculinity/masculine instead of manly or manliness, and femininity/feminine instead of womanliness or womanly.

The challenges with translation and finding the right linguistic nuances correspond with findings from an explorative focus group study with Swedish gender researchers about the problems encountered by the researchers in medicine and the health sciences. The study identified that participants found it easier to talk and write about concepts associated with sex and gender in English than in Swedish (57). This was partly because the words have different connotations and implications in the different languages and partly because the participants experienced that there is a greater confusion in the usage of words, such as sex and gender, in Swedish. This raises questions about the validity of qualitative gender research where data collection is conducted in Swedish and writing and publishing in English, as well as questions about the need for further clarification of gender-related terminology in Swedish in medicine and healthcare research.

6 CONCLUSION

This chapter sets out to highlight the conclusions from the studies and the conclusions of this thesis.

In Study I it was concluded that HCPs balance private and professional notions of masculinity, and that that masculinity in SHC needs to be addressed from both a professional and structural perspective for HCPs not to have to rely on private notions of masculinity in interactions with men seeking SHC. It was also concluded that there is a potential bias in the service and management of men's SHC, as the findings indicate deficiencies in organisational prerequisites for providing SHC for men. The study illustrates the importance of including gender awareness as part of professional education and training, to prevent private notions of gender being reflected in professional demeanour and treatment of patients.

In Study II it was concluded that HCPs' discourses constructed SHC as a feminine arena where masculinity is a potentially problematic norm violation that HCPs aim to transform, and that HCPs discourses risk othering men. It was also concluded that there is a need to include men's sexual health and masculinity in professional education and training, as HCPs lack a professional discourse on masculinity and a shared approach to men seeking SHC. A professional discourse and a shared approach could create a common foundation and a more consistent and knowledge-based approach to men in SHC.

Taken together, this indicates that HCPs' notions, attitudes and discourses on men and masculinities in SHC can pose barriers for men seeking SHC, and that there seem to be organisational and educational challenges that need to be addressed in order for HCPs to be able to provide accessible and acceptable SHC for men according to need. There is a need to address the awareness of how gender and masculinity are discussed at SHC clinics, in primary care and during medical and healthcare education and training. This includes addressing how HCPs' treatment and professional demeanour towards men seeking SHC could be negatively influenced by the othering of men and by the use of gender blindness as a strategy.

This thesis contributes to the theoretical knowledge of how gender in healthcare is constructed and to the understanding of masculinity as a social location in SHC.

7 FUTURE PERSPECTIVES

The findings in this thesis have implications for the healthcare system, specifically for SHC clinics and for primary healthcare.

HCPs experienced limitations in the conditions under which they work with men's SHC. This indicates a need to review the management and design of the healthcare system and for interventions to enable HCPs to offer the best possible healthcare for men with SHC needs.

It can be difficult to be aware of every social norm that influences us, and of our own attitudes and notions or how these relate to interactions with others. The findings presented here can be used by HCPs working with men's SHC to reflect on their notions and attitudes. They can also be used as grounds for efforts towards change and interventions at clinics that want to work with gender norms.

This thesis also has implications for medical and healthcare education and training, as the findings suggest that HCPs who work with men's SHC lack knowledge about men's sexual health, and that there is a need for a professionalisation of the understanding of and approach to men and masculinity in SHC. Since sexual health is part of public health, it is important that education and training creates the conditions for HCPs to be able to offer SHC according to need for everyone, regardless of gender.

This thesis raises questions that could be investigated in future research:

- What are the organisational prerequisites in healthcare for providing SHC for men?
- What are the formal conditions for HCPs to provide men's SHC in terms of how training and education prepare them for working with men's SHC; e.g. what is the content of curricula, syllabi and study literature?
- How are HCPs' notions of men and masculinities and discourses of masculinity enacted in interactions with men and others seeking SHC?
- How does the discursive othering of men and the construction of masculinity as a norm violation in SHC relate to experiences among those HCPs who identify as men?
- How do men with unmet needs for SHC, who have avoided seeking SHC, perceive SHC?

- What are HCPs' notions and discourses on femininities and women in SHC, and how do they relate to the findings in this thesis regarding how gendered social locations in SHC are constructed?

In addition to answering these questions, it would be interesting and relevant to conduct research that examines intersectional perspectives on patients in SHC without specifically focusing on gender. The findings presented here indicate that HCPs' notions of preferable patients in SHC relate to intersections between age, ethnicity, religion, social class and gender. It is likely that other identities, social locations and positions are relevant to consider in such explorations.

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REFERENCES

1. World Health Organization. Defining sexual health: report of a technical consultation on sexual health, 28-31 January 2002, Geneva. World Health Organization; 2006.
2. Sadovsky R, Nusbaum M. REVIEWS: Sexual Health Inquiry and Support Is a Primary Care Priority. *J Sex Med.* 2006;3(1):3-11.
3. Mollaioli D, Ciocca G, Limoncin E, Di Sante S, Gravina GL, Carosa E, et al. Lifestyles and sexuality in men and women: the gender perspective in sexual medicine. *Reprod Biol Endocrinol.* 2020;18(1):10.
4. Hendry A, Snowden A, Brown M. When holistic care is not holistic enough: The role of sexual health in mental health settings. *J Clin Nurs.* 2018;27(5-6):1015-27.
5. Hardee K, Croce-Galis M, Gay J. Are men well served by family planning programs? *Reprod Health.* 2017;14(1):14.
6. World Health Organization. The health and well-being of men in the WHO European Region: better health through a gender approach. World Health Organization. Regional Office for Europe; 2018. Report No.: 9289053534.
7. Kalmuss D, Tatum C. Patterns of men's use of sexual and reproductive health services. *Perspect Sex Reprod Health.* 2007;39(2):74-81.
8. Same RV, Bell DL, Rosenthal SL, Marcell AV. Sexual and Reproductive Health Care: Adolescent and Adult Men's Willingness to Talk and Preferred Approach. *Am J Prev Med.* 2014;47(2):175-81.
9. Collumbien M, Hawkes S. Missing men's messages: Does the reproductive health approach respond to men's sexual health needs? *Cult Health Sex.* 2000;2(2):135-50.
10. Marcell AV, Gibbs SE, Pilgrim NA, Page KR, Arrington-Sanders R, Jennings JM, et al. Sexual and Reproductive Health Care Receipt Among Young Males Aged 15–24. *J Adolesc Health.* 2018;62(4):382-9.
11. Pazol K, Robbins CL, Black LI, Ahrens KA, Daniels K, Chandra A, et al. Receipt of Selected Preventive Health Services for Women and Men of Reproductive Age — United States, 2011–2013. *MMWR Surveill summ.* 2017;66(20):1-31.
12. Lewis R, Tanton C, Mercer CH, Mitchell KR, Palmer M, Maccowall W, et al. Heterosexual Practices Among Young People in Britain: Evidence From Three National Surveys of Sexual Attitudes and Lifestyles. *J Adolesc Health.* 2017;61(6):694-702.
13. Laumann EO, Glasser DB, Neves RCS, Moreira ED. A population-based survey of sexual activity, sexual problems and associated help-seeking behavior patterns in mature adults in the United States of America. *Int J Impot Res.* 2009;21(3):171-8.

14. Chabot MJ, Lewis C, de Bocanegra HT, Darney P. Correlates of receiving reproductive health care services among U.S. men aged 15 to 44 years. *Am J Mens Health*. 2011;5(4):358-66.
15. Sonfield A. Looking at men's sexual and reproductive health needs. *The Guttmacher report on public policy*. 2002;5(2):7.
16. Porche DJ. Men: The missing client in family planning. *Am J Mens Health*. 2012;6(6):441-.
17. Baroudi M, Stoor JP, Blåhed H, Edin K, Hurtig AK. Men and sexual and reproductive healthcare in the Nordic countries: a scoping review. *BMJ Open*. 2021;11(9):e052600.
18. Ndong I, Becker RM, Haws JM, Wegner MN. Men's Reproductive Health: Defining, Designing and Delivering Services. *Int Fam Plan Perspect*. 1999;25:S53-S5.
19. Greene ME, Biddlecom AE. Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles. *Popul Dev Rev*. 2000;26(1):81-115.
20. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*. 2018;391(10140):2642-92.
21. Ruane-McAteer E, Gillespie K, Amin A, Aventin Á, Robinson M, Hanratty J, et al. Gender-transformative programming with men and boys to improve sexual and reproductive health and rights: a systematic review of intervention studies. *BMJ Glob Health*. 2020;5(10):e002997.
22. Shand T, Marcell AV. Engaging men in sexual and reproductive health [Internet]. *Oxford Research Encyclopedia of Global Public Health*; 2021 [cited 2022 Jul 27]. Available from: <https://oxfordre.com/publichealth/view/10.1093/acrefore/9780190632366.001.0001/acrefore-9780190632366-e-215#acrefore-9780190632366-e-215-note->.
23. Kalmuss D, Austrian K. Real men do...real men don't: Young Latino and African American men's discourses regarding sexual health care utilization. *Am J Mens Health*. 2010;4(3):218-30.
24. Lindberg LD, Sonfield A, Gemmill A. Reassessing adolescent male sexual and reproductive health in the United States: research and recommendations. *Am J Mens Health*. 2008;2(1):40-56.
25. Donne MD, DeLuca J, Pleskach P, Bromson C, Mosley MP, Perez ET, et al. Barriers to and Facilitators of Help-Seeking Behavior Among Men Who Experience Sexual Violence. *Am J Mens Health*. 2018;12(2):189-201.
26. Salonia A, Bettocchi C, Boeri L, Capogrosso P, Carvalho J, Cilesiz NC, et al. European Association of Urology Guidelines on Sexual and Reproductive Health-2021 Update: Male Sexual Dysfunction. *Eur Urol*. 2021;80(3):333-57.

27. Tharakan T, Bettocchi C, Carvalho J, Corona G, Joensen UN, Jones H, et al. Male Sexual and Reproductive Health-Does the Urologist Have a Role in Addressing Gender Inequality in Life Expectancy? *Eur Urol Focus*. 2020;6(4):791-800.
28. Nicolosi A, Buvat J, Glasser DB, Hartmann U, Laumann EO, Gingell C, et al. Sexual behaviour, sexual dysfunctions and related help seeking patterns in middle-aged and elderly Europeans: the global study of sexual attitudes and behaviors. *World J Urol*. 2006;24(4):423-8.
29. Folkhälsomyndigheten. Sexuell och reproduktiv hälsa och rättigheter (SRHR) i Sverige 2017 – Resultat från befolkningsundersökningen SRHR2017 [internet]. Folkhälsomyndigheten; 2019 [cited 2022 Jul 27]. Available from: <https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/s/sexuell-och-reproduktiv-halsa-och-rattigheter-i-sverige-2017/?pub=60999>
30. Beyrer C, Sullivan PS, Sanchez J, Dowdy D, Altman D, Trapence G, et al. A call to action for comprehensive HIV services for men who have sex with men. *Lancet*. 2012;380(9839):424-38.
31. Mayer KH, Bekker LG, Stall R, Grulich AE, Colfax G, Lama JR. Comprehensive clinical care for men who have sex with men: an integrated approach. *Lancet*. 2012;380(9839):378-87.
32. Hawkes S, Hart G. Men's sexual health matters: promoting reproductive health in an international context. *Trop Med Int Health*. 2000;5(7):A37-44.
33. Buzi RS, Smith PB. Access to Sexual and Reproductive Health Care Services: Young Men's Perspectives. *J Sex Marital Ther*. 2014;40(2):149-57.
34. Ezhova I, Savidge L, Bonnett C, Cassidy J, Okwuokei A, Dickinson T. Barriers to older adults seeking sexual health advice and treatment: A scoping review. *Int J Nurs Stud*. 2020;107:103566.
35. Harb C, Pass L, De Soriano I, Gilbert P. Motivators and Barriers to Accessing Sexual Health Care Services for Transgender/Genderqueer Individuals Assigned Female Sex at Birth. *Transgend Health*. 2019;4(1):58-67.
36. Hälsa- och sjukvårdslag (SFS 2017: 30). Stockholm: Socialdepartementet.
37. Burström B. What Is Happening in Sweden? *Int J Health Serv*. 2019;49(2):204-11.
38. Anell A, Glenngård AH, Merkur S. Sweden health system review. *Health Syst Transit*. 2012;14(5):1-159.
39. Folkhälsomyndigheten. Nationell strategi för sexuell och reproduktiv hälsa och rättigheter (SRHR) En god, jämlik och jämställd sexuell och reproduktiv hälsa i hela befolkningen [Internet]. Folkhälsomyndigheten; 2020 [cited 2022 Jul 27]. Available from:

- <https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/n/nationell-strategi-for-sexuell-och-reproduktiv-halsa-och-rattigheter-srhr/>.
40. Socialstyrelsen. Metod för behovsbedömning - Rapport från InfoVU-projektets kunskapsnätverk för behov [Internet]. 2006 [cited 2022 Jul 27]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2006-124-9_20061249.pdf.
 41. Barbieri D, Cazorla AG, THIL L, Mollard B, Ochmann J, Peciukonis V. Gender Equality Index 2021: Health. 2021. Report No.: 9294829227.
 42. World Economic Forum. Global Gender Gap Report 2021 [Internet]. 2021 [cited 2022 Jul 27]. Available from: https://www3.weforum.org/docs/WEF_GGGR_2021.pdf.
 43. Jezierska K, Towns A. Taming feminism? The place of gender equality in the ‘Progressive Sweden’ brand. *Place Brand Public Dipl.* 2018;14(1):55-63.
 44. Ray R, Gornick JC, Schmitt J. Who cares? Assessing generosity and gender equality in parental leave policy designs in 21 countries. *J Eur Soc Policy.* 2010;20(3):196-216.
 45. Abrahamsson L, Gonäs L. Jämställt arbete?: organisatoriska rammar och villkor i arbetslivet: forskningsrapport till Delegationen för jämställdhet i arbetslivet. Stockholm: Fritzes; 2014.
 46. Gustafsson Sendén M, Klysing A, Lindqvist A, Renström EA. The (Not So) Changing Man: Dynamic Gender Stereotypes in Sweden. *Front Psychol.* 2019;10.
 47. Nielsen AM, De Costa A, Gemzell-Danielsson K, Marrone G, Boman J, Salazar M, et al. The MOSEXY trial: mobile phone intervention for sexual health in youth—a pragmatic randomised controlled trial to evaluate the effect of a smartphone application on sexual health in youth in Stockholm, Sweden. *Sex Transm Infect.* 2021;97(2):141-6.
 48. Swedish Society for Youth Centres (FSUM). ‘Ni är grymma’ (‘Keep up the good work’) [Internet]. 2015 [cited 2022 Jul 27]. Available from: <https://fsum.nu/wp-content/uploads/2022/03/fsum-ni-ar-grymma.pdf>.
 49. Uppdrag Psykisk Hälsa. Psykisk hälsa på ungdomsmottagningen-en kartläggning av Sveriges ungdomsmottagningar [Mental health in youth clinics—a mapping of Swedish youth clinics]. Stockholm: Uppdrag Psykisk Hälsa. 2017.
 50. Asklov K, Ekenger R, Berterö C. Transmasculine Persons' Experiences of Encounters with Health Care Professionals Within Reproductive, Perinatal, and Sexual Health in Sweden: A Qualitative Interview Study. *Transgend Health.* 2021;6(6):325-31.
 51. Persson A, Lindmark S, Petersson K, Gabriel E, Thorsell M, Lindström K, et al. Potentially traumatic events, fear of childbirth and

- posttraumatic stress disorder during pregnancy in Stockholm, Sweden: a cross-sectional study. *Sex Reprod Healthc.* 2020;25:100516.
52. Socialdepartementet. *Män och jämställdhet: betänkande (SOU 2014:6)*: Stockholm : Fritze; 2014.
 53. Pousette Å. Kompetensen inom andrologi och tillgängligheten till andrologisk vård i Sverige 2013, bilaga 19 (SOU 2014:6) [Internet]. Socialdepartementet; 2014 [cited 2022 Jul 27]. Available from: <https://www.regeringen.se/49b70d/contentassets/6e2024c9c99948bfa052224089272c0e/man-och-jamstallldhet-bilaga-19-sou-20146>.
 54. Grandahl M, Bodin M, Stern J. In everybody's interest but no one's assigned responsibility: midwives' thoughts and experiences of preventive work for men's sexual and reproductive health and rights within primary care. *BMC Public Health.* 2019;19(1):1423.
 55. Krieger N. Genders, sexes, and health: what are the connections—and why does it matter? *Int J Epidemiol.* 2003;32(4):652-7.
 56. Mauvais-Jarvis F, Bairey Merz N, Barnes PJ, Brinton RD, Carrero JJ, DeMeo DL, et al. Sex and gender: modifiers of health, disease, and medicine. *Lancet.* 2020;396(10250):565-82.
 57. Christianson M, Alex L, Wiklund AF, Hammarström A, Lundman B. Sex and Gender Traps and Springboards: A Focus Group Study Among Gender Researchers in Medicine and Health Sciences. *Health Care Women Int.* 2012;33(8):739-55.
 58. King BM. Point: a call for proper usage of "gender" and "sex" in biomedical publications. *Am J Physiol Regul Integr Comp Physiol.* 2010;298(6):R1700-1.
 59. Alex L, Fjellman Wiklund A, Lundman B, Christianson M, Hammarström A. Beyond a Dichotomous View of the Concepts of 'Sex' and 'Gender' Focus Group Discussions among Gender Researchers at a Medical Faculty. *PLoS One.* 2012;7(11):e50275.
 60. Fausto-Sterling A. Gender/Sex, Sexual Orientation, and Identity Are in the Body: How Did They Get There? *J Sex Res.* 2019;56(4-5):529-55.
 61. Messerschmidt JW, Martin PY, Messner MA, Connell R. *Gender reckonings : new social theory and research*: New York : New York University Press; 2018.
 62. Connell R. *Om genus. 3., [omarb. och uppdaterade] uppl.*. ed. Pearse R, Hjukström C, editors: Göteborg : Daidalos; 2015.
 63. Connell R, Lindén Å. *Maskuliniteter*. 2nd ed. Lindén Å, editor: Göteborg : Daidalos; 2008.
 64. Courtenay WH. *Constructions of masculinity and their influence on men's well-being: A theory of gender and health*. *Soc Sci Med.* 2000;50(10):1385-401.
 65. Hankivsky O. Women's health, men's health, and gender and health: implications of intersectionality. *Soc Sci Med.* 2012;74(11):1712-20.

66. Shields SA. Gender: An Intersectionality Perspective. *Sex Roles*. 2008;59(5):301-11.
67. Weber AM, Cislighi B, Meausoone V, Abdalla S, Mejía-Guevara I, Loftus P, et al. Gender norms and health: insights from global survey data. *Lancet*. 2019;393(10189):2455-68.
68. Gupta GR, Oomman N, Grown C, Conn K, Hawkes S, Shawar YR, et al. Gender equality and gender norms: framing the opportunities for health. *Lancet*. 2019;393(10190):2550-62.
69. Hay K, McDougal L, Percival V, Henry S, Klugman J, Wurie H, et al. Disrupting gender norms in health systems: Making the case for change. *Lancet* 2019;393(10190):2535-49.
70. Hamberg K. Gender Bias in Medicine. *Womens Health*. 2008;4(3):237-43.
71. Hamberg K, Risberg G, Johansson EE. Male and female physicians show different patterns of gender bias: A paper-case study of management of irritable bowel syndrome. *Scand J Public Health*. 2004;32(2):144-52.
72. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: A systematic review. *BMC Med Ethics*. 2017;18(1):19-.
73. Salles A, Awad M, Goldin L, Krus K, Lee JV, Schwabe MT, et al. Estimating Implicit and Explicit Gender Bias Among Health Care Professionals and Surgeons. *JAMA Netw Open*. 2019;2(7):e196545.
74. Zola IK. Medicine as an institution of social control. *Sociol Rev*. 1972;20(4):487-504.
75. Hølge-Hazelton B, Malterud K. Gender in medicine - does it matter? *Scand J Public Health*. 2009;37(2):139-45.
76. Samulowitz A, Gremyr I, Eriksson E, Hensing G. "Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. *Pain Res Manag*. 2018;2018:6358624.
77. Krag MØ, Hasselbalch L, Siersma V, Nielsen ABS, Reventlow S, Malterud K, et al. The impact of gender on the long-term morbidity and mortality of patients with type 2 diabetes receiving structured personal care: a 13 year follow-up study. *Diabetologia*. 2016;59(2):275-85.
78. Travis CB, Howerton DM, Szymanski DM. Risk, Uncertainty, and Gender Stereotypes in Healthcare Decisions. *Women Ther*. 2012;35(3-4):207-20.
79. Banks I. No man's land: Men, illness, and the NHS. *BMJ*. 2001;323(7320):1058-36.
80. Winblad U, Linder W, Hanning M. Hälso-och sjukvårdsforskningens framväxt i Sverige. *Socialmed Tidskr*. 2022;99(3):320-31.
81. Lohr KN, Steinwachs DM. Health services research: an evolving definition of the field. *Health Serv Res*. 2002;37(1):7-9.

82. Sen G, Östlin P. Gender inequity in health: why it exists and how we can change it. *Glob Public Health*. 2008;3(sup1):1-12.
83. Govender V, Penn-Kekana L. Gender biases and discrimination: A review of health care interpersonal interactions. *Global Public Health*. 2008;3(sup1):90-103.
84. Connell R. Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Soc Sci Med*. 2012;74(11):1675-83.
85. Annandale E, Hammarström A. Constructing the 'gender-specific body': A critical discourse analysis of publications in the field of gender-specific medicine. *Health (London)*. 2011;15(6):571-87.
86. Heise L, Greene ME, Opper N, Stavropoulou M, Harper C, Nascimento M, et al. Gender inequality and restrictive gender norms: Framing the challenges to health. *Lancet*. 2019;393(10189):2440-54.
87. Fleming PJ, Agnew-Brune C. Current Trends in the study of Gender Norms and Health Behaviors. *Curr Opin Psychol*. 2015;5:72-7.
88. Barker G, Ricardo C, Nascimento M, World Health O, Instituto P. Engaging men and boys in changing gender-based inequity in health : evidence from programme interventions / Gary Barker, Christine Ricardo and Marcos Nascimento. Geneva: World Health Organization; 2007 2007. Report No.: 9789241595490.
89. Heymann J, Levy JK, Bose B, Ríos-Salas V, Mekonen Y, Swaminathan H, et al. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. *Lancet*. 2019;393(10190):2522-34.
90. Messerschmidt JW, Messner MA. Hegemonic, nonhegemonic, and “new” masculinities. In: Messerschmidt JW, Martin PY, Messner MA, Connell R, editors. *Gender reckonings: New social theory and research*. New York: New York University Press; 2018. p. 35-56.
91. Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): A theoretical framework for understanding men and their health. *J Mens Health*. 2011;8(1):7-15.
92. Hearn J, Morrell R. Reviewing hegemonic masculinities and men in Sweden and South Africa. *Men Masc*. 2012;15(1):3-10.
93. Rivera A. Traditional masculinity: A review of toxicity rooted in social norms and gender socialization. *ANS Adv Nurs Sci*. 2020;43(1):E1-E10.
94. Connell R, Messerschmidt J. Hegemonic masculinity: Rethinking the concept. *Gend Soc*. 2005;19(6):829-59.
95. Schippers M. Recovering the feminine other: Masculinity, femininity, and gender hegemony. *Theory Soc*. 2007;36(1):85-102.
96. Baum F, Musolino C, Gesesew HA, Popay J. New Perspective on Why Women Live Longer Than Men: An Exploration of Power, Gender, Social Determinants, and Capitals. *Int J Environ Res Public Health*. 2021;18(2):661.

97. Oksuzyan A, Juel K, Vaupel JW, Christensen K. Men: good health and high mortality. Sex differences in health and aging. *Aging Clin Exp Res.* 2008;20(2):91-102.
98. Galdas PM, Cheater F, Marshall P. Men and health help-seeking behaviour: Literature review. *J Adv Nurs.* 2005;49(6):616-23.
99. Juel K, Christensen K. Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005. *J Public Health (Oxf).* 2007;30(1):111-3.
100. Teo CH, Ng CJ, Booth A, White A. Barriers and facilitators to health screening in men: A systematic review. *Soc Sci Med.* 2016;165:168-76.
101. Zeglin RJ. Assessing the role of masculinity in the transmission of HIV: a systematic review to inform HIV risk reduction counseling interventions for men who have sex with men. *Arch Sex Behav.* 2015;44(7):1979-90.
102. Hergenrather KC, Emmanuel D, Zeglin RJ, Ruda DJ, Rhodes SD. Men Who Have Sex With Men and HIV Risk Behavior: Exploring the Influence of Masculinity Within the Social Ecological Model. *AIDS Educ Prev.* 2021;33(6):511-33.
103. Balfe M, Brugha R, O'Connell E, Vaughan D, O'Donovan D. Men's attitudes towards chlamydia screening: a narrative review. *Sex Health.* 2012;9(2):120-30.
104. Himmelstein MS, Sanchez DT. Masculinity impediments: Internalized masculinity contributes to healthcare avoidance in men and women. *J Health Psychol.* 2016;21(7):1283-92.
105. O'Brien R, Hunt K, Hart G. 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Soc Sci Med.* 2005;61(3):503-16.
106. Farrimond H. Beyond the caveman: Rethinking masculinity in relation to men's help-seeking. *Health (London).* 2012;16(2):208-25.
107. Peerson A, Saunders M. Men's health literacy: advancing evidence and priorities. *Crit Public Health.* 2009;19(3-4):441-56.
108. Cotton SM, Wright A, Harris MG, Jorm AF, McGorry PD. Influence of gender on mental health literacy in young Australians. *Aust N Z J Psychiatry.* 2006;40(9):790-6.
109. Oliffe JL, Rossnagel E, Kelly MT, Bottorff JL, Seaton C, Darroch F. Men's health literacy: a review and recommendations. *Health Promot Int.* 2019;35(5):1037-51.
110. Courtenay WH. College men's health: an overview and a call to action. *J Am Coll Health.* 1998;46(6):279-90.
111. Risberg G, Johansson EE, Hamberg K. A theoretical model for analysing gender bias in medicine. *Int J Equity Health.* 2009;8(1):28-.
112. Knight R, Shoveller JA, Oliffe JL, Gilbert M, Goldenberg S. Heteronormativity hurts everyone: Experiences of young men and

- clinicians with sexually transmitted infection/HIV testing in British Columbia, Canada. *Health (N Y)*. 2013;17(5):441-59.
113. Wamala S, Merlo J, Boström G, Hogstedt C. Perceived discrimination, socioeconomic disadvantage and refraining from seeking medical treatment in Sweden. *J Epidemiol Community Health*. 2007;61(5):409-15.
 114. Holloway I. *Qualitative Research in Health Care*. Maidenhead: McGraw-Hill Education (UK); 2005.
 115. Krueger RA. *Focus groups : A practical guide for applied research*. 4th ed. ed. Casey MA, editor. Thousand Oaks, Calif.: Thousand Oaks, Calif. : Sage Publications; 2009.
 116. Kamberelis G, Dimitriadis G. Focus group research: Retrospect and prospect. In: Leavy P, editor. *The Oxford Handbook of Qualitative Research*. Oxford ; New York Oxford University Press; 2014. p. 315-39.
 117. Smithson J. Using and analysing focus groups: Limitations and possibilities. *Int J Soc Res Methodol*. 2000;3(2):103-19.
 118. Kitzinger J. Qualitative research. Introducing focus groups. *BMJ*. 1995;311(7000):299-302.
 119. Parsons M, Greenwood J. A guide to the use of focus groups in health care research: Part 1. *Contemp Nurse*. 2000;9(2):169-80.
 120. Graneheim U, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24(2):105-12.
 121. Graneheim U, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Educ Today*. 2017;56:29-34.
 122. Yazdannik A, Yousefy A, Mohammadi S. Discourse analysis: A useful methodology for health-care system researches. *J Educ Health Promot*. 2017;6:111.
 123. Fairclough N. *Language and power*. 3., [updated] ed. ed. London: London : Routledge; 2015.
 124. Greenwood J, Parsons M. A guide to the use of focus groups in health care research: Part 2. *Contemp Nurse*. 2000;9(2):181-91.
 125. Rose J, Johnson CW. Contextualizing reliability and validity in qualitative research: toward more rigorous and trustworthy qualitative social science in leisure research. *J Leis Res*. 2020;51(4):432-51.
 126. Klaeson K, Hovlin L, Guvå H, Kjellsdotter A. Sexual health in primary health care – a qualitative study of nurses’ experiences. *J Clin Nurs*. 2017;26(11-12):1545-54.
 127. Lindroth M, Zeluf G, Mannheimer LN, Deogan C. Sexual health among transgender people in Sweden. *Int J Transgend*. 2017;18(3):318-27.

128. Areskoug-Josefsson K, Fristedt S. Occupational therapy students' views on addressing sexual health. *Scand J Occup Ther.* 2019;26(4):306-14.
129. Soundy A, Stubbs B, Jenkins S, Cooper I. Sexual professional boundaries perceived by undergraduate and graduate physiotherapists: A cross sectional survey. *Physiotherapy.* 2013;99(4):298-304.
130. Jacob JD, Gagnon M, Perron A, Canales MK. Revisiting the Concept of Othering: A Structural Analysis. *ANS Adv Nurs Sci.* 2021;44(4):280-90.
131. Roberts MLA, Schiavenato M. Othering in the nursing context: A concept analysis. *Nurs Open.* 2017;4(3):174-81.
132. Khamisy-Farah R, Bragazzi NL. How to Integrate Sex and Gender Medicine into Medical and Allied Health Profession Undergraduate, Graduate, and Post-Graduate Education: Insights from a Rapid Systematic Literature Review and a Thematic Meta-Synthesis. *J Pers Med.* 2022;12(4):612.
133. Narayan MC. CE: Addressing Implicit Bias in Nursing: A Review. *Am J Nurs.* 2019;119(7):36-43.
134. Hernandez R. Medical Students' Implicit Bias and the Communication of Norms in Medical Education. *Teach Learn Med.* 2018;30(1):112-7.
135. Spencer KL, Grace M. Social Foundations of Health Care Inequality and Treatment Bias. *Annu Rev Sociol.* 2016;42(1):101-20.
136. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making. *Acad Emerg Med.* 2017;24(8):895-904.
137. Gopal DP, Chetty U, O'Donnell P, Gajria C, Blackadder-Weinstein J. Implicit bias in healthcare: clinical practice, research and decision making. *Future Healthc J.* 2021;8(1):40-8.
138. Hansson M, Lundgren I, Hensing G, Dencker A, Eriksson M, Carlsson I-M. Professional courage to create a pathway within midwives' fields of work: a grounded theory study. *BMC Health Serv Res.* 2021;21(1):312.
139. Rainer J, Schneider JK, Lorenz RA. Ethical dilemmas in nursing: An integrative review. *J Clin Nurs.* 2018;27(19-20):3446-61.
140. Åling M, Lindgren A, Löfall H, Okenwa-Emegwa L. A Scoping Review to Identify Barriers and Enabling Factors for Nurse–Patient Discussions on Sexuality and Sexual Health. *Nurs Rep.* 2021;11(2):253-66.
141. Annerstedt CF, Glasdam S. Nurses' attitudes towards support for and communication about sexual health—A qualitative study from the perspectives of oncological nurses. *J Clin Nurs.* 2019;28(19-20):3556-66.
142. Ussher JM, Perz J, Gilbert E, Wong WKT, Mason C, Hobbs K, et al. Talking about sex after cancer: A discourse analytic study of health

- care professional accounts of sexual communication with patients. *Psychol Health*. 2013;28(12):1370-90.
143. Gerbild H, Larsen CM, Junge T, Laursen BS, Areskoug-Josefsson K. Danish Health Professional Students' Attitudes Toward Addressing Sexual Health: A Cross-Sectional Survey. *Sex Med*. 2021;9(2):100323.
144. Gott M, Galena E, Hinchliff S, Elford H. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Fam Pract*. 2004;21(5):528-36.
145. Metz ME, Seifert MH. Men's expectations of physicians in sexual health concerns. *J Sex Marital Ther*. 1990;16(2):79-88.
146. Ryan KL, Arbuckle-Bernstein V, Smith G, Phillips J. Let's Talk About Sex: A Survey of Patients' Preferences When Addressing Sexual Health Concerns in a Family Medicine Residency Program Office. *PRiMER*. 2018;2:23.
147. Baldwin K, Ginsberg P, Harkaway RC. Under-reporting of erectile dysfunction among men with unrelated urologic conditions. *Int J Impot Res*. 2003;15(2):87-9.
148. Aschka C, Himmel W, Ittner E, Kochen MM. Sexual problems of male patients in family practice. *J Fam Pract*. 2001;50(9):773-8.
149. Zhang X, Sherman L, Foster M. Patients' and providers' perspectives on sexual health discussion in the United States: A scoping review. *Patient Educ Couns*. 2020;103(11):2205-13.
150. Saunamäki N, Andersson M, Engström M. Discussing sexuality with patients: nurses' attitudes and beliefs. *J Adv Nurs*. 2010;66(6):1308-16.
151. Mursa R, Patterson C, Halcomb E. Men's help-seeking and engagement with general practice: An integrative review. *J Adv Nurs*. 2022;78(7):1938-53.
152. Smith JA, Braunack-Mayer A, Wittert G. What do we know about men's help-seeking and health service use? *Med J Aust*. 2006;184(2):81-3.
153. Koenig AM, Richeson JA. The contextual endorsement of sexblind versus sexaware ideologies. *Soc Psychol*. 2010;41(3):186-91.
154. Gündemir S, Martin AE, Homan AC. Understanding Diversity Ideologies From the Target's Perspective: A Review and Future Directions. *Front Psychol*. 2019;10.
155. McCormack B, van Dulmen S, Eide H, Skovdahl K, Eide T. *Person-centred healthcare research*: John Wiley & Sons; 2017.
156. Griffith DM. "I AM a Man": Manhood, Minority Men's Health and Health Equity. *Ethn Dis*. 2015;25(3):287-93.
157. Hammarström A, Johansson K, Annandale E, Ahlgren C, Aléx L, Christianson M, et al. Central gender theoretical concepts in health research: the state of the art. *J Epidemiol Community Health*. 2014;68(2):185-90.

158. Larsson FM, Nielsen A, Briones-Vozmediano E, Stjärnfeldt J, Salazar M. Indifferent, ambiguous, or proactive? Young men's discourses on health service utilization for Chlamydia trachomatis detection in Stockholm, Sweden: A qualitative study. *PLoS One*. 2021;16(9):e0257402.
159. Makenzius M, Gådin KG, Tydén T, Romild U, Larsson M. Male students' behaviour, knowledge, attitudes, and needs in sexual and reproductive health matters. *Eur J Contracept Reprod Health Care*. 2009;14(4):268-76.
160. Bambra C. Placing intersectional inequalities in health. *Health Place*. 2022;75:102761.
161. Øversveen E, Rydland HT, Bambra C, Eikemo TA. Rethinking the relationship between socio-economic status and health: Making the case for sociological theory in health inequality research. *Scand J Public Health*. 2017;45(2):103-12.
162. Cummins S, Curtis S, Diez-Roux AV, Macintyre S. Understanding and representing 'place' in health research: A relational approach. *Soc Sci Med*. 2007;65(9):1825-38.
163. Giesbrecht M, Stajduhar KI, Mollison A, Pauly B, Reimer-Kirkham S, McNeil R, et al. Hospitals, clinics, and palliative care units: Place-based experiences of formal healthcare settings by people experiencing structural vulnerability at the end-of-life. *Health Place*. 2018;53:43-51.
164. Goddard M, Smith P. Equity of access to health care services: theory and evidence from the UK. *Soc Sci Med*. 2001;53(9):1149-62.
165. Lindberg C, Lewis-Spruill C, Crownover R. Barriers to sexual and reproductive health care: urban male adolescents speak out. *Issues Compr Pediatr Nurs*. 2006;29(2):73-88.
166. Parchem B, Molock SD. HIV testing preferences, barriers and facilitators to receiving HIV services among young Black sexual minority men. *AIDS Care*. 2021:1-8.
167. Prestage G, Brown G, Keen P. Barriers to HIV testing among Australian gay men. *Sex Health*. 2012;9(5):453-8.
168. Ruane-McAteer E, Amin A, Hanratty J, Lynn F, Corbijn van Willenswaard K, Reid E, et al. Interventions addressing men, masculinities and gender equality in sexual and reproductive health and rights: an evidence and gap map and systematic review of reviews. *BMJ Glob Health*. 2019;4(5):e001634.
169. Dodgson JE. Reflexivity in Qualitative Research. *J Hum Lact*. 2019;35(2):220-2.
170. Reid AM, Brown JM, Smith JM, Cope AC, Jamieson S. Ethical dilemmas and reflexivity in qualitative research. *Perspect Med Educ*. 2018;7(2):69-75.
171. Watt D. On becoming a qualitative researcher: the value of reflexivity. *Qualitative Report*. 2007;12(1):82-101.

172. Poses RM, Isen AM. Qualitative research in medicine and health care: questions and controversy. *J Gen Intern Med.* 1998;13(1):32-8.
173. Sant M. WASP (Write a Scientific Paper): Qualitative research and evidence based practice: implications and contributions. *Early Hum Dev.* 2019;133:37-42.
174. Jindal AK, Singh G, Pandya K. Qualitative research in medicine – An art to be nurtured. *Med J Armed Forces India.* 2015;71(4):369-72.
175. Bishop L, Kuula-Luumi A. Revisiting Qualitative Data Reuse: A Decade On. *SAGE open.* 2017;7(1):215824401668513.
176. Long-Sutehall T, Sque M, Addington-Hall J. Secondary Analysis of Qualitative Data: A Valuable Method for Exploring Sensitive Issues with an Elusive Population? *J Res Nurs.* 2012;16(4):v3-1-344.
177. Hammersley M. Can We Re-Use Qualitative Data via Secondary Analysis? Notes on Some Terminological and Substantive Issues. *Sociol Res Online.* 2010;15(1):47-53.
178. Rolfe G. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *J Adv Nurs.* 2006;53(3):304-10.
179. Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *Eur J Gen Pract.* 2018;24(1):120-4.

APPENDIX

Interview guide for focus group interviews:

Welcome and thank you for taking the time to participate in this focus group.

My name is Tommy Persson and I will be your moderator. With me I have NN [name of co-moderator] who will be the co-moderator and who will take notes during the meeting. It would be nice if you can turn off your mobile phones. If you must have them on, please put them on silent.

You are invited to the focus group because you all work clinically with men's sexual health. We are interested in your views on men who seek care regarding their sexual health.

The purpose of the focus group is for you to discuss your experiences and your understanding of the men who come here. Feel free to start from your own experiences and from concrete examples.

I would like to point out that in research we can only use what you actually say - that is, what is recorded, therefore it is important that as much as possible is expressed.

That this is a focus group mean:

- That you discuss your experiences and views with each other.
- That there are no right or wrong answers.
- That it is not about finding consensus
- That nothing is too small to be included, often the small things can be unique and important.

The idea with the focus group is that you discuss with each other. It is your different thoughts, your different views and your different experiences that are interesting.

Me and NN [co-moderator] will mainly listen to you, but we will also:

- Introduce questions
- Ask you to clarify or elucidate what you are discussing
- Address previous topics if we think there is more to discuss about those topics

The conversation will be audio recorded and therefore it is important that you:

- Speak one at a time
- That you do not interrupt each other
- And that everyone can have a say

The interview will last until XX:XX [specify time], can everyone stay that long?

I would like to remind you all to respect what is said here and that you do not tell anyone else what the other participants have said during the conversation. Also remember not to talk about specific patients in a way that makes it possible to identify them.

Do you have any questions?

Then I think we should begin.

Presentation (rounds – participants taking turns)

- Introduce yourself by name and what year you were born.
- What do you work with and describe what your meeting with men usually look like?

Key Questions (open discussion)

- Tell us about the men who come here seeking sexual healthcare.
- What is it like to meet men seeking sexual healthcare?
- What is masculinity to you?
- What is your perception of the men that come here?
- Are there qualities that you consider to be masculine or un-masculine?

Conclusion

- Of all the things we have talked about, what is most important to understand what masculinity is?
- Have any of you thought of something that hasn't come up?
- Do you have something you want to bring up NN [co-moderator]?
- Is there something that feels unclear, something that needs to be clarified?

Thank you for taking the time to participate. If you have any questions, feel free to contact me. Is it okay if I contact you if there is something that needs to be clarified by what any of you have said? If you want the article, write your name and email address on a list and I will send a copy to that address when the article is published. A copy will also be sent directly to the reception.

Probes

- Can you give an example of that?
- Do you all agree with this?
- What do the rest of you think about this?
- Do the rest of you recognize this?
- Does anyone have more/other examples?