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To Plan or Not to Plan

*Gender Perspectives on Pregnancy Planning,
Fertility Awareness and Preconception Health
and Care*

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ACTA
UNIVERSITATIS
UPSALIENSIS
UPPSALA
2018

ISSN 1651-6206
ISBN 978-91-513-0298-0
urn:nbn:se:uu:diva-346125

Dissertation presented at Uppsala University to be publicly examined in Humanistiska teatern, Thunbergsvägen 3, Uppsala, Friday, 18 May 2018 at 13:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish. Faculty examiner: Professor Lars Plantin (Malmö universitet).

Abstract

Bodin, M. 2018. To Plan or Not to Plan. Gender Perspectives on Pregnancy Planning, Fertility Awareness and Preconception Health and Care. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* 1451. 71 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-513-0298-0.

The level of pregnancy planning is of importance to the well-being of parents and children. Unintended and/or unwanted pregnancies are often associated with less health promoting behavior during pregnancy, poorer health of the new born, and relationship dissatisfaction. Preconception care is a health service with the purpose to encourage people to become mindful about their reproductive intentions and raise fertility awareness, in order to maintain or improve reproductive health.

Reproductive health is a highly gendered area, both due to biological conditions and social expectations on gender. In most cases, the focus of reproductive health and health promotion is on cis-women and their bodies. This thesis mainly focuses on persons self-identifying as men. The aim is to scrutinize the area of preconception health, investigate what pregnancy planning means to men and explore the relationship between pregnancy planning and fertility awareness.

In Study I, 136 couples who attended their first antenatal visit answered questions about pregnancy planning. Most pregnancies were planned and couples had similar perceptions of the level of their planning. Study II describes pregnancy planning behavior and fertility knowledge among 796 recent fathers. Also in this study, most pregnancies were planned and 17% of the men had made at least one preconception lifestyle adjustment to improve health and fertility. Fertility knowledge varied greatly, although men with higher education demonstrated higher knowledge. Study III explores if Reproductive Life Plan-based counselling during a sexual health visit could increase men's fertility awareness. The counselling had a moderate effect on participants' fertility knowledge but managed to raise new thoughts about their own fertility, and was well received. Study IV follows up on the results from the first three studies, through in-depth interviews and focus group discussions with 25 men aged 23-49. Most participants took their fertility for granted. To cis-men in heterosexual relationships, the meaning of pregnancy planning usually meant taking the decision to try to become pregnant, and not much more. Trans-men and gay men where more invested in practical planning issues. In conclusion, this thesis shows how pregnancy planning is gendered, and that it is a more complex phenomenon than previously acknowledged.

Keywords: Reproductive Health, Preconception Care, Fertility Awareness, Pregnancy Planning, Men, Fathers

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ISSN 1651-6206

ISBN 978-91-513-0298-0

urn:nbn:se:uu:diva-346125 (<http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-346125>)

*"I alla gränsöverskridande samarbeten uppstår friktion.
Och där det slår gnistor kan man hitta det nya,
det som ingen hade kunnat skapa på sin egen kammare"*

Tilde Björfors (Cirkus Cirkör)

List of papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

- I Bodin, M., Stern, J., Käll, L., Tydén, T., Larsson, M. (2015). Coherence of pregnancy planning within couples expecting a child. *Midwifery*, 31(10):973–978
- II Bodin, M., Käll, L., Tydén, T., Stern, J., Drevin, J., Larsson, M. (2017). Exploring men's pregnancy-planning behaviour and fertility knowledge: a survey among fathers in Sweden. *Upsala Journal of Medical Sciences*, 122(2): 127-135
- III Bodin, M., Tydén, T., Käll, L., Larsson, M. Evaluating Reproductive Life Plan-based counseling with men during a sexual health visit: a randomized controlled trial. *Submitted*
- IV Bodin, M. & Käll, L. 'It's not a problem until it's a problem' A study on men, masculinities and fertility awareness. *Manuscript*

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Abbreviations and definitions

ART	Assisted reproductive technology
CG	Control group
CT	Chlamydia trachomatis
EDC	Endocrine disruptive chemicals
IG	Intervention group
IVF	In vitro fertilization
PCC/PCH	Preconception care/Preconception health
RLP	Reproductive life plan
SRHR	Sexual and reproductive health
STI	Sexually transmitted infection
UN	The United Nations
US	United States of America
WHO	The World Health Organization

Cis-person: Someone whose gender identity corresponds to the biological and juridical sex that was ascribed to the person at birth.

Heteronormativity: The notion that there are only two genders, woman and man, and these two are each other's opposites and are expected to desire each other.

Intersectionality: Relates to the observation that power structures based on categories such as gender, race, sexuality, functionality and class interact with each other in various ways and create inequalities, discrimination and oppression.

Trans-person: Someone whose gender identity/expression does not correspond to the legal gender the person was assigned at birth. A person who violates society's norms and expectations regarding gender, gender expression and gender identity.

Source: Swedish Secretariat for Gender Research (2018)

Assisted reproductive technology: All interventions that include the *in vitro* (extracorporeal) handling of both human oocytes and sperm or of embryos for the purpose of reproduction.

Fertility: The capacity to establish a clinical pregnancy.

Fertility awareness: The understanding of reproduction, fecundity, fecundability, and related individual risk factors (e.g. advanced age, sexual health factors such as sexually transmitted infections, and life style factors such as smoking, obesity) and non-individual risk factors (e.g. environmental and work place factors); including the awareness of societal and cultural factors affecting options to meet reproductive family planning, as well as family building needs.

Infertility: A disease characterized by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or due to an impairment of a person's capacity to reproduce either as an individual or with his/her partner.

Source: The International Glossary on Infertility and Fertility Care by the International Committee for Monitoring Assisted Reproductive Technologies (ICMART) (Zegers-Hochschild et al., 2017)

Preface

To plan or not to plan a pregnancy? This is the overarching question of this thesis. Is it an ideal to plan a pregnancy? What does pregnancy planning mean? How do the answers differ in theory and in practice, to individuals and groups, in the short and long term? In this thesis, I will try to answer these questions by looking at pregnancy planning from both a medical perspective and a gender perspective, with a focus on men's pregnancy planning behaviours.

My work is based on the collaboration between medical sciences and gender studies, and the result is the product of a balancing between them. With a background only in medicine – I began my PhD studies shortly after graduating from a midwifery program – this approach has been quite a challenge. It has meant not only getting acquainted with a whole new research field (gender studies) but also to bring two very different research traditions together. Combining a straightforward, problem-solving approach with critical inquiry and theoretical reasoning has sometimes felt like a Catch 22. With time, my understanding of the project and of science in general has broadened, and so has the aim of the thesis. Now, when I have reached the end, I feel that I have just begun to uncover the layers of analytical work that can be explored.

Introduction

As the title of this book suggests, this is a thesis about pregnancy planning, fertility awareness and preconception health and care. I begin by situating these topics in a very wide perspective to show the importance of bringing a critical gender perspective to this field.

At the centre of this thesis is human rights concerning sexuality and reproduction. Sexual and reproductive health and rights (SRHR) are recognized by the World Health Organization (WHO) as one of the most important areas to strengthen and protect in order to ensure physical and mental health of people worldwide, and to secure economic development (World Health Organization, 2017). Briefly, SRHR includes the right to knowledge about sexual and reproductive health and to making one's own decisions about sexuality and reproduction (such as planning a pregnancy). But in practice, these rights are heavily bound by gender norms. This has been acknowledged by the WHO and the UN, which recently highlighted promotion of gender equality in sexual and reproductive health programmes and policies as an important strategy to reach the organisations' Sustainable Development Goals (universal calls to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity). Reaching 'Good health and wellbeing' and 'Gender Equality' are two out of seventeen goals.

In Sweden, SRHR is one of the eleven focus areas within the Public Health Goals. Despite this, Sweden lacks a national strategy for SRHR. However, in a proposal from 2014, The National Board of Health and Welfare and The Public Health Agency suggested that there should be a national strategy based on the vision of the 'best possible sexual and reproductive health – on equal terms for the whole population and with the fulfilment of everyone's sexual and reproductive rights' (*my translation*) (Socialstyrelsen, 2014). They also suggested that the strategy should follow the work platform 'equal opportunities', which means striving for equal rights and health care for all, regardless of age, sexuality, ethnicity, functionality, religion and gender identity.

However, at the time of writing (2018), a national strategy has yet to be adopted, and sexual and reproductive health care is not equally accessible and available to everyone in Sweden, for different reasons. In this thesis, I will discuss how some of the differences in access and availability are related to gender expectations, which in turn reflect different perceptions of re-

sponsibility and concern for sexual and reproductive wellbeing. The thesis centres on three areas of SRHR that are interlinked: pregnancy planning, fertility awareness and preconception health and care. The main focus of the thesis is on people who self-identify as men. Although this group contributes half of the material needed to create a new life, men often are missing in the reproductive equation in health care, in the social debate as well as in research. To begin, we will look at the background of the current situation of men and sexual and reproductive health care.

Access to and use of sexual and reproductive health care

In Sweden, specific youth clinics work with young people's sexual and reproductive health. The aim of the youth clinics is to enhance the physical and mental wellbeing among individuals ages 12-25 through education, information, support and health care (Föreningen för Sveriges ungdomsmottagningar, 2015). The clinics are staffed with at least one midwife (who can prescribe contraceptives), a counsellor or psychologist, and a physician available for consultations. Even though youth clinics target young people of all genders, only 13% of the visitors are male. Only half as many boys compared to girls mention the youth clinic as their primary source of information concerning contraceptive methods and STIs (Folkhälsomyndigheten, 2015). Instead, young men are more prone to consulting online sources for information. To reach a larger target group, the county councils of Sweden have launched a country-wide online youth clinic (www.umo.se). Also, chlamydia tests are now offered online, which has had some success in reaching more men (Stenqvist, Lindqvist, Almerson, & Jonsson, 2010). However what is partly lost with online services is the opportunity for personal consultations and physical examinations. This leads to a continuation of the focus on the female body as an object of sexual and reproductive health care.

Psychologist William Courtenay, in his article about men's health-seeking behaviours, discusses how norms of masculinity hinder boys and men from perceiving themselves as recipients of care, and that living up to certain ideals of masculinity means putting their health at risk (Courtenay, 2000). The same norms might hinder health providers from regarding boys and men as potential care recipients. This phenomenon is especially pronounced in sexual and reproductive health care since men's sexuality, in contrast to women's, is seen as something that just works well by itself (Folkhälsomyndigheten, 2011). While, for example, adolescent girls learn that physical examinations are important and that attending them is part of being a woman (Oscarsson, Benzein, & Wijma, 2007), adolescent boys do not learn that physical examinations are part of being a man. Mahalik, Burns & Syzdek (2007) further discuss this importance of social context and how men's perceptions of other men's health practices affect their own. In their study, they

found that socio-demographic variables such as income, education and sexuality were significant predictors of men's health-promoting behaviours, but an even stronger factor was their perceptions of normative masculine behaviour. Men who conformed less to traditional masculine norms and believed that other men engaged in health-promoting behaviours reported a greater frequency of health-promoting behaviours.

When transitioning from youth to adult, many women continue to visit a midwife for contraceptive counselling and men continue *not* to seek care. There is a lack of clear health arenas for men, places where they can seek care for problems related to the male body (Arver, Damber, & Giwercman, 2017). In some bigger cities, sexual health clinics specifically for men have opened to better reach people who self-identify as men. But in terms of reproductive health, many men only figure in the health care system as companions to women. Several studies have described how fathers feel neglected by health care professionals during the antenatal and postnatal period (Asenhed, Kilstam, Alehagen, & Baggens, 2014; Edvardsson et al., 2011; Widarsson, Engström, Tydén, Lundberg, & Hammar, 2015; Widarsson, Kerstis, Sundquist, Engström, & Sarkadi, 2012). Not making time or room for men suggests that men are implicitly or explicitly considered to be of less importance in the reproductive sphere. This system is based on normative understandings of gender, where women are assumed to be more interested in and to be more central in reproductive matters than men. It also assumes that the foetus has two cis-gendered parents, one man and one woman, who are in a heterosexual relationship. These assumptions lead to normative expectations of parents, which prevent men from becoming more involved or hinder them from receiving care on equal terms. For example, in a study from the US, gay dads described that their father instincts and abilities to care for a baby were repeatedly questioned by health care personnel (Mallon, 2004).

Not only in the clinical setting does men's reproductive health get little space; the pattern is also the same within research. The empirical literature on reproductive health is almost exclusively devoted to female and heterosexual reproduction (Hanna & Gough, 2015; Inhorn, Tjørnhøj-Thomsen, Goldberg, & Mosegaard, 2009). By continuing to neglect men and fathers in reproductive health care and in research, health services and academia contribute to reproducing and cementing masculine (and feminine) ideals. Not only does this potentially affect men's reproductive health negatively; neglecting men also puts the primary responsibility on women to care for family planning issues, such as contraceptive use and pregnancy planning.

Pregnancy planning

Around 115,000 children are born in Sweden each year (Graviditetsregistret, 2017). The number of pregnancies that occur yearly is impossible to tell since many result in early miscarriages, but it has been estimated that around one out of four confirmed pregnancies are terminated by induced abortion (Socialstyrelsen, 2009). Induced abortions are most common among women ages 20-24 years, closely followed by the age group 25-29. A common reason for abortion is that the pregnancy is unplanned and unwanted because it occurs at the wrong time in life (Makenzius, 2012). Swedish researchers have found that the risk of becoming unintentionally pregnant is high even for those heterosexually active persons who use contraceptives because of inconsistent contraceptive use (Ekstrand, Tydén, Darj, & Larsson, 2009; Halvarsson, Ström, & Liljeros, 2012).

Pregnancies that are unplanned and/or unwanted are seen as problematic from a public health point of view for several reasons. International studies have shown that those who carry an unwanted pregnancy to term are less likely to engage in health-promoting behaviour during pregnancy and have an increased risk of premature birth (Hohmann-Marriott, 2009), as well as a lower probability of breastfeeding (Kost, Landry, & Darroch, 1998; Taylor & Cabral, 2002). Unintended pregnancies have also been associated with increased depressive symptoms and unhappiness among parents (Su, 2012) as well as low birthweights of their children (Shah et al., 2011).

Furthermore, disagreement between the couple concerning intention to become pregnant has the potential of negatively influencing the child's well-being (Korenman, Kaestner, & Joyce, 2002) and the parental relationship (Bouchard, Boudreau, & Hebert, 2006). However, relationship satisfaction has been associated with pregnancy planning in contradictory ways. Lawrence et al. found that higher levels of planning can slow down the experience of decline in relationship satisfaction among men (Lawrence, Rothman, Cobb, Rothman, & Bradbury, 2008). On the other hand, Bouchard et al. found that couples with planned pregnancies estimated their levels of relationship functioning higher before childbirth compared to after, while couples with unplanned pregnancies had the opposite experience (Bouchard et al., 2006). Bouchard et al. try to explain this phenomenon by suggesting that an unplanned pregnancy may trigger anxiety and doubt between couples during pregnancy but that these couples later benefit from the contrast between low expectations and positive actual experiences of parenthood.

Timing of parenthood

The terms unplanned, unintended and unwanted are sometimes used interchangeably when discussing pregnancy planning in research although they often have quite different implications. What pregnancy planning actually

entails in the Swedish context has not been well explored in relation to men, especially not men who do not identify as heterosexual or cis-gendered. What has been more thoroughly investigated is young adults' motivations for having children and their reasoning around the timing of parenthood as well as their views on good parenthood (Bergnéhr, 2008; Eriksson, Larsson, & Tydén, 2012; Plantin, 2001). Commonly mentioned is the ideal societal age of having children and the subjective feelings of having reached maturity before having children, which is manifested as having done other things first. The timing of parenthood is also seen as something contagious (Bergnéhr, 2008, p. 110); entering parenthood at the same time as friends or siblings is considered preferable. Many young adults want a settled life with a stable relationship before having children, but they also express the preference for a stable income of their own to be financially independent from their partner. The time it takes to achieve all these things can vary widely and is related to gender and class, among other factors (Bergnéhr, 2008; Plantin, 2007).

According to a Swedish survey on childbearing, the ideal age to have the first child was said to be ages 25-27 for women and ages 25-30 for men (Statistiska Centralbyrån, 2009). But most people today have their first child several years later. The mean age of having a first child in Sweden is currently 29.1 years for women and 31.5 years for men. There is a higher number of unplanned pregnancies among those who become parents at an early age (<27 years), which further supports the existence of strong norms in society for when to plan for and when to have children. In addition, there are also standards for what a family should look like: the most common family formation in Sweden is still the heterosexual nuclear family (i.e. a mother, a father and children that are full siblings) (Statistiska Centralbyrån, 2012).

Family ideals

Even though norms around family formation are strong, they are also constantly changing. German philosopher Elisabeth Beck-Gernsheim argued 15 years ago that the ideal of a traditional nuclear family was starting to lose its monopoly in Western societies (Beck-Gernsheim, 2002). This does not mean that people want to live alone; instead, they seek ties that are different from those in the past in terms of obligations and duration. Beck-Gernsheim claims that as relationships become more open, mobile and fragile, people rely more on public institutions to provide the security that the family previously gave. Furthermore, she argues that a high value on individualisation has constructed the ideal of planning as a way of coping with the insecurities and uncertainties of life. People now plan in an attempt to bring the future under control. According to Beck-Gernsheim people want to be as prepared as possible before entering parenthood. In more recent years, sociologist Gøsta Esping-Andersen has claimed that 'the family' is clearly recovering in the Scandinavian countries (Esping-Andersen, 2016). There is an increase in

marriages and stable relationships, and fertility rates are rising. He points out that people in the same social strata, specifically those with higher education, that previously preferred the ‘less family’ scenario that are now returning to ‘more family’ ideals. Esping-Andersen argues that this change towards ‘more family’ is driven by the evolution of women’s roles, which both men and society have now adapted to. In countries with more conventional gender roles, the ‘less family’ scenario still dominates. Hence, the gender equality ideal, which has been supported by governmental policies in Sweden since the 1970s, influences how people family plan and construct families.

Literature provides examples of how women and men show different approaches to family planning. Plantin (2001) found that men to a lesser extent than women admit to having actively thought about whether or not to become a parent. Still, men knew that they wanted to be mature before they entered parenthood. Plantin calls this paradoxical approach to family planning “a deliberately unconscious act”. This paradox is also portrayed in popular culture. In the layman-expert daddy handbook *Coola pappor* Swedish TV-celebrity Martin Melin writes:

‘When you’re a young man, maybe between 20 and 25 years old, you usually start thinking about having children. Not that it’s the dominant topic when you hang out with the guys [...] But the vast majority begin during that period to prepare themselves mentally for having children someday [...] When it comes to having children, many men are surprisingly poorly read and prepared. There is certainly enthusiasm among men who have made the decision to try for a baby, but they don’t get caught up in it in the same way as the mother-to-be [...] I have talked to several dads and they all say the same thing: “She wanted to have children, and, sure, there was room in the apartment, so we got going”’. (Melin, 2011)

This text describes men as more laid back when it comes to pregnancy planning compared to women, but it nevertheless claims that men start thinking about parenthood in their 20’s even though they do not talk about it with friends. It also indicates that men, or at least Melin and his friends, assume that they *can* have children and that it is an easy process. This leads us to the next major theme of this thesis, which is men’s fertility and fertility awareness.

Fertility and fertility awareness

Fertility is defined in medical literature as the ability to conceive. It has been estimated that 9% of heterosexual couples globally experience problems with fertility (Boivin, Bunting, Collins, & Nygren, 2007). In half of these cases there is a male factor involved (Esteves, Hamada, Kondray, Pitchika,

& Agarwal, 2012). Male infertility is most often classified as idiopathic, meaning that it is a result of an unknown factor (Arver et al., 2017). The most common known causes of male infertility are varicocele (abnormal enlargement of a vein in the scrotum), hypogonadism (testosterone deficiency), infections and cryptorchidism (retention of the testis in the groin).

Sometimes fertility problems are related to lifestyle and habits. Reviews of fertility and lifestyle factors conclude that there is strong evidence that male fertility can be impaired by smoking and obesity (Homan, Davies, & Norman, 2007), and likely also by diet, stress, alcohol, illicit drugs, radiation and pollution (Sharma, Biedenharn, Fedor, & Agarwal, 2013). Sexually transmitted infections, required through unsafe sex, can cause infertility by damaging the germinal cell, or through the response to the infection from the immune system (Harris, Fronczak, Roth, & Meacham, 2011). The lifestyle related infertility factors are considered *potentially modifiable* since they are caused by habits that could be changed with support from, for example, health care.

In some cases fertility problems are caused by an age-related decline in fertility. The possibility to conceive starts to decline slowly in the late 20s for both women and men. Men with normal testis function produce sperm from puberty and throughout their lives, but the quality of the sperm decreases with time. Increased age (>45 years) among men has been associated with more difficulty achieving pregnancy (Hassan & Killick, 2003), early miscarriages and foetal death (De La Rochebrochard & Thonneau, 2005), as well as increased risk of some psychiatric disorders in children (D'Onofrio et al., 2014), due to genetic mutations during spermatogenesis. However, becoming a parent at an advanced age also has its benefits, and the absolute numbers of complications caused by advanced age are rather small (Mills & Lavender, 2014). Several psychological and social advantages with delaying childbirth have been measured in quantitative studies, such as higher quality of life among mothers (Guedes & Canavarro, 2015) and increased maturity, conscientiousness and social and cultural capital among fathers (D'Onofrio et al., 2014).

Gender patterns in knowledge and behaviour

Several studies on fertility awareness conclude that men have poorer knowledge about fertility and reproduction than women (Bunting, Tsibulsky, & Boivin, 2013; Ekelin, Åkesson, Ångerud, & Kvist, 2012; Lampic, Svanberg, Karlström, & Tydén, 2006; Peterson, Pirritano, Tucker, & Lampic, 2012). Also, due to gender-related expectations regarding femininity, masculinity, motherhood and fatherhood, women usually have to carry the social burden of infertility (Inhorn & Patrizio, 2015). Qualitative studies have found that women either get or take the blame for involuntary childlessness, even when it is caused by a male factor. However, this does not

mean that men are emotionally unaffected by an infertility diagnosis. As described by Webb & Daniluk (1999), Throsby & Gill (2004) and Dolan, Lomas, Ghobara, & Hartshorne (2017), men experience a range of negative emotions such as grief, powerlessness, isolation and threats to masculinity when discovering that they and/or their partners cannot conceive.

What should be mentioned concerning the quantitative studies on fertility awareness is that the questions to measure men's knowledge mostly/only concern *women's* bodies and fertility, which means that the questionnaires themselves are already gender biased. Some exceptions can be found in the studies by Daniluk & Koert (2012, 2015) and Sabarre et al. (2013), where both female and male factors are included.

In many cases, sexuality is discussed separately from reproduction even though the two very often affect each other (Hagström, 1999), like in the example of sexually transmitted infections (STI) as a cause of infertility. A common STI in Sweden is chlamydia trachomatis (CT), of which about 36 000 new cases are reported in Sweden each year (Folkhälsomyndigheten, 2016). Untreated CT infections in women can lead to tubal occlusion and thereby cause tubal infertility and ectopic pregnancies. Chlamydia's influence on male fertility is more uncertain (Mackern-Oberti et al., 2013). But regardless of the effects on male fertility, men can be carriers and spread CT to women through unprotected sex. Still, according to a Swedish survey, fewer men than women believed that it is important to take an STI test when in a sexual relationship, and only 40% of the men had ever taken an STI test compared to 67% of the women (Folkhälsomyndigheten, 2017). When asked why they did not take tests, half of the men said that they "had not thought about it". Men in this study were generally less knowledgeable about STIs than those who identified as women or gender non-binary. Another Swedish online survey about sexual health found that 13% of boys ages 15-19 and 18% of men aged 20-24 did not even know where to get an STI test (Folkhälsomyndigheten, 2015). There are clearly gender differences in consciousness and responsibility in relation to sexual and reproductive health.

Procreative consciousness

To conceptualize men's fertility awareness, sociologist William Marsiglio has coined the term 'procreative consciousness' (Marsiglio, 1991, 2003). It refers to the way men cognitively and emotionally experience being aware of their ability to procreate. Marsiglio argues that men's procreative consciousness is influenced by cultural values, psychologically grounded events, socially grounded personal experiences, and the awareness and attitudes of romantic/sexual partners. The degree or character of consciousness also impacts men's notions of responsibility for sexual and reproductive matters. Hence, their beliefs, attitudes and preferences influence their expectations of and level of participation in contraceptive use, assisted reproductive technol-

ogy (ART), pregnancy and childcare. In an interview study with young heterosexual cis-men, Marsiglio, Hutchinson & Cohan (2001) found that some men started to think about their procreative possibilities as early as in their early teens, while others did not think about it until a female partner became pregnant or they experienced a pregnancy scare (fear of pregnancy when a partner's menses are late). The men also had quite variable understandings of their fertility. For some, becoming aware of their procreative potential represented an important development and personal experience, which had a significant impact on their life course. To others, the insight was an insignificant moment in their lives, and they did not usually give procreation any thought during sexual encounters.

The studies by Marsiglio and colleagues are interesting in that they try to conceptualize the psychology around procreative potential. However, the studies do not focus on fertility awareness in relation to health behaviour and health care, as this thesis does. In the following section, I describe preconception care, a field of health care that has quite recently developed to increase awareness of sexual *and* reproductive matters and to decrease the incidence of unintended pregnancies.

Preconception health and care

As the term suggests, preconception health (PCH) deals with health prior to conception/pregnancy. The goal of preconception care (PCC) is to help people to maintain or improve their reproductive health so that they will have the best possible chances of achieving conception, maintaining a healthy pregnancy and having a healthy child, when wanted (Moos et al., 2008). In a wider perspective, PCC could provide the key to a continuum of care through pregnancy, childbirth, the postnatal period, infancy, childhood, adolescence and adulthood, which is needed to reduce maternal and neonatal mortality and morbidity (World Health Organization, 2013). According to the WHO, preconception care is equally relevant in high-income countries as it is in middle- and low-income countries.

One tool that has been developed for preconception health counselling by the Centers for Disease Control and Prevention (CDC) in the US is the Reproductive Life Plan (RLP) (Johnson et al., 2006). It is a guide for health conversations, starting with the question, "Would you like to have (more) children in the future?". Depending on the person's answer, more probing questions follow, and individualized health and contraceptive advice is offered by a health care professional. With the RLP tool, individual needs can be identified based on the person's stage of life. It is argued that RLP-based counselling can be incorporated into clinical practice at all levels of care to improve reproductive and infant health. An important target group for RLP consultations in the US are African-American women with low socioeco-

conomic status, who statistically are at higher risk for giving birth to premature babies with low birthweights because of poorer preconception and perinatal health (Hogan et al., 2013; Malnory & Johnson, 2011). In the Swedish context, the RLP tool has been tested on a smaller scale during contraceptive counselling with women (Stern, Larsson, Kristiansson, & Tydén, 2013), but it is not an established method nationally, and it has not been directed to or evaluated for specific target groups.

PCC for men

In this thesis, the focus for preconception health is on people who self-identify as men. This is a very large and diverse group of people, and there are probably risk groups among men in Sweden who could benefit more from preconception counselling than others. For example, exposure to toxic substances is usually more frequent among men with lower education and blue-collar jobs (Agricola et al., 2016), which makes them a potential target group for information about EDCs and infertility. Additionally, men with low socio-economic positions are less likely to seek care when experiencing fertility problems (Datta et al., 2016). Both these findings would strengthen the argument for more targeted interventions. However, since men in general have been largely neglected within research on reproduction and there are no specific guidelines for preconception care for men in Sweden, there is a need to investigate this topic more broadly.

Frey, Navarro, Kotelchuck, & Lu (2008) list six distinct reasons why PCC for men is important. First, improving men's preconception health is critical in ensuring that pregnancies are planned and wanted. Second, PCC can lead to better pregnancy outcomes since it addresses lifestyle factors that can affect sperm quality. Third, it gives an opportunity for screening for and treating STIs, which is also beneficial for the preconception health of partners since it prevents the spread of STIs. Fourth, PCC addresses men, involving them in pregnancy planning, so they can support their partners in leading a healthy life. Fifth, it can result in improved responsibility-taking and capacity for parenthood. Sixth, PCC can be a venue to improve men's health through access to primary care. What Frey et al. do not explicitly say but what I see as uniting all the above reasons is that preconception care approaches men as *not at all* dissociated from reproduction, dispelling current impressions. As argued by Inhorn and colleagues, men also need to be reframed as "reproductive in their own right" (Inhorn et al., 2009, p. 3).

There is no national or international consensus about who should deliver preconception care, nor is there agreement about for whom, where, when and how this care should be given. According to a recent review, there are currently no guidelines for the delivery of preconception care to men in any of the six European countries included in the review (Shawe et al., 2015). In Sweden today, midwives are the ones most responsible for reproductive

health care, especially preventive care, which preconception care definitely could be a part of. Still, in the competence description and ethical guidelines for midwives (International Confederation of Midwives, 2014; Socialstyrelsen, 2006), men are not mentioned. The formulations concern women and, sometimes, “their families” or “childbearing families”. Hence, the reproductive health of men and gender non-binary persons seems to be nobody’s responsibility.

Theoretical perspectives

My point of departure in this thesis is that the current lack of attention to men's reproductive health in research and clinical practice is both produced by and contributes to the production of gendered reproductive knowledge (Almeling & Waggoner, 2013, p. 823). My theoretical perspective is based on the concept of 'doing gender' (West & Zimmerman, 1987), drawing on theories of performativity, masculinities and intersectionality. Over time, my theoretical reasoning has come to include theories about normative life scheduling and the intersection of age, gender and sexuality. I also touch on concepts such as risk and healthism. All of these theories can be related to doings of gender.

Doing gender

My theoretical approach is based on the assumption that gender is not static but socially constructed; gender is something we *do* in interaction with others rather than something we are or something we have, like a trait or a role (West & Zimmerman, 1987). A person's sex commonly refers to biological attributes and gender, to social habits and norms, but the terms must not be seen as mutually exclusive but, rather, as complexly intertwined. In their classic article "Doing gender", West and Zimmerman write about the concept of mothering as an example of how gender is constructed (West & Zimmerman, 1987). From an essentialist perspective, mothering is regarded as a merely biological capacity, while a constructionist perspective acknowledges mothering as produced or enabled by structural arrangements, for example, between work and family. This further means that doing gender is not an individual's voluntary and independent decision but a situated doing. Hence, the meanings of sex and gender are ambiguous and change over time and location.

Doing gender has also been described in terms of performativity. Philosopher and gender theorist Judith Butler suggests that a person's sex or gender does not exist until it has been attributed to the person by a performative speech act (Butler, 2007). For example, when a child is born and someone looks at the child's genitals and thereafter exclaims, "It's a boy!" or "It's a girl!", this is the moment when the sex/gender is done. However, performativities are based on the repetition of acts, and sex and gender must repeated-

ly be recreated to persist and be convincing. The repetitions create an illusion of stable and fixed identities. But, since it is not possible to do exactly the same thing every time, there is always a possibility for change.

The performative speech act is an explicit part of creating differences between sexes. The creation of two clearly identifiable sexes/genders, which are defined as each other's opposites and where the male sex/gender dominates, lays the foundation of what we perceive as intelligible subjects (Butler, 2007). This means, among other things, that infants who are born intersex become unintelligible. This leads to medical interventions to maintain this gender order, for example, to 'correct' genitalia so that an infant becomes consistent with one of two sexes. This example highlights that not only gender but also sex is affected by social thinking (Feder, 2014). Butler argues that the people we define as either male or female (depending on the appearance of their genitals) are expected to possess certain gendered characteristics ("masculine" and "feminine") and experience (only) heterosexual desire. She labels this logic 'The Heterosexual Matrix'. These normative and coherent presumptions about gender and sexuality determine what qualifies as intelligible subjects, for example, during a sexual and reproductive health care encounter.

Masculinities

Critical Studies on Men and Masculinities (CSMM) is a research field that scrutinises doings of masculinity and critiques the gender order that supports men's hegemonic forms of power with a profeminist and anti-essentialist approach (Lykke, 2009). I position my thesis within this field. This means, among other things, that I view masculinities as social constructions and analyse my findings from a doing-gender perspective.

Masculinity can be defined as the cultural opposite of, and a social differentiation from, femininity. Even though the content of this differentiation varies across societies and over time, masculinity is always an object of knowledge in relation to femininity (Connell, 1995). Sociologist Raewyn Connell suggests that when trying to define masculinity (and femininity), we need to focus on processes and relationships through which men and women conduct gendered lives. Connell writes that masculinity "is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture" (ibid, pp. 33-34). Hence, masculinities concern the position of men in the gender order.

One of the best known concepts used within CSMM is hegemonic masculinity as described by Connell (1995). The concept is based on the idea that masculinities within a culture are ordered in a hegemonic hierarchy into four categories of masculinity. The first and authoritarian category is the *hege-*

monic; it is a masculinity that occupies a leading position in social life and guarantees the dominant position of men and the subordination of women. The opposite is *subordinate* masculinity, which means subordination through a culturally normative relationship of dominance. For example, homosexual men represent a subordinate masculinity in Western societies since gayness can be associated with femininity in contemporary European and American cultures. A third category of masculinity is the *complicit*. Complicit masculinity is upheld by a broad group of men who do not actually embody hegemonic masculinity but uphold it as an ideal and also benefit from patriarchal structures in society. These first three categories of masculinities represent relations within the gender order.

The fourth, *marginalised* masculinity, refers to how gender interplays with other structures in society such as race, class and age, as well as the relationships between dominant and subordinate masculinities within these structures (Connell, 1995). Connell gives an example of how some black athletes in the US might hold a hegemonic position because of their accomplishments, but their fame does not give authority to black men in general. By applying an intersectional analytical approach in research we are able to examine how various biological, social and cultural categories interact on multiple and often simultaneous levels (Lykke, 2009). The underlying idea of intersectionality is that an interaction of categories creates a system of oppression that reflects the intersection of multiple forms of discrimination. Power structures and identity categories are not separate entities adding to each other; instead they mutually interact. Hence, none of the social structures can be fully understood without taking the others into account. Men's reproductive health, for example, cannot be understood solely through the lens of gender. Several other social structures intersect with gender and determine men's wellbeing, such as age and sexuality. Hence, combining an intersectional approach with biomedical research makes it possible to show that even though health is experienced at an individual level, "individual health outcomes and inequities, manifested in the body, are inextricably linked to interacting processes and structures of power at multiple levels" (Hankivsky et al., 2017). In this thesis I focus mainly on the intersection between gender, sexuality and age since I find these categories particularly relevant to the discussion about sexual and reproductive health and parenthood. These categories are associated with strong norms for appropriate behaviour at certain times during the life course, which separately and in combination can be determinants of health.

Masculinities and bodies

The physical sense of maleness and femaleness is usually central to the cultural interpretation of gender. In many societies there is a belief in the idea of

a real and natural man whose true masculinity is derived from his body (Connell, 2001). The body is believed either to drive masculine action (referred to as natural behaviour) or to set limits for non-masculine actions (unnatural behaviour). Because of these beliefs, it is important not to forget the body when conducting masculinity studies (Fausto-Sterling, 1995). Still, men's bodies and embodiment have received little attention within critical research on masculinities (Whitehead, 2002). In the media, on the other hand, men's bodies are increasingly discussed, especially in relation to health and fitness. But even though the examination of men's bodies and looks has similarities to that of women's, it is important to keep in mind that the ideals which influence male embodiment derive from a different set of power equations.

The dominant notion of embodied masculinity emerges from the ideal that the male body should represent force, strength and health (Whitehead, 2002). These expectations can affect men's likelihood of seeking health care. For example, in two studies from the UK, men in general felt restricted in their abilities to admit illness, but this feeling lessened if they had injured themselves during a typical male occupation or physical activity, like a rough sports game (Tyler & Williams, 2013). The feeling also lessened when health care was needed to preserve or restore the body so it could function to do another, more valued, enactment of masculinity (O'Brien, Hunt, & Hart, 2005). Just like other doings of gender, notions of the male body are historically differentiated, temporally and spatially located and highly specific to cultural sites. It is therefore relevant to consider contemporary ideals of masculinity in the context where the men are situated. There is not one male body that can universally represent one true masculinity. Still, the body becomes particularly relevant to studies of masculinities and reproduction since proving fertility is seen as an important step in becoming a true male in many cultures (Fausto-Sterling, 1995), an idea also based on the heterosexual matrix.

Men and family life

In past decades, quite a lot of research has been done on masculinities, equality, care and parenthood practices (Hanlon, 2012; Hobson, 2002; Johansson & Klinth, 2008; Lupton & Barclay, 1997; Mallon, 2004; Plantin, 2001). Swedish masculinity scholars argue that involved fatherhood has become an integrated part of hegemonic masculinity in contemporary Sweden and in the dominant discourses on being a man (Hearn et al., 2012). To qualify for hegemonic masculinity, it is no longer enough to live up to traditional masculine traits of rationality, goal orientation and discipline. Men must also display their orientation toward children, their readiness to engage in child care, and their willingness to live up to the ideal of gender equality (Johansson & Klinth, 2008). However, some scholars criticise the idealised

image of the egalitarian Swedish father. For example, it is argued that paternal involvement does not by default indicate gender equality. Instead being child-oriented as a man mostly means playing and talking with their children rather than taking responsibility for childcare and household work (Forsberg, 2009). Another criticism is that the gender-equal man is almost exclusively portrayed as white, middle-class and heterosexual, which results in a process of othering men who do not meet these requirements as well as reinforcing genders as stable and binary (Björk, 2017; Martinsson, Griffin, & Giritli Nygren, 2016). The gender equality project is also based on the heterosexual matrix, which means that LGBT issues do not fit into the equation and must therefore be discussed in other political contexts (Järvklo, 2008).

Gender equality and doings of masculinity during the preconception and pregnancy planning period have not been described and discussed as much as they have in relation to fatherhood (Culley, Hudson, & Lohan, 2013). However, there are exceptions, such as Campo-Engelstein, Kaufman and Parker's analysis of different types of 'new men' that have emerged in the discourse around male contraceptive use (Campo-Engelstein, Kaufman, & Parker, 2017). By analysing the content of US newspaper articles concerning new male contraceptives (NMC), they identified two types of men who are likely to use NMC. One is the caring man, who is usually in a long-term monogamous relationship and would use NMC to share the burden of contraceptive responsibility with his female partner. The other one is the reproductive man, who considers himself a reproductive being with responsibility for his own fertility and who uses NMC to enhance his reproductive autonomy. These men do not regard the use of male contraceptives as a threat to masculinity (which is otherwise a common argument for why men place responsibility for contraception on women); rather, contraceptive use may enhance masculinity since the user proves to be a responsible person. This positive approach towards preventive health care was also found by Farri-mond (2011), who interviewed men with high socio-economic position about their health-seeking behaviour. These men referred to other men who avoided doctors as Neanderthals and constructed themselves as their opposites, by framing themselves as pro-active, problem-solving and in control. Campo-Engelstein, Kaufman & Parker argue that the movement towards gender equality in parenting has made some of the caring men think of themselves as potential parents during the preconception period and consequently reflect more on their abilities and responsibilities (Campo-Engelstein et al., 2017). The reproductive man, on the other hand, is in their view a result of the increased medicalisation of men's sexuality and the conflation of virility and fertility, making this man therefore less family-oriented.

Marsiglio and colleagues, who have written about men's procreative consciousness for decades, have in more recent years started to discuss masculinity from a more critical perspective. They argue also that more inclusive constructions of masculinity that embrace a profeminist perspective enable

men to engage more fully with the procreative realm and pregnancy planning (Marsiglio, Lohan, & Culley, 2013). Marsiglio et al. also address the important point that men's procreative consciousness and responsibility evolve during the life course, which brings us to the next corner stone of my theoretical framework, the analytical tool *Lifelines*.

Lifelines

The Lifelines framework (Swedish: *Livslinjer*) was developed by Swedish social anthropologist Fanny Ambjörnsson and literary scholar Maria Jönsson (2010). The focus of their conceptual structure is on how gender and sexuality are constructed in relation to age. Ambjörnsson and Jönsson argue that age should not be seen merely as a physiological process but as a cultural and social process built on ideas about the human, the human body and the course of life. For example, where and when we grow up and live have an impact on our experiences of age and ageing. The framework is based on queer theoretical perspectives, foremost on Jack Halberstam's concept, life schedules, and Sarah Ahmed's concept, the straight line.

In the book *In a Queer Time and Place*, Halberstam claims that we use certain life schedules or life manuals to orient in life, as well as to give it meaning, comprehensibility and a context (Halberstam, 2005). The schedules are constructed by contemporary cultures and ideas about how lives should be lived appropriately. How we lead our lives is particularly influenced by heteronormativity and middle-class ideals about respectability and normality. To live a life that is comprehensible to oneself and others, one must do things in a particular order and at certain points in life. The normative life schedule tells us when and how it is appropriate to experience puberty, fall in love with someone (of the opposite sex), get a decent career, settle down, and have children, among other markers. According to Halberstam, there is a prevailing belief in society that our lives run by gradual maturation, development and a search for authenticity. Building a family and having children are seen as the pinnacles of life, giving it meaning, direction and future. The nuclear family becomes a symbol of a good and successful life, and it is a central component in the transition from childhood to adulthood. Consequently, according to this framework, those who do not follow the normative life schedule are seen as immature and inauthentic.

Ahmed uses the metaphor of the straight line in *Queer Phenomenology* to illustrate how we tread down a life path through habits and repetition that both shape our direction and ourselves (Ahmed, 2006). Each situation in life is characterized by previous experiences. At the same time as the path urges one to pursue it, it also becomes clearer for other people that this particular path is the appropriate one to choose. Ahmed writes that "for a life to count as a good life, then it must return the debt of its life by taking on the direc-

tion promised as socially good, which means imagining one's futurity in terms of reaching certain points along a life course" (Ahmed, 2006, p. 21). This life path is constructed within the frame of heteronormativity, meaning that to age properly within the frame of gender norms, one needs to be in a heterosexual relationship and achieve certain gendered life goals.

Getting out of line, willingly or unwillingly, implies that one becomes disoriented in time and space. Another important concept within the lifeline framework is therefore *timing* and *un-timeliness* (my translation, Swedish: *osamtidighet*). Un-timeliness means that one is unable or unwilling to act in ways that are normative for one's age and with what is current in society. A discrepancy is created between one's physical and social age. Ambjörnsson and Jönsson give the example of how a 20-year-old single woman who goes out partying a lot is perceived as enviable and free, while a 35-year-old single woman with similar behaviour is viewed as tragic. In sum, we have to live according to the straight line to appear as age-appropriate.

In this thesis, I will use theories of masculinities in combination with the Lifeline framework to analyse how gender is constructed and reproduced within the available data material and in relation to sexuality and age/timeliness.

Rationale for the research project

By studying men's (and couples') levels of knowledge, thoughts and expressed needs within the field of family planning, this project makes a contribution to the still-limited body of research on men and reproductive behaviours. The theoretical approach will deepen the understanding of how people of reproductive age reason about family planning and responsibility in relation to contemporary norms of gender, sexuality and age in the Swedish context. This knowledge is necessary to consider how sexual and reproductive health care might be improved and made equally available to everyone, regardless of sex/gender.

Overall and specific aims

This project seeks to explore the importance of pregnancy planning in intimate relationships, as well as the meaning of pregnancy planning and preconception health for men. It further aims to describe how societal norms and standards affect the planning of pregnancies and fertility awareness.

The specific aims of the different studies compiled in this thesis project were:

1. To investigate the level of pregnancy planning according to couples expecting a child, and to compare if the pregnant woman and her partner have similar perceptions of the level of planning.
2. To investigate how men plan and prepare for pregnancy, and to assess their fertility knowledge after having become fathers.
3. To evaluate whether preconception health counselling during a sexual health visit increases men's fertility awareness and to evaluate participants' and involved staffs' experiences of the intervention.
4. To explore how men reason about fertility, reproduction and pregnancy planning and to discuss the findings in relation to contemporary norms of parenthood, health, gender, sexuality and age.

Methods and materials

Design

An overview of the studies is presented in Table 1.

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

Study	Design	Data	Participants	Analysis
I	Multi-centre cross-sectional	Questionnaire (pilot study)	136 couples	Descriptive and comparative statistics
II	Multi-centre cross-sectional	Questionnaire	796 men	Descriptive and comparative statistics
III	Randomised controlled trial	Baseline questionnaire and follow-up interviews	201 men 6 midwives	Descriptive and comparative statistics Manifest content analysis
IV	Qualitative study	Individual and focus group interviews	25 men	Thematic interpretative analysis

Data collection, participants and analysis

Studies I and II

The aims of the first two studies were to measure levels of pregnancy planning and men's fertility knowledge. The studies are based on cross-sectional data from the longitudinal prospective cohort study Swedish Pregnancy Planning (SWEPP) study. Pregnant women were recruited at the time of enrolment in antenatal care, usually gestational week 10-12. The studies consisted of three questionnaires; the first was filled out at the first antenatal visit (pQ1 and Q1), the second was sent home in gestational week 33-35 (pQ2 and Q2), and the third one year after childbirth (pQ3 and Q3). Partners were only invited to fill out one questionnaire: in Study I at the first point in time (pQ1), and in Study II at the third point in time (Q3).

Data in Study I were derived from the pilot study, which was conducted in 2011-2012. Participants were recruited at 17 antenatal clinics in Mid-Sweden during a seven-month period. In total 293 women as well as their partners if they were involved were invited to participate in the study; 232 women and 144 partners accepted. The data of Study I are derived from the first questionnaire (pQ1), which was answered by both the women and their partners. The analyses include 136 couples.

Data in Study II are derived from the final SWEPP study. In that study, 216 antenatal clinics in 10 counties were asked to recruit participants, and 153 accepted. A total of 5493 pregnant women were invited to take part in the study, and 3389 (61%) women ultimately completed the first questionnaire (Q1). The second questionnaire was completed by 2583 women. The third questionnaire (Q3) was sent to the first 2000 women who had completed both Q1 and Q2. Those who had stated that they were in a relationship were also sent a partner questionnaire (Q3P). In total 1988 partner questionnaires were sent out and 818 were returned. Answers from 796 men were included in the final analysis. Partners that self-identified as female (n=14) and men who were new partners (not the same as during pregnancy, n=8) were excluded from the analysis.

The questionnaires concerned socioeconomic background, lifestyles, health, pregnancy planning, and relationship satisfaction. Validated scales were used to measure levels of pregnancy planning and relationship satisfaction. The measurements used in Study I were the Relational Assessment Scale (RAS), the London Measurement of Unplanned Pregnancies (LMUP) and the Swedish Pregnancy Planning Scale (SPPS). *The LMUP* was developed by Barrett and colleagues to include different aspects of pregnancy planning, such as intention, timing and behavioural change, into one measurement (G Barrett, Smith, & Wellings, 2004). The measurement was developed from qualitative findings and has been used and validated in several

different countries (Almaghaslah, Rochat, & Farhat, 2017; Borges et al., 2016; Hall et al., 2013; Morof et al., 2009). The SPPS, on the other hand, is a one-item question where pregnancy planning is estimated by the respondent on a five point Likert scale. The question is “How planned was your pregnancy?”, and possible answers are “Very planned”, “Fairly planned”, “Neither planned nor unplanned”, “Fairly unplanned” and “Very unplanned”. The SPPS was used in both Study I and II.

The questions used to measure fertility knowledge were study-specific, but based on The Swedish Fertility Awareness Questionnaire used in several previous studies (e.g. Lampic et al., 2006; Skoog Svanberg, Lampic, Karlström, & Tydén, 2006) and further developed in collaboration with clinical experts. The questions were open-ended, but a unit was given (e.g. days/percent/years). The questions are found in Table 2.

The pilot study excluded non-Swedish speaking participants throughout. The final survey offered Q1 in English and Arabic translations, or a shortened version of Q1 in any language via telephone (interpreted). A total of 124 women (2%) used a translated questionnaire (around 25% of all women giving birth in Sweden are born abroad, but there are no statistics showing how many do not speak Swedish). However Q3 was only available in Swedish, which means that non-Swedish-speaking men were unable to participate.

Data were analysed using the statistical software SPSS (Versions 20-24). Descriptive statistics were used to present sociodemographic variables. To test if there were any differences within couples concerning pregnancy intention and planning, McNemar’s and Wilcoxon signed rank tests were used in Study I. An independent samples t-test was performed to investigate differences in total mean LMUP score in relation to socio-demographic factors and to compare women whose partners participated in the study with those whose partners did not. In Study II, Chi-square test was used for comparisons between men who had made a lifestyle adjustment and those who had not, in relation to categorical background variables. Independent t test was used to analyze difference in mean age (years) between the two groups, and Mann–Whitney U test to analyze difference in time to pregnancy.

Table 2. Questions used to measure fertility knowledge

Knowledge questions	Used in study
1. How long is the ovum viable for fertilization after ovulation?	II, III
2. How long does sperm usually survive in the uterus/fallopian tubes after intercourse?	II, III
3. How likely is it that a 25-year-old woman becomes pregnant if she has unprotected intercourse with a young man at time of ovulation?	II, III
4. At what age is there a marked decline in a woman's ability to become pregnant?	II, III
5. How often is involuntary childlessness among heterosexual couples caused by a male factor?	III
6. What are the average chances of having a child through IVF, for each attempt?	II, III

Study III

The aim of this study was to evaluate preconception health counselling with men. It was designed as a randomised controlled trial, with one intervention group (IG) and one control group (CG). The intervention was a brief midwife-led consultation about preconception health, fertility and lifestyle with men during their visit at a sexual health clinic. Men ages 18-50 were recruited at two sexual health clinics in two of Sweden's largest cities. Clinic A had about 3000 male visitors per year, and most of them came in for STI testing. Participants were recruited at drop-in hours by staff at the front desk at the clinic. Clinic B was a small clinic for men integrated into a larger health centre, which was only open once a week and targeted men ages 20-29. Most visits there were pre-booked. Participants were recruited in the waiting room by the midwives who were in charge of the clinic.

Participants were randomized by picking up a color-coded envelope from a box. All participants completed a baseline questionnaire in the waiting room, including sociodemographic questions, questions about sexual and reproductive history, and questions to assess fertility knowledge (Table 3). When called in for the appointment, midwives could determine from the colour code whether the man should have the intervention or not. All participants received standard care, and men in IG also received a brief preconception health counselling session guided by the RLP tool and an informational

brochure to take home. Three months later, participants were phoned and asked to answer the same knowledge questions as at baseline. Comparative statistics were used to measure if the intervention had any effect on fertility awareness.

To further evaluate the intervention, men in IG were asked about their impressions of the counselling session. Closed questions were used and answers were chosen from a Likert scale. Spontaneous additional comments were noted in the margins of the questionnaire. When data collection was completed, the study was also evaluated by midwives through group discussions at the clinics. The discussions were recorded, transcribed, and thereafter analysed with manifest content analysis.

In total 750 men were assessed for eligibility; 87 were excluded since they did not meet the inclusion criteria, and 434 declined participation. Of the 229 men who accepted participation, 201 (106 in IG and 95 in CG) were eventually included in the analysis at baseline, and 161 men were included at follow up (79 in IG and 82 in CG).

Study IV

The last study aimed at exploring men's reasoning around fertility, reproduction and pregnancy planning. It was designed as an interview study and included 25 men, ages 23-49 years. The inclusion criteria for participating in the study were 1) to self-identify as a man, 2) to be able to speak Swedish, and 3) to be around 20-35 years of age. The age criterion was set to capture men who are most likely to be in a preconception state of mind, referring to that the mean age of having the first child in Sweden is 31.5 for men. However, this criterion was flexible and no man was excluded from participating because of his age. It was also stated in the study information that it did not matter whether or not the participants wanted to have or already had children.

The interviews took place between May and December, 2016, at various locations in Mid-Sweden, most of them in urban settings but some in smaller towns and in rural areas. Participants were recruited strategically with the aim for variety with regard to socio-economic positions, educational levels, occupations, sexuality, and countries of birth. I recruited participants through my own social networks, an advertisement through a LGBTQ organization, and through the snowball sampling technique. In the end, the sample turned out to vary in all areas except country of birth (only two participants were born abroad, both of them in the Middle East).

Eight men were interviewed individually, and the remaining 17 were interviewed in four groups made up of friends or colleagues, with 3-6 men in each group. I used both individual and group interviews since I was interested in hearing how men reflected on certain topics when only talking to me versus when discussing them in a group. The individual interviews also

made it possible to linger and probe deeper into matters that I wanted to know more about, while during group interviews the participants themselves chose what to expand on and asked each other follow-up questions. The groups were comprised of men who were acquainted with each other since I wanted the discussions to somewhat resemble an authentic conversation between friends or colleagues. Two of the group interviews took place in homes in the evening, and two, at work places (one after work, and one during an extended lunch break). The group interviews lasted between 60-80 minutes. Individual interviews took place at a location chosen by the participant. Most men preferred coming to my office, though one interview took place in a library, and two, in the home of the participants. The individual interviews lasted between 50-80 minutes.

I used a semi-structured interview guide, starting with questions about family and parenthood visions and ending with questions about fertility. The interview guide was developed with inspiration from the questions designed by Marsiglio to promote life story narratives (Marsiglio, 2003). All interviews were recorded with permission from the participants, transcribed verbatim and anonymized. After each interview, I made notes in a journal about my impressions of the interview (the ambience, interesting things that were discussed and reflections around their possible meanings). I have come back to these notes in later stages of the analytic process.

In this study, I worked with Marsiglio's theoretical concept procreative consciousness (Marsiglio, 1991) when analysing the interviews using an interpretative thematic approach. Thematic analysis is "a method which works both to reflect reality, and to unpick or unravel the surface of 'reality'" (Braun & Clarke, 2006). According to Braun and Clarke, it is an analytical process which involves moving between the entire data set, the codes and the produced analysis, constantly taking notes and writing down ideas.

After having transcribed and read the interviews several times, I extrapolated the passages that concerned fertility, which then became my data set. I condensed these passages to shorter meaning units and then to initial codes. The coding of the interviews was mainly theory-driven, meaning that I approached the data with specific questions in mind and I coded around them. More specifically, I analysed how men talked about fertility in relation to Marsiglio's criteria and definitions of procreative consciousness. However, I was open to other ways of interpreting the narratives that fell outside Marsiglio's framework. In that sense, I had both a deductive and an inductive approach. I did not limit the analysis to a semantic level. Rather, I conducted an interpretative analysis, which means that I examined underlying ideas and assumptions that shaped or informed the semantic content (Braun & Clarke, 2006, p. 13). Next, I sorted codes that were related to each other and formed a base of repeated patterns into different themes. The themes were then revised, refined and named during the process of writing and producing the analytical report.

Ethical considerations

Before the studies began, they were approved by the Regional Ethical Review Board in Uppsala, Sweden (reference numbers 2010/085, 2012/101 and 2016/037). All participants received information about the study before making a decision whether or not to participate. They were informed that participation was voluntary and that they could quit the study at any time without giving a reason. All participants were age 18 or older. In studies I and II, participants gave oral and/or written consent to participate. Providing personal information (for follow-up) was voluntary and if given, it was treated with confidentiality. In study III participants signed a letter of informed consent and provided a telephone number so that they could be reached for follow-up. In the interview study, written and oral information about the study aim and procedure was given in advance by e-mail and again right before the commencement of the interview. Participants gave their informed consent to participate orally. To ensure the anonymity of the participants, questionnaires were coded and transcription data files were de-identified and locked with a password. Contact details for participants and other personal information were kept separate from questionnaires/transcriptions in a locked room where only the principal investigators could access them.

Several questions in the surveys dealt with delicate topics, such as sexual life and relationship satisfaction. Therefore, it was very important to stress the voluntariness of participation and to be understanding about possible non-responses to certain questions. When collecting data for Q2 and Q3 in the SWEPP study, we also had to deal with the possibility that some of the pregnancies were not carried to term. Because of this, we made room for additional comments at the beginning and the end of the questionnaires, and suggestions were listed on the back of the survey where participants could seek professional support. In the end, only a few couples who had lost their children responded to the final questionnaire. We had personal contact with these couples to make sure that they had gotten/would get support, if needed.

From time to time throughout the interviews, I summarized what I perceived the participant to have said to make sure that I interpreted what he told me accurately. I also ended the interviews with some evaluating questions where participants had the opportunity to express their impressions of the questions and the interview in general.

Summary of findings

Study I

The main finding was that there were no statistical differences in how pregnant women and their partners estimated the level of pregnancy planning (Table 3). The partners in this study had made a mutual decision to attempt to have a baby and planned the pregnancy to a high extent. Furthermore, almost all couples were satisfied with their relationship. Level of planning did not seem to be affected by individual socio-demographic variables. However, when conducting a dropout analysis, we found a difference worth noting between women whose partner did participate in the study (paired) and women whose partners did not. Paired women had a higher level of pregnancy planning and were more satisfied with their intimate relationship.

Table 2. Intentions of pregnancy and levels of planning among 136 pregnant women and their partners¹.

	Pregnant women		Partners		p-value
Deliberately became pregnant	114	(83.8)	111	(81.6)	0.727
Who took the initiative to get pregnant?*					0.275
Only/mainly me	17	(14.7)	3	(2.7)	
Both equally	94	(81.7)	94	(84.7)	
Only/mainly my partner	4	(3.5)	14	(12.6)	
Level of pregnancy planning					0.669
Very planned	65	(48.1)	64	(47.4)	
Fairly planned	40	(29.6)	38	(28.1)	
Neither planned or unplanned	16	(11.9)	20	(14.8)	
Fairly unplanned	8	(6.0)	7	(5.2)	
Very unplanned	6	(4.4)	6	(4.4)	

¹ The table differ from Table 3 in Paper I since an additional analysis was made after publication

* The question was only answered by those who deliberately became pregnant

Study II

Of the 796 participants, 646 (81%) stated that the pregnancy had been very or fairly planned, and 17% (n=128) had made a lifestyle adjustment before pregnancy to improve their health and fertility. Roughly one third of them had made more than one adjustment. The most common adjustments were to reduce/quit the consumption of alcohol, cigarettes, or snuff, and to exercise more. First-time fathers were more likely to have made adjustments than fathers with previous children (25% compared to 9%). Those who had used ART to become pregnant were more likely to have made adjustments than those who became pregnant spontaneously (43% compared to 15%). Fertility knowledge varied greatly, although the mean knowledge scores were fairly high. Men with university educations had higher fertility knowledge than men without university educations, and those who had used ART were more knowledgeable about the success rate of IVF than others.

Study III

The mean age of the participants was 28 years. Almost half had a university education and 15% were born abroad. Four out of ten were in a stable romantic relationship. A history of STI was common, and the most frequent type was Chlamydia. One out of three men had been involved in at least one pregnancy, and 23.5% had experienced an induced abortion. Seventy-one percent wanted to have (more) children (75% of the men without children and 33% of the fathers) and 12 % were unsure. When asked about their motivations to have children, most men referred to emotional reasons (e.g. “I love children”, “There’s more to love”, “The joy they bring”), biological/natural reasons (e.g. “To pass on my genes and create life”, “A biological necessity”, “A natural step in life”), relational reasons (e.g. “Experience it with my partner”, “It’s important to my partner”, “To create a family with the one I love”) and personal development (“Take responsibility and grow as a person”, “I want a child to care for, teach things, see the child grow and guide him or her through life”, “You want children because this changes the course of your life”). Arguments against having children were fewer and less uniform, but some men referred to a feeling of fright or doubt about one’s own capabilities (e.g. “A big and essential commitment that scares me”, “I don’t like children, I don’t think I would be a good parent” or “The world is rough”). Some had more concrete reasons, like “There are already too many people on Earth”, “I would like to adopt as a single person, but it seems impossible for men in Sweden”, “I have a hereditary disease”. Again, the relationship with the partner was important (“Bad relationship, the conditions must be right, in other words, the right partner, otherwise it’s just selfish to have children”, “If I don’t love her”, “If my partner doesn’t want children”).

However, the most common arguments against having children were economic (“No apartment”, “I can’t afford it from a financial point of view”, “Insecure employment”) or concerned personal development (“Takes focus and time from my other ambitions in life”, “A limitation of my autonomy”, “Mentally challenging”, “Time- and energy-consuming”, “You’re not as flexible”).

At baseline, the mean fertility knowledge score for the whole sample ($n = 201$) was 4.6 ± 1.9 out of 12. There was no difference between IG and CG. Those who were fathers ($n = 21$) were more knowledgeable than non-fathers (5.4 ± 1.7 and 4.5 ± 1.9 respectively, $p=0.046$). Men with secondary educations had lower knowledge than men with university educations (mean score 4.3 ± 2.0 and 5.0 ± 1.9 respectively, $p=0.043$). At follow-up, men in the IG had increased their mean knowledge score from 4.6 ± 2.1 to 5.5 ± 2.2 ($p=0.004$). There was no improvement in the CG (4.6 ± 1.9 to 4.7 ± 2.3 , $p=0.693$).

The total mean number of lifestyle factors (that could impair male fertility) mentioned was 3.4 ± 1.8 at baseline. The most commonly mentioned factors were tobacco use (mentioned by 57.5%), alcohol (55%) and unhealthy diet (50%). Few mentioned the possible impacts of STI’s, age, weight and endocrine disrupting chemicals (EDC). Some men mentioned additional lifestyle factors that are not evidence-based and therefore not included in the statistical analysis, such as wearing tight underwear and bicycling. At follow-up, men in IG had improved their mean from 3.6 ± 1.9 to 4.4 ± 1.6 factors, ($p<0.001$), but there was no improvement in the CG (3.4 ± 1.7 to 3.5 ± 1.5). The factors that men in IG were more knowledgeable of after the intervention were alcohol, unhealthy diet and illicit drugs. The effect of the intervention was not associated with any of the possible confounders tested for.

As for men’s understandings of the intervention, most men had a positive experience being asked about their reproductive life plan and had gained new information. One out of four had never previously thought about the matters that were discussed during the intervention. Twenty-eight percent stated that the counselling had brought about new thoughts about fertility, and 22% had searched for more information about fertility afterwards. Two out of three stated that they would probably turn to a midwife again if they wanted more information about fertility. However, two recurring comments were that googling would be the first option if they would want to know more and that they would not seek more information until the time to conceive a child. Even though a majority found it likely that they would make a preconception lifestyle adjustment in the future, some also commented that they found it unnecessary because they perceived that they already lived a sufficiently healthy life or that it was unnecessary to change anything before a fertility problem occurred.

The midwives found the RLP tool quite user-friendly, but they were concerned about the low participation rate in the study. They felt that many men were taken by surprise by the request to participate. Even though the coun-

selling sessions ran rather smoothly and most participants were perceived as interested in the topic, the midwives expressed mixed feelings about continuing using RLP-based counselling in the future because of the low interest. They emphasized that a RLP discussion should take place on the man's initiative to be productive.

Study IV

The participants in this study were in general in favour of having children. Seven were fathers already and one was co-parenting. Fifteen men wanted to become parents and only two were unsure. As for their procreative consciousness, it seemed at first that most men had never given much thought to their fertility. They had not questioned their ability to procreate or given thought to lifestyle factors that could affect their fertility. It was common to express a fatalistic approach towards fertility and argue that "it is not a problem until it is a problem". There was also an assumption among cis-heterosexual men that potential fertility problems lay with the woman. Men who were trying to have children outside the heteronormative nuclear format argued that their focus on other practical concerns (like searching information about surrogacy) had taken their mind off fertility concerns.

Since fertility was not thought about often, it was not spoken of either. Some men could not understand why a person would talk about something that was not (yet) a problem, and others found the topic uninteresting or even strange to talk about. It was clearly non-normative for men in the study to talk with their male friends about fertility. They were nevertheless open to talking to friends about their preferences to have children or not. As friends and siblings had started to have children, it was more common and acceptable to talk about children and family plans. Furthermore, it seemed as if it was easier for men to talk about reproduction and fertility with women. Some already talked about it with their female friends or partners, and others said that they would turn to their mother for consultation if a problem occurred. No one said that they would talk to their father.

Although very little procreative consciousness was expressed at first, it gradually became clear that several men had sometimes worried that they would not be able to procreate once it was time to have a family. Participants became aware of their unconscious ideas during the interviews. Their procreative consciousness had been raised over the course of their lives by several different triggers, such as having been kicked in the crotch, the occurrence of a friend getting testicular cancer or by reading intimidating headlines in the tabloid press about adverse lifestyles and infertility. Some heterosexual cis-men related their worry to the fact that they had been careless with contraceptive use on several occasions without any pregnancy occurring. To others, consciousness was raised just by the sight of one's semen or

scrotum. However, there was insecurity around what actually affects male fertility and which headlines to trust, and this was probably one of the reasons to why the subject was not easily discussed. When asked about their preconception lifestyle, some men said that they would live as healthily as possible when they and their partners would try to become pregnant. They assumed that a healthy lifestyle would be generally beneficial. A few were aware of that there are sperm tests available and intended to use one. Others believed that there was nothing one could do about fertility on an individual level and would therefore not take any action.

Discussion

This thesis touches on many different issues, but they can be categorised into three major themes: *pregnancy planning*, *fertility awareness* and *preconception care*. I will now discuss these themes in relation to previous studies and my theoretical perspectives.

Pregnancy planning

Studies I and II showed that most pregnancies that were (intended to be) carried to term were more or less well-planned. Furthermore, in early pregnancy participants with unplanned pregnancies were more likely than those with planned pregnancies to estimate their relationship as poor (Study I), similar to what was found by Bouchard et al. (2006). These results indicate that it is a contemporary ideal that a pregnancy should be planned within this specific context. The study samples constituted a rather homogenous group of mostly well-educated and healthy persons, living in stable, (almost exclusively) heterosexual relationships, and the mean ages of having children were representative for the country in whole. My assumption is therefore that most of the participants were probably living in accordance with the heteronormative lifeline (Ambjörnsson & Jönsson, 2010), and the success in having achieved a pregnancy at the socially right time had a reassuring effect on their relationship and contributed to their relationship satisfaction. Making a mutual decision to become parents appears as a strong norm, which could be interpreted as a reflection of the equality culture and the ideal to share responsibilities for parenthood, which dominate in contemporary Swedish society (Hearn et al., 2012; Johansson & Klinth, 2008).

But what are the practical implications of pregnancy planning for men? How do they relate to the practical implications for women?

Health-related activities (like changing life habits) did not appear as an important part of pregnancy planning for men. In comparison with previous studies with women, a smaller proportion of men made preconception lifestyle changes to improve their health and fertility (Stephenson et al., 2014; Tydén et al., 2011). Men who were a part of a couple that became pregnant with medical assistance were more likely to have made lifestyle adjustments than other men (Study II). One explanation could be that men who attend

infertility treatments are the only ones who are likely to get health advice about fertility and lifestyle from health care providers.

As for other men who had made lifestyle adjustments, we do not know much about their motives. But given previous studies on lifestyle adjustments *during* pregnancy (Edvardsson et al., 2011; Högberg, Skagerström, Spak, Nilsen, & Larsson, 2016) and what was expressed as a reason for adjustment by one man in Study II, it is likely that some men changed their habits to support their partner. The supportive man thereby becomes a caring man (Campo-Engelstein et al., 2017) who indirectly takes responsibility for the family's health, which aligns well with ideals of gender equality. Supporting the woman during and after pregnancy is a typical role ascribed to or taken on by men, which is also encouraged by health care (Culley et al., 2013; Edvardsson et al., 2011; Wells, 2015). But this approach does not include expectations for men to be involved for the sake of their own reproductive health. They are not, as put by Inhorn et al. (2009), "conceived as reproductive in their own right", not by themselves, and not by others.

The interview study confirmed that pregnancy planning usually did not mean more than preparing your partner for the fact that you would like to have a child, and making a joint decision to try for a baby. Conception was not something that men were thinking about or prepared for long in advance, and men did not seem to associate themselves with preconception harm (Study III and IV). There are currently no other qualitative Swedish studies to compare these results with. However, Barrett and Wellings found that British women defined a planned pregnancy in quite similar but slightly more comprehensive ways. They identified four criteria that needed to be fulfilled to define a pregnancy as planned: agreeing with the partner before pregnancy, a clear intention to become pregnant, taking a longer-term view of how the baby would fit into their lives and stopping using contraceptives (Barrett & Wellings, 2002). Pre-conceptual preparations were also found to be a minor criterion in their study.

The findings of this thesis suggest that planning for children remains a "deliberately unconscious act" among many heterosexual cis-men (Plantin, 2001). However, men in the interview study mentioned several things unrelated to health that they wanted to be fulfilled before having a child, like having a job and a permanent residence. It was important to have done other things first and have children at the same time as friends (Bergnéhr, 2008). Cis-men in same-sex relationships and trans-men, on the other hand, were to a larger extent forced by circumstances to have a more active role in family planning and spend more time thinking about how to reach their reproductive life goals. They were also less likely to mention timing or age when discussing family planning. Hence, timeliness was more important to those living according to the heteronormative life schedule (Halberstam, 2005).

Ideals about timeliness were also affected by factors other than sexuality, such as context. Postponement of parenthood, which is seen as something

quite problematic in the public health care sector (Balasch & Gratacós, 2011), was regarded as a sign of maturity and proper masculine behaviour in a metropolitan context but less appropriate in, for example, the rural context, where more men did manual labour and being an older dad was associated with fatigue and lack of strength (i.e. having a body that is less able). Moreover, there were several men from different backgrounds who mentioned poor mental health as a hindrance to taking the next step to becoming a parent. They had experiences of depression, either first-hand or second-hand (growing up with a depressed parent), which convinced them that it would not be a good idea to start a family without mental stability. Additionally, several men in Study III believed that mental ill-health and stress could negatively affect their fertility. A US study of bipolar women of childbearing age revealed similar concerns about family planning (Stevens, Daggenvoorde, van der Klis, Kupka, & Goossens, 2017). Women in this study saw their mental health problems as risk factors, in terms of not being able to care for the child in a positive way, that the child would inherit the disorder and that their medication might cause foetal harm. The American CDC recommends that women “Get mentally healthy!” as one of ten steps to get ready for a healthy pregnancy (CDC, 2017) and “screening for social and mental concerns” is part of the professional guidelines for preconception care (Johnson et al., 2006), but men’s mental health in relation to preconception health is rarely discussed in research. The findings of this thesis suggest that men’s mental health in relation to reproductive health is an area that needs more attention.

When comparing my findings to Swedish studies on men and fatherhood from the late 1990s and early 2000’s, there are many patterns that persist. The reasons why men want to procreate (or not) are similar, as are the requirements that need to be fulfilled before entering parenthood (Bergnéhr, 2008; Eriksson et al., 2012; Plantin, 2001). Gender equality in family life and the dual earner/dual carer model ideals have become more mainstream in society since then. There is, for example, more expert literature available directed at fathers and several antenatal clinics offer so-called daddy groups, where men can discuss future fatherhood with other men. But *pregnancy planning* still seems to be regarded as a predominantly female interest and task, not included in the concept of gender equality and hegemonic masculinity. I can easily recognize the caring, child-centred man in my studies, but it is hard to identify the reproductive man, concerned with his reproductive health for his own sake (Campo-Engelstein et al., 2017). There were, however, a few examples, which I will come back to later on.

Fertility awareness

If people want to be as prepared as possible to avoid risks and therefore generally plan a lot to be in control, as argued by Elisabeth Beck-Gernsheim, why do so few men improve their health before conception and engage actively in pregnancy planning? Do they already feel healthy enough? Or do they not think of their reproductive health in terms of risk? The results indicate that it is a combination of both. Only a few participants in Studies III and IV demonstrated procreative consciousness by mentioning the risk of passing on so-called bad genes. Instead, as described in other studies (Eriksson et al., 2012; Webb & Daniluk, 1999), most men took their fertility for granted. The general lack of awareness about men's health risks contrasts with current healthcare discourse on female reproduction, which is heavily focused on health risks. How could it be that only one sex is affected by the risk discourse when everyone knows that it takes both egg and sperm to procreate? Deborah Lupton urges us to ask how risks are constructed as social facts (Lupton, 2013b). She argues that people are portrayed as free actors only constrained by ignorance, while they are, in fact, heavily influenced by their social and cultural group membership. In the context I have investigated, health risks related to reproduction are constructed as something that do not to concern the social group called men.

As in many other studies measuring awareness, knowledge was related to level of education. Men with higher education levels had higher knowledge scores on average. Furthermore, men in Studies II and III knew more about sperm than egg functions, which is unsurprising since sperm related to their personal health. The awareness about lifestyle factors that could affect male fertility was superficial overall. The awareness was not higher among men with previous experiences with childbirth, which was unexpected. This result could be related to the norm that pregnancy planning seldom includes preparatory actions for men, like reading up on fertility. Health care providers should therefore not assume that someone who has fathered a child is automatically more knowledgeable about fertility, especially if the first pregnancy was easily conceived and the child was born healthy. In fact, it might be even more valuable to direct preconception information to fathers who want to have more children because of the age-related decline in fertility. Several men in the interview study mentioned the so-called biological clock as a concern but only in relation to female fertility. Some were opposed to becoming a dad at an advanced age though it was usually not because of the risk of chromosomal abnormalities in sperm but because they did not want to be old-man dads. A few had read about the impact of age on male fertility in the newspaper, but no one had gotten the information through health care. A similar result was found in a US study by Mitchell, Levis and Prue (2012), suggesting that lack of preconception health messages directed to men is not only a Swedish phenomenon. Unfortunately, the brief RLP-based counsel-

ling session in Study III did not have the desired effect on men's awareness about lifestyle factors such as age or STI's. Considering that the intervention took place at sexual health clinics, where most men attended to have an STI-test, it is quite a surprise that the intervention did not increase their awareness about the negative effects of STI's on fertility. Whether this is due to shortcomings in the study design or related to participants' (un)receptivity to health risk messages is difficult to tell, although it is probably a combination.

From a critical perspective, I did not find that men deliberately exposed themselves to health risks as a way of doing masculinity. This is otherwise a rather common conclusion from studies on men and sexual risk-taking (Hyde, Drennan, Howlett, & Brady, 2009; Kalmuss & Austrian, 2010). Rather, the men's lack of knowledge about preconception health seemed more related to the image of the healthy, strong and virile man being so heavily imbedded in society that it was almost impossible to imagine that there could be something wrong with sperm. In an interview study from the US, for example, men expressed that they needed concrete evidence before even perceiving a need for sexual health care (Kalmuss & Austrian, 2010). Several studies on men's health-seeking behaviours have described that men avoid seeking care for what they see as minor problems since it is considered a weakness to pay attention to less severe symptoms; rather, it is preferable to stay strong and silent (Culley et al., 2013; O'Brien et al., 2005). My study revealed that many men regarded male fertility as less sensitive than female fertility, and they assumed that women in some kind of natural way care more about reproductive matters than men do. These respective ideas about men's and women's concerns and exposure to risks might explain why the intervention in Study III did not lead to a greater increase in men's fertility awareness. Another factor that needs to be taken into account is the trust in advanced technology to solve potential problems, which was also found by Eriksson et al. (2012) and Sabarre et al. (2013). This trust makes it possible to keep health-related risks at a distance.

However, when continuing the interview analysis, I did identify another type of risk awareness other than that of health. It concerned the social implications of infertility. There was a latent procreative consciousness and worry about infertility that reflected how important it was to procreate and a fear of what would happen if one could not deliver fertile sperm. Infertility would mean losing the dream of being a link between generations. It could force a person off the comfortable normative lifeline and into the unknown. If a person cannot have children at the normative time, or not at all, one becomes untimely with friends, and a man's masculinity might be questioned. It was clear that men were concerned about how potential infertility could affect their relationships. They said that the reaction from their partners would determine how they would handle the situation; if having biological children was very important to the partner, the situation would be worse. Despite these potential social implications, few associations were made be-

tween fertility and health/lifestyle, which probably meant that the men did not see a connection between the two elements.

Gender identity and sexuality clearly had relevance to the perceptions of procreative possibilities in the sense that gay men and trans-men have to bring several other components into their family planning process compared to heterosexual cis-men. However, sexuality did not seem to determine fertility and risk awareness. Fertility awareness was superficial overall. Beyond gender norms (in this case, low expectations on men to be involved), low levels of awareness could be further explained by the decoupling of sexuality and reproduction in society, as described by Hagström (1999). For gay cis-men and some trans-men, sexuality and reproduction are clearly separated by biology. For heterosexual cis-men, modern contraceptives have made it possible to have penile-vaginal intercourse for decades without having to think about reproduction. This allowed for a nonlinear relationship between sexual practices and reproductive health.

Media play an important role in delivering health messages and creating norms around sexuality and reproduction. This became clear during the interviews in Study IV, when men picked up on things they had read about fertility in newspapers. How media representations influence men's and women's perceptions of themselves as responsible for preconception harm has previously been discussed by Campo-Engelstein et al. (Campo-Engelstein, Santacrose, Master, & Parker, 2016). In an analysis of US newspapers, they found that articles regarding preconception harm centred on women, and they were more likely to blame women than men or couples for any harm to offspring. They also found that paternal risk factors were described with a surprised tone in articles, which is a sign that society is still sceptical about men's influence on foetal health. I could recognize this tendency of surprise and scepticism towards health messages in the media among the interviewees in my study as well as an uncertainty about what could be trusted. That there are myths about preconception harm became evident in the intervention study as well, where several men mentioned lifestyle factors they believed harmed fertility that are not evidence-based. Here, the public health sector has an important responsibility to step in and deliver trustworthy and inclusive information.

Preconception care

Despite the limited increase in knowledge, Study III revealed that midwives (and possibly also other health care professionals) have the potential to raise some aspects of men's procreative consciousness just by asking a few questions about their reproductive intentions. Many men did not expect but appreciated being asked and informed about fertility matters. They felt comfortable about discussing these issues with a midwife, and many were open

to talking about this with other health professionals as well. Still, their answers also revealed that preconception health did not feel like a relevant topic until it was time to conceive or until a fertility problem arose. A similar approach was described by Kalmuss and Austrian (2010), who found that a major barrier to sexual health care utilization among US men was that sexual health concerns were not perceived as relevant unless something was clearly wrong. In that sense, the preventive purpose of care was not understood or perceived as valuable in either study.

Callegari et al. have summarised several pitfalls regarding RLP-based counselling for women (Callegari, Aiken, Dehlendorf, Cason, & Borrero, 2017). For example, women who do not yet have clear intentions about pregnancy timing can perceive RLP-based counselling as less meaningful. Furthermore, the concept of pregnancy planning might not be meaningful or achievable for everyone. Their conclusion was that preconception counselling had to be person-centred and that information delivery should be based on patient preferences. The midwives in my intervention study had the same view and stressed the importance of only having these conversations on the man's initiative. We found a similar attitude in our study with midwives who had used the RLP tool during contraceptive counselling with women (Stern et al., 2015). When asked about the possibility to consult men, several of the midwives in that study were hesitant, either because they lacked training in andrology or because they did not think that men's health was in their area of responsibility.

Another important finding from Study III was that if men wanted to find more information about preconception health in the future they would first search with Google rather than turn to a health facility for consultation. This finding confirms what previous studies and national surveys have shown about men's health-seeking behaviours (Folkhälsomyndigheten, 2016; Tyler & Williams, 2013): that they prefer searching for information online. This could be interpreted as a means to stay in control by men since seeking help is associated with vulnerability and possible emasculation (Tyler & Williams, 2013). In a more practical sense, it also suggests the importance of access to information online that is reliable, inclusive and comprehensible. As I have already pointed out, this is a possible area for practical improvement by the health sector.

Although not in majority, there were some men in study III and IV who displayed a reproductive health-seeking behaviour already and interest in taking part of preconception care. One man in Study III even expressed anger and disappointment over not having anywhere to turn with his sexual and reproductive concerns as an adult man. There were also some men who brought up the issue of gender inequality concerning responsibility for sexual and reproductive matters and access to care. This is where my material show glimpses of the reproductive man, although the caring man was more prevalent.

Methodological discussion

Study I and II

The strength of these studies lies in the effort to include participants from various socioeconomic and geographical areas, which was done by involving antenatal clinics in several counties and in both urban and rural areas. Extra effort was made to include non-Swedish speaking women in low-resource areas. Unfortunately, due to lack of resources, non-Swedish speaking men were not represented at all in Study II. The study can therefore not be said to represent the multicultural population living in Sweden today. However, this is the first study to describe preconception lifestyle adjustments among a general, not only infertile, population of men, which gives the study high value.

Another limitation of both studies is that partners were only involved at one point in time. It limited us in performing analyses of how the relationship and other estimates changed over time. Furthermore, the questionnaire for partners in Study II is a mix of questions from women's questionnaires 1, 2 and 3. This means that partners answered all questions at one point in time, but the women answered at three points in time. Partners estimated the level of pregnancy planning one year after birth, and a recall bias should therefore be considered. However, we think that people can still estimate, even two years after conception, if their child was planned or not. We used the LMUP to arrive at a more nuanced definition of pregnancy planning, but we could not say anything about the individuals' interpretation of the terms. For example, "planned" and "unplanned" can be interpreted differently depending on the situation and context. The reasoning behind such an answer can only be better understood through qualitative inquiry, which is one of the reasons why Study IV was initiated.

Lastly, the questions in the surveys were formulated based on a heteronormative discourse. In my first study, I focus on "couples", which reproduces the common notion of what constitutes a family. To a large extent this implies heterosexuality and reproduces heteronormativity and nuclear family ideals.

Study III

The strength of Study III is that the intervention had already been tried out before in a similar study but with women (Stern et al., 2013). The material and methods that were used during the prior study could be used again, modified to suit the new setting and target group. To optimize the communication of the health message, the informational brochure was evaluated and commented upon by men in different phases of their reproductive life before

initiation of the study. Another measure taken was to engage only midwives with long experience in sexual and reproductive health counselling, with formal training in andrology and who were used to counselling men.

The study took place at one of the largest sexual health clinics in Sweden, and both I and the involved staff therefore expected the study to be finished within three months. However, the recruitment of participants turned out to be much more difficult than expected, and the interest in the study was much lower than in the prior study with women. Many eligible participants were stressed and eager to leave the clinic as soon as possible. Hence, after 6 months, recruitment was still ongoing. At the same time, it turned out that 22 men had changed their minds about participating after having received the envelope, possibly because of the long waiting time at drop-in hours, and left the clinic without participating. We then tried to generate interest in the study by offering participants a lottery ticket, without any noticeable effect. There were also a few mistakes made by staff at randomization, which led to the exclusion of ten follow-up interviews. Following this, a second clinic was recruited to be able to finalize the study within an acceptable time limit. Clinic B was located in a different city but had similar clientele, and the midwives involved had the same kind of training and experience. This made it possible to add this clinic to the study without the expectation of great differences in results.

The goal to include 200 men was not achieved until 17 months after the initiation of the study, which could be viewed as problematic. However, to our knowledge, no societal initiatives or educational efforts were carried out during this time period that would have influenced men's general knowledge of reproduction. However, the motivation among the involved staff at Clinic A did decrease with time, which is completely understandable.

Something that could be questioned concerning this study is the different methods used to measure men's fertility knowledge at time points one and two. At the first measurement, questions were answered on paper in a waiting room that could be more or less crowded with other people. Some participants had very little time to answer the questionnaire while others had an hour or more to complete the survey (depending on the waiting time). The second measurement was carried out by telephone, and the questions were read aloud by me. I generally contacted the participants in advance by text message to ask for a suitable time to do the follow-up. Still, many conversations took place while the participant was out walking, sitting on the bus, out grocery shopping, having dinner or in bed just after having been woken up by my call. These circumstances were, of course, quite different from the waiting room situation. Listening to and orally answering questions is also different from reading questions and writing down answers. This is also one of the reasons why I do not want to draw too many conclusions from the statistical results but, rather, focus on the more qualitative aspects of the study.

Study IV

This interview study was not part of the initial project plan for my PhD; it is the result of a desire to know what was behind the quantitative findings in Studies I-III. Adding a qualitative study to the thesis had many positive effects. Not only do I understand some of the quantitative results more deeply; it was also easier for me to frame the thesis. Combining individual interviews with group interviews was very useful and valuable for learning as a researcher.

When interviewing men within the framework of Critical Studies on Men and Masculinities, it is important to reflect on the interview process, power dynamics and how gender is performed in the encounter between interviewer and interviewees since the interview can be a venue for reproducing and challenging understandings of men and masculinities (Hearn, 2013). My impression from the interviews was that participants were generally easy-going. The atmosphere during group interviews was a bit tense in the beginning, but as soon as the conversation got going, men talked to each other in a relaxed and friendly way. The probing questions I had prepared were often spontaneously asked by someone in the group instead of me, which made it possible for me to sit back and not interfere with the discussion for long periods of time. Most of the individual interviews also ran smoothly although some men were a bit insecure at first and seemed to wonder what I expected from them. Nevertheless, I had expected more difficulties of this sort and more uncomfortable moments related to the topic and my position as a woman and researcher.

Having said that, I still understand that my presence and the presence of other men during group interviews influenced the conversations in several ways. Masculinity, family and other performances were done through the conversations in relation to the listeners. On rare occasions participants turned to me with questions. Usually they wanted me to clarify something about fertility, and I was then addressed as a midwife. On these occasions it became apparent to me that my position as a health care professional had relevance to the encounter. Even though I had presented myself as a PhD student and midwife, it was the latter profession that most men related to. Midwives in Sweden are responsible for most preventive work within the field of sexual and reproductive health, and most men have met a midwife at some point in their lives (during sexual education at school or contraceptive counselling, at youth clinics, and at STI testing, for example), although seldom on a regular basis. As a midwife I probably represented familiarity, intimacy and trustworthiness as well as authority. What it means to be a PhD student is probably less clear to people not working within academia. As summarised by Hearn, women who interview men can be subject to gender power but can themselves be more powerfully placed because of other structures, such as education, class or profession (Hearn, 2013). My perception of

the interviews was that my profession(s) and the similarity in age between me and the interviewees balanced the power dynamics between us. I, for example, never felt subjected to master suppression techniques.

Study IV was planned and carried out in the end of my PhD program, and because of time constraints the sample had to be limited. I tried to compensate for this by actively recruiting informants that were not too similar in background characteristics and in other ways. However, I limited myself to Swedish-speaking participants. The result is thus that I did *not* focus on preconception health and pregnancy planning among newly-arrived immigrants, which could be an important future research area. Moreover, I have not discussed the relationship between religion and preconception health and pregnancy planning, although I understand it to be an influential factor. I had one interesting pilot interview with a man with strong religious beliefs which made me realize that religion can intersect with gender, sexuality and age in a significant way. However, I had to exclude this interview from my analysis since the interviewee and I were acquainted.

The age limit I decided upon when recruiting participants had both benefits and disadvantages. My intention was to interview a group of men who were likely to be affected by the family planning discourse in their everyday life, but by setting an age limit I also limited the possibility of looking at how age might work as factor. I also contributed to reproducing the norm that men ages 20-35 *should* be the ones to care most about family planning issues. However, I decided during the recruitment process to be flexible with the age criterion, and some focus groups therefore included men older than 35. My experience is that this contributed to interesting group dynamics and a richer material to analyse.

Even though I have highlighted several traditionally masculine behaviours in my material, I should also stress that there were a variety of masculinities expressed, confirming that doings of masculinity can be very local and contextually bound. After having read interview studies from other countries, I was struck by the idea that men in my study did not openly value traditional masculinity. They never said that they would do or avoid something to be more of a “real man”, something that I have found in studies from other countries (Dixon-Mueller, 1993; Hyde et al., 2009; Kalmuss & Austrian, 2010). Rather, the few times manliness was raised, it was presented more as something negative, and the interviewees showed in different ways that they devalued machoism and viewed gender equality as self-evident. This happened in all settings and for all age groups, confirming that gender equality has become a widespread social norm. However, *how* gender equality was practiced was more individual or contextually bound.

Conclusions

This thesis has, by quantitative and qualitative methods, explored estimations and understandings of pregnancy planning, fertility and preconception health in the Swedish context. It involves the views and estimations of couples, recent fathers, men with or without children or wish for children, and midwives. The findings contribute to a deepened knowledge about men's consciousness and sense of responsibility for reproductive matters. To plan or not to plan a pregnancy is a gendered, but also more complex than previously acknowledged, phenomenon.

The studies indicate that

- In the predominantly middle-class, native-Swedish population that was investigated, it is a norm for family planning couples to make a *joint* decision to start a family.
- According to most men, planned pregnancy means that a decision to try for a baby has been made. Preparing for pregnancy (for example, reading up on fertility, changing lifestyle to improve health) is uncommon. It is potentially something a man does when the decision has been made to start trying but not months or years in advance.
- Few men actively reflect on their procreative potential or make lifestyle adjustments to enhance fertility unless they have a reason to expect fertility problems.
- Male fertility is taken for granted and viewed as less sensitive than female fertility. Consequently, the knowledge of what could affect male fertility is superficial.
- There are several other considerations, unrelated to physical health that need to be addressed before having a child, like getting a job and a permanent residence. When (timeliness) and how to have children is heavily influenced by the heteronormative life schedule. Hence, timeliness becomes secondary to those on an untimely path.
- Mental health struggles can be a reason to postpone or hesitate entering parenthood.
- Midwives have the potential to raise men's consciousness about fertility just by asking men a few questions about their reproductive intentions.

- Many men do not expect but appreciate being asked and informed about fertility matters, and they feel comfortable discussing these issues with a midwife.
- Midwives have mixed feelings about routinely caring for men's reproductive needs. Insecurity is often related to fear of intruding or lack of training in andrology.

Fertility awareness is affected by contemporary expectations on gender and sexuality. Even though many men in Sweden value gender equality in family life, they do not see themselves as equally targeted by reproductive risk messages and health promotive information. According to my interviewees, fatherhood (with all its responsibilities) starts when the pregnancy is confirmed or when the child is born. This is why the concept family planning is more comprehensible for most men and filled with much more substance than pregnancy planning. However, men who do have questions or worries about fertility are unsure of where to seek reliable information or care. I posit that these findings are a part of the overarching issue that men are not socially constructed as a group at risk of reproductive vulnerability.

Thanks to assisted reproductive technology and new laws, new possibilities for pregnancy planning are now opening for singles, same-sex couples, trans-persons and heterosexual couples with fertility problems. It remains to be seen what effects this will have on pregnancy planning behaviours and fertility awareness in relation to gender and sexuality. In any case, health care services need to offer individualised preconception counselling to everyone regardless sex/gender and make an effort to clear up the gendered reproductive myths, if the goal of equal sexual and reproductive health and rights are to be achieved.

Future research

Using the findings from this research as a starting point, it would be interesting to more deeply analyse different opinions and reflections around family planning in relation to gender and equality. For example, a study could investigate how people from various family constellations (such as families with one, two or more parents) plan for children and argue around these matters, both individually and in negotiation with people that they will potentially share childcare responsibilities with.

To be able to give future recommendations for preconception care, it would be necessary to follow up on the effectiveness of preconception counselling with men and couples. Does increased involvement of men actually have any effect on their and others' sexual and reproductive wellbeing? And does it have any effect on gender equality in the family? Identifying providers of PCC is another crucial step. Could school health nurses possibly be key actors in the pursuit of improved SRHR? If andrology were included in midwifery training, would midwives be equally prepared to consult people of any gender about sexual and reproductive matters?

From a reproductive health perspective, it is relevant to highlight that more than one out of four fathers in Study II used smokeless tobacco (*snus*) daily. There are studies showing that cigarette consumption can impair sperm quality, but it is not yet clear if there is a relationship between smokeless tobacco consumption and male reproduction. Considering the amount of daily users, the matter should be further investigated. If smokeless tobacco turns out to impair male fertility, it would be an important topic of information during preconception counselling.

The areas that I have studied are heavily influenced by social norms as well as hetero- and cis-normative thinking. My studies are no exception. I have tried to address this matter recurrently throughout my thesis, though I have given more attention to gender norms than other social norms. I hardly give any attention to, for example, class, ethnicity or religion, and I hope that this will be done in future research.

Final reflections

In this thesis I have, by a combination of methods, highlighted an important but often missing part of reproductive research. I have also brought in different gender perspectives to the discussion of how pregnancy planning is performed and can be understood in contemporary Sweden. It has been an interesting but a challenging task, which has raised many ethical questions. I will end this thesis by mentioning some of them.

In recent years, several medical studies have pointed to the need for educating men and women about reproduction since fertility awareness is often low and more and more people seek infertility care. A problem has been identified from the public health perspective. However, when talking to men about reproduction, I did not find the same perception of the problem. Rather, most men expressed that it is not a problem until it presents itself as a problem. One could easily claim that this is an issue of ignorance, but I believe that it also identifies an interesting dilemma in this thesis: who decides what a problem/risk is, and on whose terms is the problem/risk formulated?

Policy researcher Carol Bacchi urges us to ask, what is the problem represented to be? What presuppositions or assumptions underpin this representation of the problem (e.g. heteronormativity, nuclear family ideals)? Is the so-called problem the risk of declining fertility rates that could jeopardise our welfare system, or is it the individuals' possible grief over not being able to procreate? If individuals do not perceive being unaware as a problem, should the government still make policies to solve what public health perceives as a problem? According to Bacchi, policies do not solve problems; rather, they produce problems, and lives are lived in specific ways due to how we understand problems.

When an infertile man expresses that he wished he had known more, is that reason enough to improve health education and implement preconception care? Or is increased prevention and planning more of an illusion of being in control of the future?

Another dilemma is that the preventive health message of preconception care is not always as obvious to the recipient as it is to the sender. This is not only because one might not see oneself as the recipient but also because of the insecurity around what truly affects fertility. Can men trust the tabloid headlines (if this is their only source of information around preconception health)? Even as a health professional, it is very difficult to grasp from clini-

cal studies how much individuals can actually influence their own reproductive health, especially in relation to endocrine disruptive chemicals that seem to exist everywhere in our everyday environment. What does the risk ratios mean on individual levels? And who should be responsible to prevent or care for the problem/risk? The individual or the state?

Another dilemma has been the risk groups and the way they are approached. In the Swedish health discourse, postponement of parenthood and obesity are brought up as two major threats to fertility and pregnancy-related health (Balasch & Gratacós, 2011). But who are the ones postponing parenthood to an age when the fertile period is almost over and why are they doing it? Why are the positive aspects of postponing parenthood so seldom discussed in medical literature?

During the work with my thesis, I have tried to take a feminist approach. My argument regarding preconception care and fertility education has been that we will not reach gender equality if we do not have the same expectations for and give the same possibilities to persons of all genders to learn about their body and take responsibility for family matters. As noted by several feminist scholars, women are often exclusively blamed for foetal harm and morally pressured to prevent foetuses from harm, while men's responsibilities and moral duties are neglected (Campo-Engelstein, 2014; Lupton, 2012). This is one of the major arguments for why men should also be involved in preconception health and care. But at the same time, I struggle with the benefit of preconception education and care in general because of its potential to lead to higher pressure on all individuals to live up to pronatalist, heteronormative and healthist ideals. Preconception health has been criticized for putting women in a constant state of pre-pregnancy, which falsely assumes that all women want to carry a child in their uterus and pressures women to worry about potential foetal health risks every day of life, from puberty to menopause (Campo-Engelstein, 2014). Furthermore, constant monitoring of health, through means like mobile health technologies, can lead to anxiety and reproduction of gender-stereotyped bodies rather than having a positive effect on health (Lupton, 2013a, 2015).

These are complicated dilemmas without a clear solution. I therefore believe that these issues and many other issues related to this project need to be discussed extensively before, during and after any potential future implementations of preconception care.

Sammanfattning på svenska

Den här avhandlingen handlar om sexuell och reproduktiv hälsa, graviditetsplanering, hälsa och vård innan befruktning, kunskaper om fertilitet, relationer och rådgivning. Eftersom avhandlingen är ett tvärdisciplinärt projekt som involverar både medicinska vetenskaper och genusvetenskap berör den hälsoaspekter utifrån såväl kliniska som mer samhällsteoretiska perspektiv. Det övergripande syftet med avhandlingen är att på olika sätt mäta och förstå innebörden av graviditetsplanering. Syftet är också att beskriva hur samhällsnormer för kön/genus påverkar planeringen av och förväntningarna på graviditet samt kunskaperna om fertilitet.

Avsikten med delstudie I var att mäta hur överens par, som befann sig i tidig graviditet, var gällande graviditetens planeringsgrad. Studien baserades på enkätsvar från 136 par. Resultatet visade att en övervägande majoritet av graviditeterna var planerade och att de blivande föräldrarna hade samma uppfattning om graviditetens planeringsgrad. De flesta var även nöjda med sin parrelation i början av graviditeten. I delstudie II var syftet att undersöka om och hur nyblivna pappor planerat inför graviditet och att mäta deras nuvarande kunskaper om fertilitet. En enkät skickades ut till pappor ett år efter att de fått barn och studiens resultat baseras på 796 svar. Även här visade det sig att de flesta graviditeter hade varit planerade, och att 17 % hade gjort en eller flera livsstilsförändringar inför graviditet för att förbättra sin hälsa och fertilitet. Det vanligaste var att sluta eller dra ner på konsumtionen av cigaretter, snus och/eller alkohol, och att träna mer. En stor del av dem som lagt om sin livsstil var män vars barn blivit till med hjälp av assisterad befruktning, vilket innebär att de och/eller deras partner haft fertilitetsproblem. När det gäller kunskaper om fertilitet så varierade det stort mellan individer och mellan frågor. Generellt hade män goda kunskaper om spermiers livslängd. Högutbildade personer hade i snitt högre kunskapsnivå än lågutbildade.

Den tredje studien var en randomiserad kontrollerad studie med syfte att ta reda på om kortfattad muntlig och skriftlig information om reproduktiv hälsa och fertilitet i samband med besök hos barnmorska kunde höja mäns kunskaper och medvetenhet kring reproduktiv hälsa och fertilitet i förhållande till levandsvanor. Syftet var också att utvärdera männens och barnmorskornas upplevelser av rådgivningstillfället. Männerna rekryterades på två kliniker dit de flesta män kom för att testa sig för könssjukdomar eller få annan rådgivning kring sexuell hälsa. Deltagarna randomiserades till interventions- eller kontrollgrupp och fick börja med att fylla i en baslinjeenkät

med frågor om sociodemografiska uppgifter, nuvarande sexuella relationer, tidigare erfarenhet av könsjukdomar eller graviditet, samt frågor som ämnade mäta deras kunskaper om fertilitet. Alla deltagare fick sedan sedvanlig vård, men interventionsgruppen fick också ett samtal om fertilitet och levnadsvanor. Barnmorskorna använde sig av verktyget Reproaktiv Livsplan (RLP) som samtalsguide under konsultationen. Tre månader efter besöket blev deltagarna uppringda och fick besvara kunskapsfrågorna igen. Interventionsgruppen fick även besvara frågor om upplevelsen av samtalet. När datainsamlingen avslutats intervjuades personalen som varit involverade i studien om deras upplevelser av studiens process.

När svaren på kunskapsfrågorna jämfördes (före och efter intervention) kunde vi se att männen i interventionsgruppen statistiskt hade ökat sina kunskaper genom samtalet men att det i praktiken var en ganska liten förbättring. Däremot hade männen en positiv upplevelse av samtalet, de tyckte att informationen var viktig och kunde tänka sig att vända sig till en barnmorska igen om fler frågor uppstod. Ett flertal män kommenterade dock att de skulle söka information på internet i första hand och/eller att de upplevde att informationen och eventuella livsstilsförändringar inte kändes aktuella förrän det var dags att försöka bli med barn. Personalen som deltagit i studien var bekymrade över att det var så svårt att rekrytera deltagare och sa att många män hade blivit väldigt förvånade när de tillfrågats om deltagande. Barnmorskorna var tveksamma till att fortsätta använda RLP rutinmässigt i samtal med män, men betonade att män ofta har lika många frågor som kvinnor om de väl får chansen att prata och reflektera kring sin sexuella och reproduktiva hälsa.

Den avslutande studien var en intervjustudie där syftet var att gå djupare in på det som framkommit om graviditetsplanering och kunskaper om fertilitet i de tidigare studierna. Totalt 25 män i åldrarna 23-49 intervjuades, varav 8 intervjuades enskilt och övriga 17 i fokusgrupper om 3-6 män i varje grupp. De flesta intervjuer genomfördes i Uppsala och Stockholm, men ett antal intervjuer gjordes också på mindre orter/landsbygd i Mellansverige. Olika utbildningsnivåer, sysselsättningsområden, sexualiteter och erfarenhet av föräldraskap finns representerade i urvalet, som dock har en underrepresentation av utlandsfödda.

I intervjuerna framkommer att de flesta män inte funderat så mycket på sin fertilitet och de tar för givet att de ska kunna få biologiska barn. Att få barn är viktigt och för många meningen med livet. Eftersom de inte tänkt så mycket på fertiliteten har de heller inte pratat om det med sina vänner. En del tycker att det är onödigt eller till och med märkligt att prata om det, eftersom det inte är ett problem eller ändå inte går att göra något åt. Det framkom dock efterhand att flertalet män hade på ett mer latent plan funderat kring sin reproduktiva förmåga, t.ex. i samband med att de läst skrämselfabriker i tidningarna om vad som är farligt för fertiliteten, fått ett slag mot pungen eller hört om någon som drabbats av testikelcancer. Männen ut-

tryckte förtroende för att vården kommer att hjälpa dem som eventuellt visar sig ha problem med fertiliteten. Kunskaperna om vad den vården innebar var dock begränsad. Några få hade funderat över att göra spermatest för att i preventivt syfte kontrollera sin fertilitet.

I intervjuerna framkom också en uppfattning om att mäns fertilitet är mindre skör än kvinnors, och att kvinnor är mer intresserade av att prata om reproduktion än män. Det märktes att det finns en ovana eller ovilja bland männen att prata om spermier, könsorgan och infertilitet eftersom de vid flera tillfällen använde omskrivningar som ”inget bläck i pennan” eller ”dåligt med patroner” istället för mer precis terminologi. Trots detta var det vanligt att vid intervjuens slut uttrycka en uppskattning kring att ha fått prata om ämnet, och en förvåning över den egna okunskapen om ämnet.

Sammanfattningsvis kan sägas att studierna, både genom resultaten och också svårigheterna med att rekrytera deltagare, pekar åt att det inte finns så stora förväntningar på unga män idag att vara engagerade i sin reproduktiva hälsa och graviditetsplanering. Medvetenhet och förhållningssätt skiljer sig dock en del mellan hög- och lågutbildade, och mellan dem som lever i linje med heteronormativa livsideal och dem som avviker från dem. Om vi som samhälle ämnar sträva efter en mer jämlik hälsosituation och jämställt ansvarstagande för familjers välmående anser jag att reproduktiv hälsovård och tillförlitlig information borde bli mer tillgänglig för alla, oavsett kön/genus. Men det är också viktigt att reflektera över vem eller vilka som formulerar och definierar problem och hälsorisker, varför det görs och med vilka konsekvenser.

Acknowledgements

First, I want to express my deepest appreciation to the more than one thousand people who have participated in my studies. Obviously, this thesis would not exist without your time and dedication. Thank you!

I would like to thank my supervisors for giving me the opportunity to be part of this project in the first place. Thank you for considering me in your search for a new PhD candidate and inviting me to the research group. Thank you, Margareta Larsson, for putting so much trust in my abilities and always being open-minded about my ideas. Thank you, Tanja Tydén, for teaching me the importance of networking within academia and for helping me keep up-to-date with new research. Thank you, Lisa Folkmarson Käll, for your unwavering support in the interdisciplinary storm and for your magical ability to sort out my unfinished thoughts.

Thanks to all the great people at the Department of Public Health and Caring Sciences. Jenny Stern, you have been like a co-supervisor to me. Thank you so much for introducing me to the project, showing me everything I needed to know, and for all the work we have done together—and thanks for your high spirits. Thank you, Maria Grandahl, Jennifer Drevin, Elenor Kaminsky and Maria Gottvall, for being such great colleagues. Thank you, Anna T Höglund, for the interesting Gender Seminars.

I would like to thank all my colleagues at the Department of Women's and Children's Health. Elin Ternström, my first midwife+PhD-student colleague, thank you for being such a great supporter, both at work and off. Your friendship has been invaluable. Maria Wickström, Pernilla Svefors, Jessica Påfs, Anna Wahlberg, Malin Jordal, Jonna Arousell, Rebecca Baylis and Karin Cato, it has been a pleasure spending time with you brilliant people, and I hope we will continue with our feminist agenda forever. Many thanks to Shirin Ziaei and Soorej Puthooppambal for generously helping me out with different quantitative and qualitative issues. Maria Ekstrand and Lana Salih Joelsson, thanks for help and inspiration with the RLP studies. Thanks to everyone at the PhD seminars for midwives/paediatric nurses for valuable discussions. Thank you, Karin Törnblom and all other administrative staff, for being the cornerstones of the department. Fanny Kullendorff, thanks for helping me out during parental leave with the intervention study.

Thanks to everyone working at the Centre for Gender Research, who all contribute to a warm and inspiring environment. I have enjoyed every moment I have spent with you. Many thanks to my fellow PhD students for all the support you have given me throughout the years: Klara Goedecke, Anders Johansson, Johanna Larsson, Nadine Lake, Nicole Ovesen, Elina Nilsson, Catarina Wahlgren, and Katerina Günter. You are all brilliant. Thank you to the director Anita Husénius for being the best leader possible and giving me support whenever needed. Special thanks to Helena Wahlström Henriksson for introducing me to family/kinship, masculinity and fatherhood studies and always being open to discuss my work. Gabriele Griffin, thanks for generously sharing your knowledge. Thanks to Julia Benjaminsson, Karin Lindelöf, Annie Woube, Klara Goedecke, Anita Hussénius and Elina Nilsson for enthusiastically joining me in the planning and implementation of the Feminist City Tour. Thanks to everyone who joined the Masculinity Seminars and Family/Kinship seminars and contributed to valuable discussions.

Thanks to members of Nätverket för sexualitetsforskning, The PrePreg Network and the Swedish Network for Family and Kinship Studies for inspiring meetings!

Last but not least, I would like to thank everyone close to me who helped me through this process, by recruiting participants, reading my texts, listening to my presentations and my worries, offering childcare and much more. I am incredibly grateful for your generosity and thoughtfulness. Thank you Kim Creutzer for the beautiful cover photo. Members of the Book Club, thank you for wanting to read and discuss non-academic texts with me. It has been such a pleasure!

Warmest thanks to my parents, Anna and Staffan, and siblings Clara and Theo for introducing me very early on to activism, feminism, writing, health care and research. To my late brother Markus, I just want to say that I miss you and I wish you could have been here. Tomas, thank you for encouragement and affection throughout the years and for joining me in the feminist family planning project. Finally, thanks to our children Fride and Eli, for giving life new dimensions.

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