

*Knowledge, attitudes, and perceptions regarding  
sexual and reproductive health services among  
ethnic Somali female adolescents in Oslo, Norway*

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2018

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IV

**Abstract:**

Somali second generation female adolescents frequently underutilize services provided by the Sex and Society clinic in Oslo, possibly due to cultural contradictions associated with the discussion of sexuality. This qualitative study explores the sexual and reproductive health concerns provided by a group of second-generation Somali female adolescents residing in Oslo, an under-researched group in the Norwegian context. Fourteen semi-structured interviews were conducted, focusing on knowledge, attitude and practices of the sexual and reproductive health services of the clinic, including contraceptives. The following themes emerged: 'The clinic could best serve sexually active individuals', 'Sensitivity regarding SRH services', 'I may need them after marriage', and 'Valued resources'. Facilitating factors discovered were: adolescents' high degree of knowledge about the importance of using the services of the clinic to improve health and wellbeing in general, e.g. contraceptives. Barriers identified included socio-cultural issues such as cultural insensitivity, marital status, and sexual and reproductive health issues and contraception being untimely and inappropriately provided for female Somali adolescents. To promote the coverage of the clinic's services and contraceptive use in the future, the participants suggested culturally sensitive service delivery initiatives, campaigns with the use of internet and peers, and maintaining confidentiality of services. Further research is recommended to understand more about the health needs within this age group of Somali females.

**Keywords:** Somali, Oslo, Sex and Society, adolescence, sexual and reproductive health services.

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## List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
CDC	Centers for Diseases Control and Prevention
FGM	Female Genital Mutilation
FP	Family planning
HBM	Health Belief Model
HIV	Human immunodeficiency virus infection
HVP	Human Papilloma Virus
IDI	In-depth interview
IUS	Intrauterine System (T- shaped hormonal device for contraception)
IUD	Intrauterine device (hormonal product for contraception)
LGBT	Lesbian, gay, bisexual, and transgender.
MC	Menstrual cycle
NSD	Norwegian Center for Research Data
OCP	Oral contraceptive pill
REK	Regional Committees for Medical Research Ethics (Norway)
RHA	Regional Health Authorities
STIs	Sexually transmitted infections
STDs	Sexually transmitted diseases
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights

SSB Norwegian Statistic Bureau (Norwegian: Statistisk Sentralbyrå)

TV Television

UNFPA United Nations Population Fund

WHO World Health Organization

## Glossary

**Abortion** The deliberate interruption of pregnancy, which is not spontaneous or natural loss of the fetus.

**Apotek** Mentioned by participants; synonymous for pharmacy.

**Birth control** Birth control is the use of various devices, drugs, agents, sexual practices, or surgical procedures to prevent conception or pregnancy.

**Contraception** It is a term used to describe a method or device used to prevent pregnancy.

**Family planning** Family planning allows people to attain their desired number of children and determine the spacing of pregnancies.

**www.lommelegen.no** A Norwegian health information site, with the slogan, 'Your doctor on the Internet'.

**Store** Supermarket or pharmacy. The term was used interchangeably by participants.

**Patch** Dermal patch containing hormone for contraceptive purposes.

**Period:** Synonymous with menstrual cycle (MC).

**P-pillers** Oral contraceptive pills for women (popular Norwegian term).

**P-ring** Hormone-containing vaginal ring; used as a contraceptive.

**www.ung.no** A Norwegian website providing information for youth about a wide variety of topics.

## **Executive definitions**

### **Attitude**

Most commonly, the term is used to describe an individual's thoughts and feelings with regard to a specific object or concept, which are often aligned in some respect with the positive or negative end of a hypothetical spectrum. In this way, attitude constitutes an evaluative process, by which outside influences work upon the mind of the individual and result in the generation of specific perceptions that may be expressed in their behavior (1).

### **Awareness**

Awareness can be defined as knowledge or perception of a situation or fact. Mustapa, M. C., (2015) stated that awareness about sexual and reproductive health (SRH) can combine knowledge, attitude and behavior patterns of reproductive and sexual health among individuals (2).

### **Confidentiality**

Confidentiality denotes the maintaining of a secret or private state (3), usually in relation to a piece of information. In a medical context, it is often used to describe the regulation that professionals must not give out to unrelated third parties information patients provide them with. It has been shown to be a significant concern of adolescents when it comes to healthcare (4).

### **Culture**

Culture is a term that covers behaviors (learned socially) that are shared between the members of a group. These include their attitudes, values, and assumptions about life, legal and behavioral codes, and social and religious beliefs. Such factors, while they exert influence over how a person in the group may act, and the ways in which they view the actions of other members, do not totally define their actions or views in all cases (5).

### **Health**

The World Health Organization (WHO) defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This definition may cover people with or without diseases or infirmities, since individuals who experience a disease or infirmity can still reckon their health as good. The Norwegian medical

dictionary defines good health as physical and emotional well-being and good adaptation to society (6).

### **Knowledge**

Knowledge is defined as facts, information, and skills acquired through experience or education: that is, the theoretical or practical understanding of a subject.

Nsubuga, H., et al defined knowledge as the state of awareness of something (7). In this research, ‘something’ is the clinic, the contraceptive methods and the sexual & reproductive health and needs of adolescents.

### **Practices**

It can be defined as the actual application or use of an idea, belief, or method, as opposed to theories relating to it (by an individual, a community, an organization etc.) (8).

### **Perception**

The organization, identification, and interpretation of sensory information in order to represent and understand the presented information, or the environment (9). This term precisely refers to an individual’s understanding and interpretation of, and opinion towards, a specific item or concept. This is a prominent determinant of the utilization of health services, as the decision to make use of them is significantly affected by a person’s knowledge, experiences, and practices, all of which influence their overall perception. Furthermore, perception is often conditioned by assessing factors linked to tradition and culture. In order for the clinic to achieve greater coverage of female Somali adolescents with regards to their services, it is imperative that the relevant perceptions of such individuals be taken into account (10).

### **Sex education**

Sex education describes the imparting of knowledge on issues relating to human sexuality, including emotional relationships and responsibilities, anatomy, sexual activity, reproduction, age of consent, reproductive health, reproductive rights, safe sex, birth control and sexual abstinence.

As De La Mare, Jeanette stated: “sex education may also be described as "sexuality education", which means that it encompasses education about all aspects of sexuality, including information about family planning, reproduction (fertilization, conception and development of the embryo and fetus, through to childbirth), plus information about all aspects of one's sexuality including: body image, sexual orientation, sexual pleasure, values, decision making, communication, dating, relationships, sexually transmitted infections and how to avoid them, and birth control methods” (11).

### **Sexually Transmitted Infections (STIs)**

The term ‘STI’ or ‘STD’ (meaning sexually transmitted infection and sexually transmitted disease, respectively) is used to denote a form of disease that is spread solely through sexual contact between individuals. There are a range of known STIs, some of the most common being chlamydia, gonorrhoea, genital herpes, human papillomavirus (HPV), syphilis, and human immunodeficiency virus (HIV).

According to the CDC, young people between the ages of 15-24 ‘acquire half of all new STDs’, and 1 in 4 members of the adolescent female population who are sexually active have some type of STD (12). If left undiagnosed and untreated, certain STDs (such as syphilis and HIV) can be fatal, while others can result in significant complications during pregnancy, including stillbirth, congenital infections, sepsis and neonatal death. (UNFPA 2012). Furthermore, HPV has been proven to cause pelvic inflammatory disease, infertility, and cervical cancer; the latter is a serious health threat for women worldwide (13).

### **Sexual and reproductive health rights**

Sexual and reproductive health (SRH) is a state of physical, mental and social well-being in all matters relating to the reproductive system. As Metusela, C. & Jane Ussher M. and her associates stated:

“Sexual and reproductive health (SRH) is a key component of quality of life encompassing physical, emotional, mental and social well-being as well as pleasurable, safe sexual experiences that are free from coercion, discrimination or violence. This includes the right to receive education and information about sexual health, the right to equality and non-discrimination, the right to decide the number and spacing of one’s children and the right to feel and express sexual desire.” (14).

SRH services include sex education, contraceptive services, family planning counselling, information services for sexually transmitted infections and related treatments, information and services related to pregnancy, etc.

Sexual health (according to WHO) as being 'not merely the absence of illness or sexual problems, but also encompasses physical, mental, emotional, and social well-being in relation to sexuality' (15).

Sexual and reproductive health rights (SRHR) is a term used to reference the basic entitlements of all individuals in relation to matters of sexuality and human reproduction. It covers, but is not limited to, suitable provision of sexual and reproductive health services (such as easily accessible contraception, testing and treatment for STIs, and information regarding pregnancy and abortion), the protection of individuals from sexually-motivated violence and coercion, and ensuring that healthcare, especially as linked to these fields, of a basic acceptable standard is available for all (16).

SRHR is a concept that encompasses the individual's aforementioned SRH needs, which must be met in order for these human rights to be established.

As the UNFPA has stated, when there is a failure in meeting SRH needs, 'individuals are deprived of the right to make crucial choices about their own bodies and futures, with a cascading impact on their families' welfare and future generations.' SRHR promotes delaying marriage and childbearing, reducing unintended childbearing, narrowing gender disparities that put girls at risk of poor SRH outcomes, expanding health awareness or enabling access to SRH services (17).

## **Taboo**

Rodrigo, suggested in his online editorial that a taboo constitutes enforced prohibition of an action, based on the traditional belief that such behavior is too sacred or that the action of an individual can lead to their being cursed if they undertake it (18).

## **Introduction**

The Sex and Society Clinic in Oslo (Norwegian: Sex og Samfunn) is focused on the promotion of healthy lifestyles, especially with regards to the sexual and reproductive health of young people. At this time in their lives, individuals often begin to explore their sexualities, and engage in sexual contact and relationships. As a result, they become vulnerable to a set of more specific health risks, such as the contraction of STIs, and unexpected pregnancies (19).



Recognizing this, the clinic provides a range of information and services about SRH specifically tailored to and aimed for those aged between 16-25 years. These are intended to ensure that young people have the appropriate support and methods at their disposal to offset potential risks and maintain a safe and stable SRH state. Such services are provided free of charge to clients, and include sex education, STI and pregnancy testing, and the offer of a selection of contraceptives (20). The clinic has observed that female adolescents from a Somali background utilize their services at a notably lower rate in comparison to the expected level of usage by this age group, despite the fact that the Somali population of Norway comprises the country's fourth largest immigrant group (21). This underutilization occurs due to a variety of circumstances, but is most prevalently influenced by the cultural differences existing between the Norwegian and Somali perspectives on approaches to dealing with SRH matters among adolescents. Since these differences are so pronounced, and since health is a culturally dependent concept, adolescents in this demographic refrain from using the clinic (22, 23). However, there has been no previous research conducted that explores knowledge, attitudes towards and perceptions about SRH and related services existing among members of the Norwegian Somali community, which likely play a significant role in this aforementioned avoidance (24). This study, done in collaboration with Sex and Society, aims to provide insight into this field. The information thus gained could potentially influence the development of strategies to reach this group or adapt existing services so that their perspective is taken into consideration. Eventually the findings of the current study may help to redesign and improve these services to make them more accessible to adolescent females with a Somali immigrant background.

## **Background literature**

### **Adolescent health from a global perspective**

#### **Adolescence**

According to the WHO, a person may be classed as an adolescent if they are aged anywhere between 10 to 19 years. In order to reduce complications during the data collection process, 16 was taken as the lower limit, thus negating the legal requirement for parental consent on behalf of the participants. However, it must be noted that the status of being in the adolescent period can vary between individuals; that is to say, the various changes that occur in both body and mind do not uniformly begin at age 10, and end at age 19 (25). Indeed, the

boundaries of the period have been variously demarcated by different researchers (19). Therefore, the upper limit for participation was determined as 20 years.

### **Health concerns**

During the adolescent period, various changes occur in the physical and mental states of both male and female individuals. These changes have a major impact on the health and wellbeing of the individual and permanently modify the person's perception of health, especially their mental health (26), which can extend beyond this phase of development.

The physical changes during this phase of life, according to WHO, are as follows:

#### **a) Externally visible and easily recognized by the individual**

1. Increases in height
2. Acquisition of muscle mass
3. The distribution of body fat
4. The development of secondary sexual characteristics.

#### **b) Internal changes**

1. Hormonal changes, for example, changes in oxytocin and vasopressin regulation
2. Neuronal developments.

#### **c) Psychological and mental changes**

These changes are linked with the hormonal and neurodevelopment of the individual. They are:

1. Psychosocial and emotional changes
2. Cognitive capacity and intellectual ability
3. Self-identity, including sexual identity, concerns over others' opinion of themselves, and a strong existence of the peer group in daily life activities
4. Sense of independence and responsibility

5. Exploring and experimenting with the unknown, leading to risky behavior (which may include sexual behavior, substance abuse, etc.).

In females, the primary change that occurs during puberty is the menarche. Alongside various physical changes, which includes the inception of the menstrual cycle (MC) and breast growth, hormonal and psychological changes also occur (27). Shifts in hormone levels induce the individual to think more about her own physiology, and induce a strong curiosity regarding bodily changes. The resulting effect on cognition is chiefly related to ideas of self-identity and sexuality. However, girls of this age often feel uncomfortable seeking SRH help for multiple reasons: for instance, concerns about confidentiality, uncertainty about the health facilities, cultural differences, etc. (28).

Adolescents are more vulnerable to STIs in comparison to other age groups (29). According to Weinstock H. et al, young people aged 15-24 account for only 25% of the sexually experienced population, but they acquire almost half of all new STIs and are at greater risk of becoming infected because of a combination of age-derived behavioral, biological and cultural reasons (30). Females are at increased vulnerability due to their physiology. Untimely and unintended pregnancy is the greatest concern facing adolescent girls, not only due to social stigma, but also the burden that planning for the long term will impose upon her own life, and that of her family. Adolescents and young adults' risk-taking behavior, leading to a hindrance to health, is also exacerbated by underlying social and cultural understanding. Adolescents, therefore, have varying attitudes to healthcare, and will sometimes not seek it, putting them in more danger due to sexual activity, than others who adopt the available services.

According to the Norwegian Statistics Bureau (31):

- a)** The chlamydia contraction rate was 4.5% in 2012, among those aged 15-19 years
- b)** As of 2015, the abortion rates were 8.3% & 21.1% among the 15-19 & 19-25 age groupings respectively, the highest among all age groups (31).

Focusing on educating and aiding young people is likely to be the most effective approach to confronting potentially risky behavior related to sexual and reproductive health (19). The influence of a non-Western immigrant background and its associated culture can affect the way in which an individual utilizes health services, or if they use them at all. Some immigrant

adolescents face many difficulties related to acculturation and integration into a new society and the failure to implement the offers of the state system. Due to contrasts between their ethnic culture and that of their country of residence, they may not use sexual and reproductive health services (32). To add more, girls of a young age, including adolescents, were documented as being particularly vulnerable to being coerced or forced into non-consensual sexual acts. At this age of development, such negative experiences can cause significant damage to their long-term physical and mental health. This is reflected in the statistics contained in a 2008 WHO report, which shows that, of the total percentage of girls who had been the victim of a non-consensual sexual experience before age 15, 10% went on to have an unplanned pregnancy in subsequent years (19).

### **Immigration and adolescent health**

About 2.9 percent of the total population of Norway, or 149,700 persons as per 1st January 2016, is Norwegian-born to immigrant parents. Among them, those who were Norwegian-born to Somali parents constituted the second-largest group (11,800), after those Norwegian-born to Pakistani parents, the trends continues in subsequent years as well. As the Open Society estimates, 80% of Norwegians born to Somali parents are currently below 10 years of age, and are going to enter the adolescent period in few years (33). Their health and well-being thus may constitute a public health concern of the state health system.

Therefore, the female adolescents' health calls for attention, and research for health promotion of this group of individuals. This may help to develop a stable future with a complete state of health and positive wellbeing for them.

### **SRH services for the adolescents**

#### **A multicultural capital**

Immigrants constitute 17.3 % of the total Norwegian population, with ethnic Somalians (both first generation, and those born in Norway) numbering 43,196 amongst them (Statistics Norway) (34). The second generation is a growing population subgroup, which currently comprises 3.2% of the total population in Norway (35).

Oslo, previously known as Christiania, is the capital of Norway. About 666,800 people currently live in the city. Almost 33.1 per cent of the population of the city came from other countries, making it home to the majority of the total Norwegian immigrant population. Oslo

currently houses 168,700 immigrants, 54,100 of which were born here to immigrant parents, according to the Norwegian Statistics Bureau. It is an accessible city and a targeted hub for jobs, education and business both for native Norwegians and citizens from all over the world. Individuals from a variety of cultural backgrounds reside in Oslo: for example the Middle East, Latin America, Australia and Oceania. Immigrants come to this Scandinavian city for many reasons: they may be political, socio-economic, educational, etc. Having an open society, Oslo welcomes people with different cultural and religious backgrounds. A recent study found that 1 in 3 people in Oslo is from an immigrant background. The immigrant population in the city is growing somewhat faster than the native Norwegian population both in relative and absolute measures, as Thomas P., has stated, making it the fastest-growing in Europe (36). Muslims from the Middle East or Africa, especially, favor Oslo due to the presence of multiple mosques. This is not the case in other cities, which has led to Oslo becoming the area with the largest Muslim population (36). According to the latest SSB online resource (published in 2017), Norwegian citizens born to Somali parents total 5,724 of the population in the capital (31).

According to SSB, Oslo has the largest population of young immigrants, including those that are Norwegian-born to immigrant parents. This is reflected in both relative terms and absolute figures. As such, these groups constitute 34 percent of the capital's entire population under the age of 25 (34).

Following is a map of Oslo showing that 33% of the area's population comes from immigrant backgrounds. The parts of Oslo (administrative sectors, or *Bydel*) marked in red are areas in which immigrants total 50 per cent or more of the total population, such as Grorud, Stovner, Alna, central Oslo (Sentrum) and Søndre Nordstand (Figure 1).

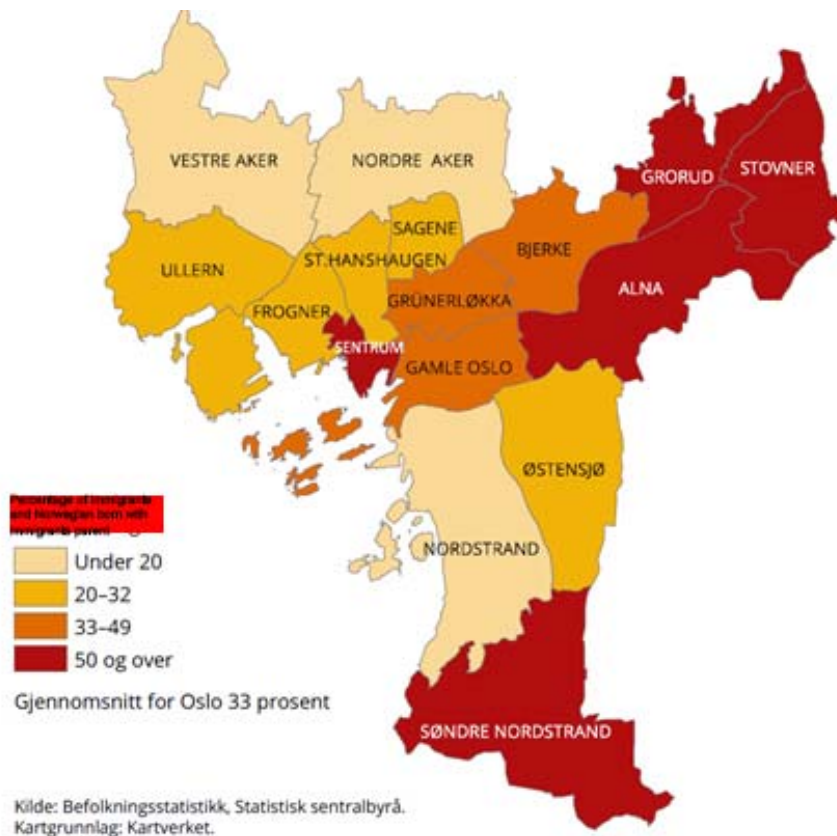


Figure 1: Proportion of immigrants and Norwegian born with immigrant parents living in different part (Bydel) of Oslo. (21)

In the capital city, the adolescent Somalis constitute the third largest group among immigrant adolescents (Table 1).

Table 1: Immigrants and those Norwegian-born to immigrant parents, as counted in Oslo c. 1<sup>st</sup> January 2017 (21)

Kommune	Innvandrere og norskfødte med innvandrerforeldre
<b>Oslo</b>	
Innvandrere og norskfødte med innvandrerforeldre i alt	218 777
Pakistan	23 010
Polen	16 624
Somalia	15 137
Sverige	13 018
Irak	8 215

Source: Statistics Norway

Therefore, their culturally conditioned health needs to be acknowledged to facilitate the development of an inclusive society.

### **The Sex and Society clinic (Sex og Samfunn)**

Sex and Society is a non-profit foundation whose aim is to promote sexual and reproductive health and rights at the individual, group, and community level. Its work is rooted in the principle that all individuals should have control of their own bodies, and be able to make free choices regarding their sexuality. The organization works towards this goal via clinical and educational activities, as well as through professional development and advocacy work. This venture is also politically independent.

### **History of the initiative**

Sex and Society was established in 1971, under the name of 'Socialist Doctor Society Clinic for Sexual Enlightenment' (SOSLF). The name was changed to the 'Clinic for Sexual Enlightenment' (KSO) in 1990, and again in 2007 to 'Sex and Society'.

### **Activities of Sex and Society**

The clinic has been working to prevent unsafe abortion since their inception. They work to tackle a variety of sexual health issues through initiatives such as the provision of selected free contraceptives, a public health nurses' affiliation, sexual counselling, and free STI testing and treatment if needed. They also provide support for adolescents' mental health, as well as to victims of sexual violence and substance abuse, and to members of the LGBT community. In 2015, an online chat service was implemented. Active during certain hours on weekdays, it aims to answer the questions of the anonymous individuals who make use of the service. Sex and Society is the largest platform for sexual and reproductive health and rights for people under 25 in Norway. The center runs different courses for health service providers, sex education in schools, and produces reading materials and brochures. It is also involved in advocacy of related policies and regulations for the government and municipalities.

The clinic has published guidebooks for SRH (in Norwegian) and contraceptive methods (in seven languages, including Somali), which can also be found online. Following is the cover of the published guidebook for SRH from the clinic (Figure 2):

## Metodebok



*Figure 2: The cover page of the guidebook for sexual health by Sex and Society.*

The clinic is open every working day (except Friday) in the evening from 15:00 to 19:00 for drop-in services, and open for telephone calls from 9:00-11:00 and 12:30-14:30. For online question & answer sessions, the forum is open from 17:00-20:20.

The Sex and Society clinic is situated in Oslo, although it works all around the country on several events. It aims to prevent STIs and unplanned pregnancies, and to spread information about free abortions to prevent consequences of unintended pregnancies and to promote the sexual and reproductive health and rights for young adults. Contraceptive and sexual counseling is also available for young adults under 25 years of age, which is free of cost for the individuals. With a positive view of sexuality, promotion of healthy behaviors and working to dismantle sexual taboos and stigmas, understanding the sexual and reproductive



needs of young people is critical. The Sex and Society clinic provides the following contraceptives: Progestin pill, IUS, IUDs, condoms (the only free of charge option available to all its visitors), the Mini Pill, birth control pills, contraceptive patch, P-ring, Depo-Provera, and P-strip.

For improving the health of school students, representatives from the clinic visit schools and provide information sessions for both students and school nurses mainly in Oslo. On many occasions, the staff from the clinic take part in national radio services to discuss or highlight the health concerns of young adults and to raise awareness. In collaboration with many organizations, the Sex and Society clinic is actively working to improve young people's health and wellbeing by suggesting new or modified policies to municipalities, ministries, the Norwegian parliament, and other responsible authorities. The clinic has a website that can be found online at: [www.sexogsamfunn.no](http://www.sexogsamfunn.no). This organization also has a Facebook page, Instagram account, and a YouTube channel under the name of 'Sex og Samfunn'. It is situated in Trondheimsveien 2, Bygg B, 0560 Oslo, near the Heimdalsgate bus and tram station. Sex and Society works tirelessly to advocate the importance of improving reproductive and sexual health and related rights for young adults regardless of ethnicity, religion and sexual identity.

Some recent statistics about Sex and Society include (Figure 3):



Figure 3: Statistics about the services of Sex and Society in 2017.

1. Around 6,000 girls received an HPV vaccine from the clinic in 2016
2. Sixteen thousand five hundred and twenty six young people took a chlamydia test from Sex and Society in 2017
3. Eight thousand two hundred and sixty young people made use of the online chat service in 2017
4. The clinic gave sex education lessons to 7,700 students of class nine in schools in the year of 2017.
5. Seven hundred and twenty six individuals used IUDs, and seven hundred and thirty the contraceptive spiral, provided by the clinic in 2017 (20).

## **Culture, SRH and adolescents**

### **Culture, Sexuality, Sexual Health and Adolescence**

Boislard, M. A., van de Bongardt, D., & Blais, M. discussed youth sexuality and the impact of collectivistic and individualistic culture on sexual and reproductive health (15). They found that young people raised in some African and Asian countries with ‘collectivist cultures’, which place great value upon social belonging and group responsibility, are significantly impacted by it, which results in differences in their sexual development when compared to those raised in more ‘individualistic’ countries. Examples of such countries include the United States, Canada, Australia, and various Western European nations. The cultures of these countries tend to emphasize the value of independence and individual wellbeing. Young people in collectivistic cultures typically possess, overall, more conservative sexual norms, in comparison to those in more individualistic cultures. The authors distinguished differences between ethnic groups regarding the sexual attitudes and experiences of those aged 13 to 20 years with immigrant and varying religious backgrounds (both Muslim and Christian) (15). Among these groups, attitudes towards sex and sexual experiences were more traditional, and more strongly influenced by community taboos and fear of judgment by that community. The immigrant females tended to practice the sexual norms conveyed by their parents, culture and religion to protect personal and family honor. They were particularly concerned with the idea of abstinence until marriage, due in part to a willingness to follow the precepts of their religion as they relate to this subject, and a desire to avoid being the subject of malicious gossip or to be exposed to public slander (15).

The Somali immigrants in Norway (which is a relatively new immigration destination, in comparison to other western nations such as the United Kingdom or United States of

America) have been living in a diaspora for almost 20 years (37). Those who were Norwegian-born to Somali parents, and who were first-generation members of the diaspora, have a varied understanding of health when compared to ethnic Norwegians (37). Again, cultural differences between Norway and Somalia are substantial (38). Their diverse schools of thought about life display significant differences with regard to the challenges to health that adolescence can bring. The effective integration of the Somali community is hampered due to the lack of precise data about them and acknowledgement of their views towards the Norwegian healthcare system and its facilities (38). Ensuring the optimal health and wellbeing of all parts of society will naturally lead to the desired outcome of the highest standard of health across the whole population including female Somalis. This is why adolescent Somali girls' attitudes towards contraceptives and SRH services need to be explored: to improve the health services and their utilization.

However, barriers for adolescents seeking SRH services are not limited to ethnic differences only. Much literature that is concerned with the perceived barriers that prevent adolescents from utilizing sexual and reproductive health services highlights the adolescent period as also a contributory factor to a larger barrier made more prominent by cultural differences (39). Major obstacles for a young individual may include: controversy surrounding sexual and reproductive health which prevents them from talking about their needs; reluctance about personal needs as an adolescent and lack of cultural appropriateness (40). All of these factors have a significant influence on the underuse of existing services by those who come from varied cultural backgrounds.

### **Prohibition of premarital sex**

The major thread between the Somali communities in Somalia and abroad is the religion and Somali tradition and culture which influence their behavior including seeking the SRH services. Religious influence on the sexual health of adolescent Muslims living in the western world is obvious (41). There is a distinct difference between 'legitimate' and 'illegitimate' sexuality (referred to as *nikah* and *zinah* respectively) in Islam. Muslims, unlike non-Muslim participants, irrespective of gender, frown upon sex before marriage as it is considered *haram* (a sin) in Islam. Retaining one's virginity until marriage is the standard practice. Therefore, sexuality is not only subject to religious rules, but also has consequences for people's social, economic and public status. Opinions on sexual issues among participants are influenced

enormously by Islamic beliefs, as sexual activity between married partners is not restricted to procreation, but is rather considered an expression of spirituality to be practiced in private in Islam. The follower values privacy and modesty to the highest degree, and questions about sexual health and gathering information about sexual behavior are socially unacceptable, especially before marriage. General reluctance to discuss sexual matters is thus profound and undesirable among Muslim youths (42).

### **Varying importance of sexual and reproductive health**

In Norway, health is one of the highest prioritized sectors of the state. Therefore, female reproductive and sexual health is of equal importance to any other health concerns. In Somali women's lives, their religious identity is intertwined with their daily lives. The long-standing liberal stance on religion that exists in Norway allows them to practice their faith freely (43). Prayer, performed five times daily, is part of their routine, which also includes dietary restrictions and conducting activities in the name of Allah. Their perspective on health issues, especially those pertaining to sexual health and the sexual behavior of young adults, is strongly influenced by culture and traditional value (and marital status). The resulting cultural difference leads to a diminished interest in, and perceived irrelevance of the services provided by the Norwegian state. As a consequence, (sexual) health initiatives in Norway may not be appealing to female Somali adolescents (44).

### **Desirable sexual behavior and perceived needs of SRH services among Muslims**

Islam prescribes a lifestyle for its adherents with specific regulations for political, economic and social behavior. This includes guidelines for the familial and conjugal life of a Muslim. In the holy book (the Qur'an) and the sayings of Hadiah (in accordance to the Prophet; peace be upon Him), sexuality is discussed in the context of one's marital and family life. Sexual intercourse outside marriage is a punishable sin; on the other hand, sex with one's spouse is an act of worship. Sexual abstinence until marriage is considered virtuous, while it is regarded as unusual in the West (41, 45).

The term 'sex education' has been perceived negatively in some Muslim communities, and often interpreted to mean the promotion of immoral practices amongst young people by providing them with information that triggers their curiosity and the desire to experiment with

prohibited premarital sex (41). Contemporary sex education in the Western world, for Muslims, is highly controversial, as it tends to present certain behaviors as normal or acceptable, which Muslims believe to be sinful. They are not permitted to touch, date, or have intimate relationships with members of the opposite sex outside of an Islamic marriage. With the high likelihood that it will contain lessons regarding correct condom use, and sexually explicit material such as videos depicting nude people or detailed diagrams of the human form, secondary school sex education contrasts with Islamic principles of decency, modesty, chastity, sexual responsibility and accountability (45). In addition, sex education for Muslim students, as well as seeking help and advice with sexual health, is considered a form of protective measure and cannot go beyond the limits of what the family believes to be appropriate and honorable.

Marriage is viewed as a holy obligation and the cornerstone of building a family, which is the basic unit of Islamic society. The practice of cohabitation is regarded as adultery; the latter also includes pre-marital sex, and is thought of as a crime not only against one person, but against the whole society. The Qura'nic command, 'Do not approach adultery', dictates that any sexual contact outside of marriage, as well as anything that has the potential to lead to such contact, is prohibited. This also includes sex education (41).

The Sex and Society clinic has a program for students in Oslo, which involves their visiting schools to offer lessons on sexual health and education. Considering the above religious and cultural factors, modified steps need to be taken by the clinic to recognize and respect the reality, diversity and cultural specificity of student experiences in the classroom, including appropriate sex education for Muslim students (41) (45).

### **Cultural influence on adolescents' SRH**

Roudsari, R. L., and her associates explored the challenges of sex education and found that the discussion of sexuality is a taboo, and providing sexual health education for non-married adolescents is culturally unacceptable among Muslim students in Iran (46). A similar situation exists in many communities around the world. The authors considered multiple themes in the data, such as denial of premarital sex, social concern about negative impacts of sexual education, perceived embarrassment and reluctance to discuss sexual issues in public, sexual discussion as a socio-cultural taboo, and concerns over non-Islamic patterns of education, where pupils are taught to have safe sex, like those which largely prevail in the West (46).

The study concluded that cultural resistances as well as religious influences acted as important prohibitions, consequently having more of an effect on the nature and context of sexual health education in the region, eventually constituting barrier to gain the knowledge needed for health (46).

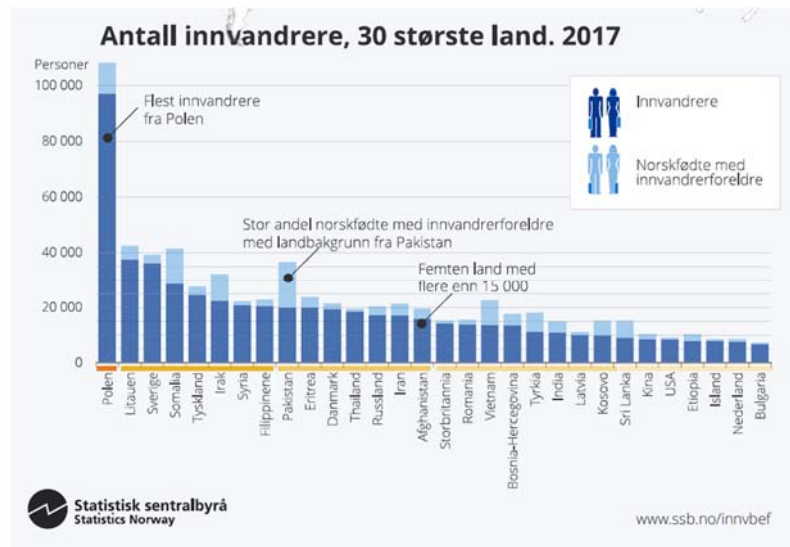
Inevitably, culture shapes an individual's sexuality, reaction to sexual action, and sexual response in certain circumstances. The surrounding environment, family upbringing, education, beliefs, historical state, personal experience and interaction with others through the culture influences personal perceptions about sexual health. Therefore, minorities and immigrants in various parts of the world may have different attitudes regarding SRH than the natives of a particular region (47).

### **Norwegian and Somali context:**

#### **Somali immigrants and their health concern:**

The Somali community is the largest African group in Norway and the third largest non-Western group of immigrants in the country (24). The sum of Norwegian residents coming from immigrant backgrounds, and those born to parents of an immigrant background, was 884,000 (16.8 per cent of the country's total population) as of the beginning of 2017. Of those Norwegian-born to immigrant parents, 87 per cent were aged under 25 years (21). Following is the table showing that Somalis are the fourth largest among immigrants (Table 2):

Table 2: The immigrant population of Norway, arranged according to size, as measured by the number of individuals from specific backgrounds (18).



Source: [www.ssb.no/innvbef](http://www.ssb.no/innvbef)

In 2017, the Norwegian Statistics Bureau found that the number of immigrants of Somali descent resident in the country totaled just above 40,000. This made the Somali the fourth largest immigrant group.

Table 3: Table showing the number of individuals Norwegian-born to immigrant parents, with their country of origin. Norwegian born to Somali parents stands as second largest.

Landbakgrunn	I alt	0-5 år	6-15 år	16-19 år	20-66 år	67 år og eldre
<b>Norskfødte med innvandrereforeldre i alt</b>	<b>158 764</b>	<b>60 568</b>	<b>51 861</b>	<b>12 870</b>	<b>32 306</b>	<b>1 159</b>
Pakistan	16 727	2 246	4 420	1 951	8 110	-
<b>Somalia</b>	<b>12 767</b>	<b>6 003</b>	<b>5 175</b>	<b>816</b>	<b>773</b>	<b>-</b>
Polen	11 059	7 700	2 628	122	597	12
Irak	9 811	3 710	5 059	719	323	-
Vietnam	8 908	1 326	2 992	1 254	3 336	-
Tyrkia	6 842	1 186	2 297	945	2 424	-
Sri Lanka	6 199	932	2 487	1 276	1 504	-
Kosovo	5 294	1 502	2 470	643	679	-
Litauen	4 853	4 133	713	4	3	-
Iran	4 195	1 283	1 603	536	773	-
Marokko	4 159	847	1 432	511	1 369	-
Bosnia-Hercegovina	4 093	1 112	1 738	541	702	-
India	3 911	1 011	937	431	1 532	-
Eritrea	3 661	2 434	749	166	312	-
Afghanistan	3 574	1 964	1 457	68	85	-
Russland	3 219	1 636	1 480	48	44	11
Tyskland	2 992	1 279	1 151	97	360	105
Sverige	2 951	1 245	692	139	508	367
Etiopia	2 499	1 422	836	99	142	-
Filippinene	2 355	913	664	183	595	-
Kina	1 991	802	602	172	410	5
Danmark	1 953	343	297	104	1 084	125
Chile	1 789	191	424	208	966	-
Romania	1 775	1 364	337	18	51	5
Syria	1 462	776	432	106	148	-
Makedonia	1 345	326	425	147	447	-
Serbia	1 035	478	272	46	239	-
Latvia	1 020	839	161	7	13	-
Storbritannia	991	225	188	72	417	89
Libanon	973	196	384	143	250	-

Source: Befolkningsstatistikk, Statistisk sentralbyrå. 1st January 2017 (21).

In the year 2018, the figure is 43,196, showing the rapid increase in immigrant Somali population. There is continued immigration to Norway from Somalia even after the conclusion of the main population displacement in 1995. As such the majority of the current Somali population arrived after 2000.

Almost all members of the Norwegian Somali diaspora came to Norway as asylum seekers in the beginning, due to catastrophic political events such as tyranny, civil conflict, and the invasion of Somalia by a radical group. A bombing, occurring in 1988, caused the first significant population displacement of that period from the Northern part of Somalia. This produced the first wave of significant Somali migration into Norway and other parts of Europe (48). After that, the second wave of refugees came to Norway during 1991 mainly from the Southern part of Somalia, and beyond. This almost doubled the initial number of refugees, and was the result of an ongoing political unrest and the desire of families to be reunited abroad (48) (49). To date, Somalian females (born to two ethnic Somali parents) number 19,758 in Norway, as shown in a 2016 survey (31).



As in many other African nations, Islam is the predominating religion in Somalia; around 99% of ethnic Somalis are Muslim (50). This is reflected in their lifestyle and traditions, and has a significant influence upon perceptions of sexual and reproductive health (SRH) matters by those who identify as a member of the Somali diaspora. The notion of modesty, and by extension chastity, is a particularly prevalent one, forming a core respected feature of the construct denoting appropriate female behavior, and thus identity. Exemplified in a study speaking to Somali women, it was found that openly talking and thinking about sex was especially challenging for them due to its contravening their moral values and modesty (51). A previous report demonstrated many features of this immigrants including their health aspects, for example, female Somalis have the highest fertility rate among immigrants in Norway (3.16 per cent) (21). This fact indicates that the SRH needs of future mothers from a Somali background are of particular importance, and may require special attention.

Culture has a huge impact on girls' life. It has been indicated that generally, Somali individuals fall into the bracket of those who have the least prevalence of mental health problems. According to previous study, Somalis even reported having a generally better state of mental health than some other immigrant groups. Furthermore, to an extent this is also seen with physical health. Despite immigrants on the whole having a lower level of self-assessed health, those of a Somali background fare better than ethnic Norwegians in terms of chronic conditions. This study also explained that Somali adolescents have less health-risking behavior; simultaneously, they adopted less health promotion initiatives than ethnic Norwegians (22).

With discussion of SRH carrying cultural controversy, it follows that young female Somalis residing in Norway might not have a realistic chance to explore or adopt Norwegian views regarding sex or the SRH services provided by Sex and Society clinic. Learning about sexual health or having sexual relationships is considered not only irrelevant during adolescence, but prohibited until they are married. This extends to having a romantic/sexual partner outside of marriage, which is not permitted in accordance with *sharia* law, which a female Somali adolescent would likely be expected to adhere to. Therefore, the preventive services related to sexual activity and SRH needs has different cultural acceptance and not be a priority health service for female unmarried Somalis (36).

## **Differences in healthcare systems in Norway and Somalia**

The government funds all the hospitals in Norway as part of the national budget and welfare system. Any person younger than sixteen has access to free treatment (52). However, adult residents must pay medical fees up to a certain amount before they are eligible for an exemption card. The card entitles one to free healthcare for the remainder of that year.

Hospitals in Norway are run by four Regional Health Authorities (RHA), which are governed by the Ministry of Health and Care Services. In addition to these hospitals, there are a few privately owned health clinics currently operating in different parts of the country (52).

Every inhabitant in Norway has a general practitioner according to their choice. An individual has to pay a part of the consultation fee. When they have a health concern, an individual typically sees a general practitioner first, who may refer them to a specialist if necessary. A doctor-on-call service (legevakten) is also available at Storgata, Ryen and Linderud in Oslo, in case of an emergency or if a general practitioner cannot be accessed. Most doctors' offices are open from 8:00 to 15:00 (52).

All schools have at least one nurse (helsesøster), who is able to provide healthcare services during school hours free of charge. Many also have a psychologist and visiting health personnel. In addition, there is a health center in every municipality, which is mostly free of charge and provides many other services which do not require payment, such as standard vaccinations for children, and against diseases such as Human Papilloma Virus (HPV). Disease screening, family planning, and contraceptive services are also included (52).

On the other hand, an estimated 80 per cent of the population of Somalia has no access to healthcare. The country has a physician coverage of 0.4 per inhabitant (53), and there is no national health authority. People are therefore obliged to visit private facilities rather than attend a public hospital. Paid services are commonly regarded as the best, whereas public services provided by the state are viewed with utter skepticism (54). In addition, Somalian understanding of healthcare is limited to the treatment of clinical symptoms, with clinical care and privatization being the key concepts of healthcare (54). By contrast, preventive care is prioritized in Norway, and healthcare is part of the social welfare system. This is exemplified in the approach of the Sex and Society clinic, which is oriented towards education and prevention of negative SRH consequences for adolescents. For Somalis, this kind of clinic is a new concept, since it is free and provided by an independent organization, targeted specifically for young adults to provide SRH services.

### **Contraceptive practice and related concerns**

In Norway about 70% of persons aged between 16-79 years are in a live-in relationship (Norwegian: *samboer*). One out of four couples are cohabitants, and the rest are married couples. As a proportion of everyone either in or not in a live-in relationship, 18% are cohabitants and 49 per cent are married (55). Research has shown that in Norway, four out of five cohabitantes aged between 18-35 years old did not have the intention to get married in next three years, and needless to say, the highest level of acceptance of unmarried cohabitation is in Scandinavia (such as Denmark: 96 per cent Norway: 90 per cent (55). Use of contraception, among Scandinavians, thus is not necessarily solely meant to be dependent on marital status, as Somalis might perceive.

According to the Centre for Disease Control and Prevention (CDC), contraceptives such as implants, vasectomies, female sterilization, and IUD are the most effective methods for the prevention of unplanned pregnancies (56). Sex and Society provides free condoms, contraceptive prescriptions, and free counselling. The clinic also provides other types of contraceptives for a relatively reduced fee. As part of their health promotion initiative, the organization has also published a free guide to contraception (see Appendix F), which contains details of all the contraceptive methods they offer. To date, it is available in seven languages, including Somali, and is available both online and in paper format for free (57).

*Table 4: Page from the guide to contraception published by Sex and Society, summarizing the options that are available.*

## TYPES OF CONTRACEPTIVES

### NON-HORMONAL CONTRACEPTIVES

Duration	Type	Find out more
5 years	Copper IUD	Page 8
Each time you have sex	Condoms	Page 10

### HORMONAL CONTRACEPTION WITH PROGESTERONE ONLY

Duration	Type	Brand name	Find out more
3 or 5 years	Hormonal IUDs	Mirena (5 years), Levosert (3 years), Jaydess (3 years)	Page 12
3 years	Birth control implants	Nexplanon	Page 14
3 months	Birth control shot	Depo-Provera	Page 16
24 hours	Progesterone pills	Cerazette, Desogestrel, Orifarm, Conludag	Page 8

### HORMONAL CONTRACEPTION WITH OESTROGEN AND PROGESTERONE

Duration	Type	Brand name	Find out more
3 weeks	Vaginal rings	NuvaRing	Page 20
1 week	Birth control patches	Evra	Page 22
24 hours	Birth control pills	Microgynon, Oralcon, Loette, Synfase, Mercilon, Marvelon, Yasmin, Yasminelle, Yaz, Qlaira, Zoely	Page 24

3

Source: [www.sexogsamfunn.no](http://www.sexogsamfunn.no)

However, contraceptive use among immigrant women living in Norway is quite low in comparison to native women. Omland, G., Ruths, S., & Díaz, E. researched the use of hormonal contraceptives among immigrant and native women in Norway based on data from nationwide registries (58). From the total sample of 893,073 women, of whom 130,080 were immigrants, it was found that women aged 16-45 years born abroad with two foreign-born parents (immigrants) are 47-71 per cent less likely to use hormonal contraceptives than women born to two Norwegian-born parents (natives) (58). Cultural contradictories, such as marital status being a significant cultural barrier in relation to immigrants living in western nations seeking aid with sexual and reproductive health matters, is a concern among researchers (59). Potential barriers to contraceptive use that resulted in this disparity were

identified by Karoline Kragelund Nielsen; most prominently, controversy regarding contraception, which is closely tied to sociocultural issues (59). These include the importance placed upon an individual's remaining a virgin until marriage, combined with taboos surrounding the discussion of sex and contraception.

## **Theoretical framework: The Health Belief Model (HBM)**

The Health Belief Model (HBM) is a health behavior change model developed in the 1950s to explain and predict health-related behaviors, particularly in regard to the uptake of health services, for example, vaccination, tuberculosis screening, diabetes control programs, etc. to understand the underutilization of these services by individuals. The HBM is a theory suggested by Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventhal (60). It has six main constructs, and attempts to predict or explain health behavior choices, particularly preventive health care, of an individual from their personal perspective. These are as follows:

**Perceived susceptibility:** the degree to which a person believes that they are susceptible to an illness, condition or outcome.

**Perceived severity:** A person's perception of how severe a condition is, and its consequences.

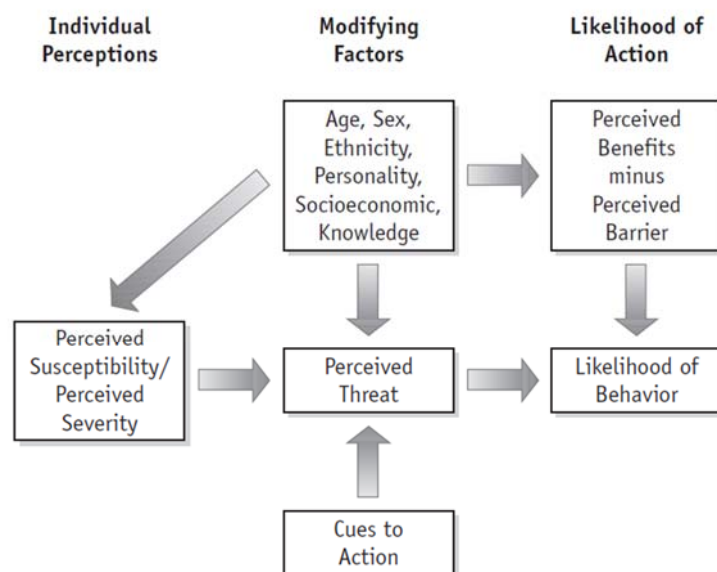
**Perceived benefit:** A person's belief that the proposed action will have positive outcomes.

**Perceived barriers:** A person's perception of the physical, emotional and financial barriers to changing behaviors.

**Cues to action:** The participating force or the actions that make a person change a behavior, or to feel the need to take an action.

**Self-efficacy:** The confidence a person has in his or her ability to pursue a behavior.

To make recommendations for the improvement of a health organization or an institute (such as Sex and Society) the model is implemented in this research. Elvis E. Tarkang & Francis B. Zotor emphasized that if HBM is used appropriately, redesign of the health program could be found to better suit the health needs of an individual (60). The basic concept of the HBM is illustrated in the figure 4:



Source: Stretcher, V., & Rosenstock I.M. (1997). The Health Belief Model. In Glanz K., Lewis F.M., & Rimer B.K., (Eds.). *Health Behavior and Health Education: Theory, Research and Practice*. San Francisco: Jossey-Bass. Reprinted with permission.

Figure 4: Health belief model (HBM).

Knowledge and awareness about the services of the clinic, and contraception, contribute to individual perceptions about the severity of unintended pregnancies and STIs, and the lack of perceived SRHR and SRH needs in the participants' life. These perceptions may be modified by a participant's age, sex, ethnicity, marital status, education, knowledge, socioeconomic circumstances (including peers, traditional belief, and cultural standpoints) etc. Consequently both individual perceptions and mentioned factors (demographics, personality, socioeconomic situation and knowledge) modify the individual's perceived threat of a disease or unwanted health conditions. The demographics and knowledge also modify the understanding of benefits and barriers toward the development of the changed behavior of an individual. These threats and understandings finalize the behavior of that individual in the end towards health promotion. It should be mentioned that perceived threat (which in this study is comprised chiefly by the presumed health outcomes of female Somali adolescents who underutilize the clinic) could be modified by the redesigned actions of a health system (e.g. culturally sensitive health education, appropriate promotion through internet or media, empirical interventions with the help of general physicians, school health nurse, integrated health centers etc.). This model was developed considering the person's perceived needs, motivation

and self-efficacy to formulate further actions to promote desired healthy behavior of the target group of individuals (60).

Furthermore, the HBM works on the assumption that a person would take a health related action (i.e. making use of the SRH services of the clinic) if that person feels that a negative health condition (like unwanted pregnancy or STIs) could be avoided. The realization of the individual is posited to be that the services could potentially help to avoid unwanted conditions, which could only happen when they have true knowledge of the problem and sufficient risk of encountering the negative health consequences. This understanding of the problem may therefore lead them to take appropriate measures regarding prevention. This model also requires the persons' have a positive expectation of the recommended preventive action. If the individual could not find any benefit by performing the preventive action, it is less likely for them person to seek out or make use of the necessary preventative strategies, or to practice preventative action. Moreover, the HBM also assumes that any individual required to be confident enough to take the preventive action in a supportive environment (60). The person needs to be self-assured that they could carry out the preventive actions based on the necessary knowledge and skills (60). As a result, it may be said that the female participants of this study would only be willing to visit the clinic and utilize the SRH services voluntarily if their current situation fulfilled all the above criteria, which is not the case.

## **Rationale of the study**

The research attention devoted to the sexual and reproductive health of female Somali adolescents residing in Norway has been scarce at best, with the exception of several studies on female genital mutilation (FGM), changes in family dynamics, and cultural differences, by Gele A. et al, Gabowduale, K. G., and Thomas P. (24, 36, 38). It is clear, therefore, that the sexual and reproductive health needs of second-generation individuals in this group has the potential to be a research field of much importance (61). In addition, there is significant underuse of the services of the Sex and Society clinic by Somali adolescent females. In order to increase the inclusivity of the clinic and its services, the reasons behind this need to be identified, so that they may be successfully redesigned and updated to cater for a wider range of cultural demographics. To that end, an evaluation of the current situation is required, alongside an assessment of the knowledge gap existing in relation to SRH service use and

choices of contraceptive methods on the part of adolescent Somali females, and their rationale of these choices.

## **General objective**

The aim of this research is to investigate the attitudes and perceptions toward the services of the Sex and Society clinic held among female Somali adolescents in Oslo.

## **Specific objectives**

1. To understand attitudes held by female Somali adolescents about the Sex and Society clinic and the services it provides.
2. To identify the facilitating factors and potential barriers that affect the use of contraceptives.
3. To identify means for the clinic to improve the services to reach the highest coverage of female Somali adolescents.

## **Methodology**

### **Research design**

In this research project, a qualitative research approach was implemented for knowledge production. Since this approach is purely exploratory in nature, it was the most effective choice in this context. According to Guba E. G. and Lincoln Y. S., people's behavior in human settings can be explored through naturalistic inquiry, as there is a presence of multiple realities that modify individual's actions (62). This naturalistic approach can be conducted via the qualitative method, giving room for the researcher to understand and rebuild the realities, as Paul, M. and her associates stated (61). To know properly about human events, the knowledge seeker is also required to understand, correlate and interpret the ideas under study with participants throughout the research process (61). A qualitative approach was favored in this research, due to its flexibility, and the possibility for the researcher to adjust the interview guide, since SRH is understandably a sensitive and highly confidential subject for many minorities living in Scandinavia (51). By qualitative approach, the researcher would be able to



gain a more in-depth knowledge of certain subjects. As Gabowduale K, G. elaborated on the implications of qualitative research (from Denzin, Norman K., & Lincoln, Yvonna S.): “emphasis [is placed] on the qualities of entities and on processes and meanings that are not experimentally examined or measured in terms of quantity, intensity or frequency” (63). The choice of method is derived from the issue at hand, and the questions that need to be answered through research. As Patton M. Q. stated, it should arise as the ‘phenomenon of interest unfold[s] naturally’ (64). The qualitative research constitutes a subjective experience of reality by the participants, based on their understanding and interpretation of health needs, and the influence of their cultural background and belief system. Considering the effectiveness of the qualitative method, this technique was adopted to conduct the research.

### **Study setting**

When female Somali adolescents and their reproductive health, and their understanding of the SRH services of the Sex and Society clinic came to attention, Oslo was selected as the study area. Since its foundation, the clinic has based its operations in the Oslo area. This clinic’s interest in the underutilization of services by adolescents from a Somali background, and said clients’ social integration from a health perspective, also contributed to the choice of study area. Moreover, this area was especially appropriate due to the majority of Somali immigrants in Norway residing in Oslo, and the requirement of the researcher to commute. To enhance the appropriateness of their services and raise acceptance of the services in this cultural bracket, the clinic was willing to give me the opportunity to conduct research on this sensitive topic. Therefore, it was necessary to conduct the study in Oslo, for the clinic to fill the knowledge gap existing for these aspects.

### **Sampling procedure**

Purposive sampling was used to collect the highest possible amount of data contributing to the research. Gentles, S. J., and his associates argue for the usefulness of purposive sampling: “The logic and power of purposeful sampling lie[s] in selecting information-rich cases for in-depth study (65). Additionally, Patton, M.Q. has stated that “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry...Studying information-rich cases yields insights and in-depth understanding.” (66). Furthermore, participants cannot be selected randomly. They must be selected only if they

were of particular research interest: in short, selected individuals must have the necessary characteristics to fulfil the criteria of a participant. The sample must be comprised of respondents who can give the maximum possible input in order to enable effective analysis of the phenomenon that is being studied (67). Recruiting visitors to the clinic and their peers, who might or might not utilize the services of the clinic, therefore ensured variation of the sample.

The greatest challenges in terms of recruitment were the language limitations of the researcher, and the researcher's originating from a different ethnic background to that of the participants. A Somali-speaking research assistant was involved initially in an attempt to counteract these issues; however, their being of the same ethnic background to potential participants appeared to constitute more of a challenge than an aid.

In addition, the snowball technique was implemented; this involved one participant who had already taken part in an interview, or gotten in contact with me during the visit to the clinic, suggesting close associates or other members of the community who might be willing to participate. This technique has positive aspects, as it forms an environment of trust, comfort and confidentiality.

### **Study participants and recruitment process**

Norwegian adolescents of Somali origin, aged between 16-20 years, were the target population. My introduction to the clinic's deputy director was facilitated by Professor Johanne Sundby (Institute of Health and Society, University of Oslo). Taking the interest of the clinic's inclusive purpose into account, the research questions were developed. After several meetings with the Deputy Director, Tore Holte Follestad, I was granted permission to stay in the clinic to make contact with adolescent females for research purposes. I started to stay in the clinic during their opening hours in the spring of 2017. For primary recruitment, I approached and spoke with females directly who seemed to me as being of Somali origin, during the opening hours of the clinic. Also, I tried to give them a small piece of paper, which included my name, phone number, and my research interest, to make first contact.



Figure 5: The paper name card was given to potential participants to enable further contact.

With the help of the clinic staff, I as the researcher spoke to them after they had registered at the clinic, and obtained information regarding the service they were looking for.

***Inclusion criteria:***

1. 16-20 years of age
2. Somali adolescent female with both parents from Somalia
3. Living in Oslo
4. Willing to participate.

***Exclusion criteria:***

1. Having one parent who is Norwegian, or who identifies as something other than Somali
2. Living outside of Oslo.

It was difficult to know initially what might constitute relevant categories for recruitment, as this must often be determined and adjusted along the way as the researcher gains more knowledge about the process (68). However, those who fitted these criteria were eventually considered to be the most appropriate choice for participants. Due to the highest concentration of Norwegian Somali immigrants residing in the capital, this was an enabling factor to participant recruitment, which would enable more information-grounded redesigning of the clinic's services.

The figure below illustrates the outcome of the participant recruitment process for this study, including the initial number of potential participants, those that were dropped at various stages for the reasons outlined, and finally the number of suitable, willing individuals.

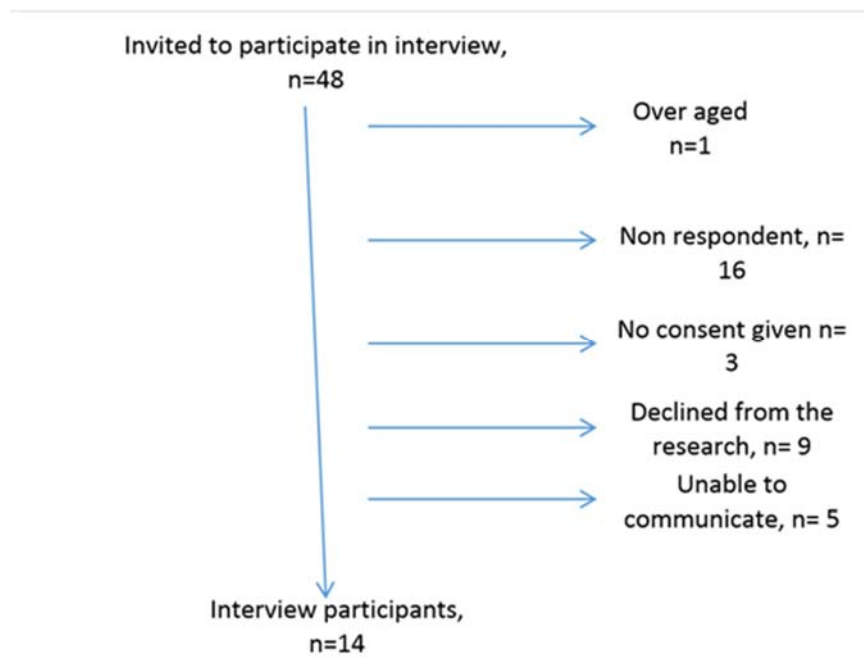


Figure 6: Participant recruitment process

### Challenges of recruitments

During this study I encountered multiple challenges regarding the recruitment of female Somali adolescents, which differed depending on the stage of the process.

Primary recruitment was done in the clinic. After spending four months there, the result was that only one interview had been completed successfully, as some potential participants were unwilling to talk about the research itself or did not respond to further attempts at contact.

Furthermore, some showed up at the agreed time, but refused to participate in interviews after reading the consent form or hearing about the research topic. They explained that they had misunderstood the intention of the contact and claimed that they had nothing to contribute to a discussion of the clinic or its services. Some participants wanted to see the interview guide beforehand, and were very precise about the time they had available for interviews, with none agreeing to talk for more than 10-20 minutes at a time. Sometimes they would attempt to negotiate, stating that they had an appointment and thus could only spare 10 minutes, or asking if I would accept a 15-minute conversation, as they were unable to stay any longer. In these formal meetings with the purpose of giving interviews, one participant agreed to a second meeting of 30 minutes, while two later claimed that their appointments had been cancelled, and they were able to talk for a further 10 minutes. Four interviews were taken in

the clinic while they were waiting in the queue, as they claimed that they did not have time to commit to participation for the full length of the research period. Of these, two participants later refused to let me use their data for the research.

In another case, after her interview was over, one participant walked with me for an hour, and asked about the future implementations of the study. She was reassured that I would send her a transcription of the interview, and that she would have to give her permission for the information to be used; only then could this material be included in the study results. I obtained feedback permitting me to use the transcription one month after sending her a hard copy.

Secondary recruitment through the snowball technique was time-consuming, and was not concluded until the end of May 2017. Significantly, one adolescent female who came to the Sex and Society clinic to accompany her friend agreed to let me contact five other potential participants who fulfilled the inclusion criteria.

### **Sample size**

Although qualitative research does not necessarily need a certain number of participants to generate a hypothesis, the initial plan was to interview around 30 adolescents for the study, as suggested by previous research. Mason M. advocated that a total of 31 respondents was the mean sample size for studies with semi-structured open-ended interviews (69), although the number of participants of this study ideally needed to be higher to cover missing interviews or respondents who eventually declined to participate. The choice was made to invite more participants/respondents, in case there was a high loss to follow-up. In addition, the point of saturation could be achieved by this sample size; this means that the number of participants is thought to be enough to reach a point where no new information can be obtained, or the repetition of the same information prevails over instances of new information (68). Fourteen interviews were taken into account, and the point of saturation was considered to have been reached. Repetition of answers and declining to answer certain questions were taken as the primary indicators of the saturation point.

In qualitative studies, a large amount of data is not needed to reach a suitable level of understanding. Here, the frequency is not the deciding factor; rather, a single piece of information can be enough to shed light on the phenomenon being discussed. Again, qualitative research does not lead to making generalizations. It seeks to generate a hypothesis, so the number of respondents can be smaller in comparison to quantitative research.

At the end of the summer of 2017, 14 interviews were determined to be contributory. The qualitative methods do not aim to generalize on the basis of a representative sample. Rather, the strengths of this technique rest on acquiring a multitude of different stories that would provide a rich data set for hypothesis generation, as explained by Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (70).

### **Data collection tool**

A semi-structured open-ended interview guide, along with a digital recorder, was used for the study (Appendix B). A thematic outline was made, developing an interview guide for collecting data according to the research objective, based on what the clinic had expressed interest in knowing. The interview guide followed several themes. These included:

1. Knowledge about contraception and the services of the clinic
2. Participants' own perception of contraceptives
3. Attitudes towards the services of the clinic
4. Suggestions to improve the services of Sex and Society.

All four themes had guiding questions, with follow-up questions depending on participant's responses.

### **Qualitative in-depth interviews**

In-depth interviews leave space for the participants to take time to speak their own mind, according to their perspective, within a confidential and comfortable setting. Open questions enable participants to elaborate on certain topics, and on the subject of the interview (71). They also enable the conversation to flow freely and with flexibility (62). With thematic progress, the topic under discussion can be spoken of with room for the probing and processing of specific ideas. Thus, in-depth interviews are well-suited to gaining insight into interviewees' experiences, thoughts, and feelings. Through the interview guide, themes and issues were largely determined and shaped in advance, and modified alongside the ongoing interview process. However, it was not followed exactly in real interview situations, as the situation itself was dependent upon the participant's willingness to answer and my interest in delving deeper into this sensitive issue. Eventually, I spent several months in the clinic making contact with Somali girls, who were extremely rare visitors; thus, face-to-face

interviews were not concluded until the end of summer 2017. I also made contact with the available participants whenever any confusion arose during interpretation, and took their opinion accordingly. The interview guide was pretested by one adolescent girl who visited the clinic, and had one parent of Somali descent (Appendix A).

### **The clinic's services: Sex og Samfunn**

Sex education and counseling sessions,

Contraceptive services,

Contraceptive and family planning counselling,

STIs testing and treatment,

Adolescent's health services- youth counseling, selective free contraceptives for adolescents under certain age, sexual and reproductive health rights movements etc.

Sexual undervisning- in schools,

Pregnancy tests,

Information about abortion,

Online chat services and telephone contractibility,

Drop in services in the clinic with or without appointments on weekdays from 1500 to 1900 except Friday,

Advocacy for policy development for youth friendly health services in Norway,

Courses for health professional,

Website- [www.sexogsamfunn.no](http://www.sexogsamfunn.no)

Sometimes talks about health on radio- NRK.no

*Figure 7: The chart used to talk about the clinic during interviews, or to secondary participants whilst obtaining consent or explaining the research.*

The topics covered in the interviews included: the services of the clinic, contraceptives, the clinic, cultural differences, sexual and reproductive health needs, and how they correlate services designed for them, friends, internet, family members, and health.

## **Data collection and management**

Only after collecting informed written or oral consent were interviews conducted, with confidentiality. They were carried out at locations determined as comfortable by the respondents. To ensure a neutral space for interviews, the participants were asked to choose the interview place: for example, a private room in the clinic, a café, a room in Oslo

University Hospital (Ullevål hospital), or in their residential place. Their anonymous participation and ability to decline the interview at any time also contributed to the establishment of a comfortable environment. Moreover, the seating arrangement of the interviewer and the interviewee was decided after discussion with a fellow researcher and the project supervisor, to ensure that conversation could flow as freely as possible. Questioning about marital status – a pertinent yet sensitive topic - was deliberately avoided to let them talk freely on the issue.

During the data collection period, several interview sessions with a single participant were required in order to follow up on questions, or have issues or responses clarified. I tried to meet the girls more than once where needed and allowed. This increased the likelihood of gathering more information, as the researcher's understanding matured, data collection evolved, or new insights arose which might have been missed previously. Moreover, there was an ever-present possibility that some participants would decline. With permission from the participant, the full conversation was recorded or written down, and later transcribed and interpreted. As I did not know the Somali or Norwegian languages, interviews were conducted in English. The transcribed data was therefore in English. Field notes were also collected during each interview. After interpretation, the materials were to be stored securely for five years and then destroyed. Respondents were given the opportunity to receive a copy of the outcomes of the study, if they so desired. Moreover, the participant had every right and opportunity to withdraw, or change or repeat the interview at any time of the research. Data collected from the field was kept under the researcher's personal care, being stored on their researcher's personal computer and at their e-mail address.

### **Data analysis**

Data analysis was ongoing alongside data collection, data interpretation, and narrative writing. Firstly, the transcriptions were read to gather a general impression. Transcriptions were made from recording or written interviews, and crosschecked comments by the participants.

Secondly, the transcriptions were reread for further understanding of the adolescents' perspective on health, the services of the clinic and their cultural background, in context. Through an iterative process of reading and rereading transcripts and field notes, recurring, emergent themes were identified. The aim was to identify frequent issues in the accounts given.



The theory chapter was grounded at a draft stage, as the overall outcome of the research was uncertain. Additionally, a knowledge gap existed concerning the use of the clinic's services among Somalis, and whether the participants' background affected their engagement with the concept of using SRH services during adolescence. Although my background is similar to that of the participants, my understanding of health sector and Somali community in Norway was based solely on theoretical grounds. However, this background was concrete, with literary support from Scandinavian studies, as well as a selection of literature from other Western countries where Somalis reside.

Categories were drawn directly from transcript texts. Emergent themes were verified through transcripts and were categorized. For each category, the data was re-examined to determine whether subcategories were needed. Text that could not be coded into one of these categories was given another label, which may have led to the formation of additional categories leading to subthemes or even main theme.

For discovering themes in transcriptions, reading and rereading of the transcriptions, as well as listening to interview recordings (where applicable) while checking accompanying field notes, was done. The semantic approach was in effect to describe each of the participants' interviews within a short paragraph, or 2-3 sentences, to understand the surface meaning of the each of the interviews (72). However, the main guiding force for determining appropriate themes for this data set was theoretical knowledge (as aforementioned), and information provided in the interviews. Once coding had been done, they were divided up to enable the creation of main and sub-themes keeping in mind the main objective of determining related knowledge, attitudes and practices among the participants. This allowed for a more focused and organized analysis of the data, as will be evident in the 'Findings' chapter.

## **Ethical Considerations**

Before starting the data collection process, ethical clearance was sought from the Norwegian Research Council. This project was approved by the NSD (Norwegian Social Science Data Services) (Appendix C) and REK (Regional Committees for Medical Research Ethics) (Appendix D). There were several ethical considerations to be made during the research. Informed consent and anonymity, researcher behavior towards informants and processing and interpretation of data were regarded as vital steps in knowledge generation. Three main ethical principles were considered: informed consent, confidentiality, and the consequences of participating in research projects (73). These were as follows:

**1. Informed consent:** In order to ensure that the human rights of all the individuals who participated in the study were upheld, a full explanation of the study and its purposes, as well as the consequences of participating in research projects, was provided as in the form of informed written consent developed from the format of REK (Appendix B). Written or oral consent was then obtained from the participants before the interview was conducted, as per the Declaration of Helsinki (73). Participants were allowed to ask about the purpose, scope and results of the study. They could ask questions regarding the research, and were permitted to be debriefed or to have the research outcomes explained by the researcher at any time during or after the research period. The semi structured questionnaire was suitably modified to prevent any form of conceptual misunderstanding (Appendix A).

**2. Confidentiality:** As the issue under study was particularly sensitive, this was of great importance (73). Participant confidentiality was maintained by agreeing that the data they provided would be collected anonymously, and if required, used in the findings under a pseudonym. Additionally, it was ensured that no mental or physical harm would be caused, that participants' social positions were respected, and that face-to-face interviews were carried out only after written or oral informed consent had been provided with certainty (73). Moreover, participant's anonymity was scrupulously maintained, and at the request of some participants, conversations were not recorded on several occasions. Some also declined to give their exact age, only stating that they were under 20 years of age, although some then agreed to provide their age during further interaction. I did not request any contact information from the participants; instead, I gave them my details, allowing them to choose whether to contact me in future or not. On several occasions, participants declined to give written consent, and this decision was respected; however, oral consent was definitively obtained from them before the interview process began. All interviews were cross-checked by participants, immediately after their conclusion or in later interaction with the researcher. As the topic would naturally produce a level of reservation with regards to participation, every initiative was taken to protect participant confidentiality.

**3. Voluntary participation:** Participation in this study was fully voluntary (73). Those who agreed to take part were given the option to decline their participation from the process at any time. This was permitted even after their interview had been completed and data collected; an

option fully and clearly explained in the informed consent document with which each participant was provided. Furthermore, they had the right to withdraw their participation in full, even beyond the period of research completion. Participants had the right to decline to answer any questions during the interview, and after the interview could choose to omit their answers from the data pool in part or in entirety.

## **Reflexivity**

Reflexivity has been referred to as ‘the knower’s mirror’; it needs to be acknowledged to clarify how the actions and decisions on the researcher’s part could inevitably impact upon the meaning and context of the phenomena under discussion (74).

Conducting research among participants from a different ethnic and cultural background than my own proved both an advantage and a disadvantage. I re-read my thoughts and assumptions, and questioned myself thoroughly to prevent from drawing premature conclusions, or taking the meaning of a statement for granted. I became concerned after a while that the participants might not respond well to the interview questions, due to my being an outsider of their community, and having a highly specific research interest in SRH issues in the female Somali adolescent demographic. I tried to develop an interview guide with simple language and non-personal questions, with follow-up questions written and practiced beforehand, so that I could remember them whenever necessary.

However, being female, unmarried, Muslim, a foreigner to Norway, and a student, I do possess a similar background to the participants in several respects. Therefore, it was not a great challenge for me to understand the adolescents’ discomfort, or perceptions of cultural inappropriateness, regarding a Norwegian institution providing sex education in schools or free sexual and reproductive health facilities to young adults, although I did not encounter any such institution during my upbringing in Bangladesh. Being raised in an urban environment allowed me to be informed more easily about women’s basic health needs, and strive for more knowledge of them during my adolescence. As a result, it was easier for me to get a close insight into the cultural and traditional lifestyles of their parents, and note how they differed from a typical Norwegian lifestyle. Furthermore, I began this course of study before I was 20 years of age, studying a bachelor’s degree in medicine. The prioritizing of other issues, physical and mental changes, and natural curiosity of the adolescent participants, was thus not a big challenge for me to understand.

As suggested by Lincoln, Y. S., Lynham, S. A., & Guba, E. G., during the project, I tried to eliminate, or seriously limit, my personal proposition and perspectives regarding the research, by paying close attention to my own background and experiences, especially during the interpretation of statements made by participants (70). During in-depth interviews (IDIs), I tried to make reflections on how my positionality (any personal values, views, and aspects of one's location in time and space that may influence how they understand the world), could impact on data collection (75), and how interpersonal relationships in the research processes can affect findings. For example: some participants asked about my country of birth, religion, and reasons behind my interest about Somali female health, or how I felt about the services of Sex and Society during the formal interviews as well as about the importance of the services in my current state. Some found it more reliable for me to be studying women's health after being informed that I had previously worked as a doctor of gynecology for three and half years. In addition, they may also have found it more comfortable to talk to me, as I was not part of the local Somali community.

### **The rigor of the study**

The rigor (trustworthiness) of the study was ensured through credibility, transferability, dependability and conformability (63).

#### **Credibility**

The researcher needs to be close to the study participants to understand the subjects' propositions and perspective, in order to adapt, as previously referenced, multiple realities (71). This requires a considerable amount of time. I started my work in the field from the first week of February 2017, and ended in the last week of September 2017. This time period gave me adequate opportunity to understand Somali adolescents' outlook regarding the SRH services provided by Sex and Society. Moreover, spending this time thus occupied allowed me to build trust between myself and the participants, and ask for follow-up interview sessions. Furthermore, I was invited to several Somali events by the participants, which enabled me to deepen my understanding of their culture and attain an insider's perspective. The interviews were cross-checked by the participants. This made the study more credible, as it reduced the possibility of transcription errors or misinterpretations of meaning. During the data collection process, and once it was concluded, peer briefings were done. To further limit

potential errors and misinterpretation, discussions with experts on the Somali community were held at various stages of the study. Somali classmates, fellow researchers (some of whom were conducting their work in the Oslo area), or teachers based at my institute were also asked for their feedback and insights. Finally this project, was carefully re-evaluated and monitored, all the way from protocol development to the end of data analysis and discussion of the findings, by my supervisor. Especially during the data analysis period, discussions with my supervisor were effected to assess identified codes and analyse emerging themes. This essential step aided me in making the appropriate adjustments in the development of themes and categories. These conferred enough certainty to make the research credible, able to reproduce knowledge generation. In addition, an interview guide was developed that would be appropriate for the situation, and did not contain any questions which could potentially breach the privacy of the participants. Collected data was analyzed following specific themes and subthemes, as aforementioned, to obtain the most authentic interpretation possible. This measure is also contributory to a study's credibility (63).

### **Transferability**

Transferability, also referred to as external validity of the research, is the extent to which the findings from a research project could be applicable to other contexts (63). I aimed to establish transferability by sufficiently describing details of the fieldwork, thus enabling the methods used to be successfully implemented in another research environment. The concept of transferability denotes methods that can effectively be repeated by others in a similar context. The research methods have been explained step-by-step, with adequate information being provided about the practicalities of carrying out each step. The methods are thus rendered more dependable.

### **Conformability**

The concept of conformability in qualitative research relies on the neutrality of the data rather than the neutrality of the researcher (63). To ensure this concept, the neutrality of the data was taken as the main guiding force to conclude a finding. The researcher must be reflective to interpret the meaning of the data, rather than doing so in accordance with their own preferences. Being objective as much as possible maintained this conformability, alongside the advice of other researchers and my supervisor. Finally, data analysis and findings would be so demonstrated that the findings exhibited would be taken solely from the data. In order to

effectively fulfil these last criteria, reading and rereading by the principal investigator, and interpretation with the help of the supervisor, were conducted.

### **Dependability**

Dependability denotes whether or not, if the work was repeated in the same context, with the same methods and with the same participants, similar results would be obtained. However, when using the qualitative method, such repetition is nearly impossible. The ability of the researcher to engage with the research environment was constantly changing, and adaptation towards the strategic response might be varied depending on the situation (63). Under the constant monitoring of my supervisor, established protocol was followed or smaller changes were made after discussion, and adequate decisions were made to keep the task sufficiently clear, which would allow other researchers to follow it, if they so desired.

## **Findings**

### **Demographics of the participants**

Fourteen out of forty-eight of the individuals approached responded to participant recruitment, the refusal rate was more than 70%. Four participants were recruited from the clinic during primary recruitment, and ten in secondary recruitment via snow-balling. Eight of them had completed higher secondary schooling (*Videregående*) in Oslo of which three of them had completed varying amounts of schooling in other countries (for example, 3 years in Sweden and England, and 1 year in United States of America). One participants had three years of schooling in Tromsø; two were in higher secondary school in Oslo, and one participant had completed secondary schooling (*ungdomskole*), also in Oslo. Two participants did not want to disclose their schooling details. The average length of their time spent living in Norway, in years, was above sixteen years (ranging between 8-20 years). All of them expressed a desire to get higher education in Oslo, and to seek employment in future. The participants had previously lived in such countries as Somalia, the USA, England, Sweden, Finland and Portugal, though they were all currently permanently resident in Norway at the time of the study. All the participants were Muslim. Three were born in Somalia, one in Sweden, and one in England. One participant's place of birth was not disclosed, while the

remaining eight were born in Norway. The table below contains the demographic information of the participants found out through the interviews (Table 5):

*Table 5: Demographics of the participants.*

<b>Number of participant: 14, refusal rate: 70.8%</b>				
<b>Average age of the participants</b>	<b>Average length of residency in Norway, in years</b>	<b>Average length of time spent in schooling in Norway, in years, (n=12)</b>	<b>Marital/relationship status</b>	<b>Employment status</b>
18.6 years (16.5-20years)	16.2 years (8-20)	10.7 years (10-13 years)	In a relationship: 2 Single: 12	<b>At the time of interview:</b> Part time: 6 Full time: 2 Unemployed: 2, Unknown: 4 <b>During school years:</b> Part time: 3 Full time: 1

**Findings through thematic analysis**

Taking into consideration the thematic analysis, four main themes were identified, along with sub-themes. Participants’ attitudes and perceptions regarding the services of the Sex and Society Clinic and their recommendations for the improvement of services for adolescents, emerged throughout analysis of these themes.

Table 6: The themes and findings from the in depth interviews (IDIs) with the participants

Main themes	Sub-themes	Information	Findings	
The clinic could best serve sexually active individuals	<ol style="list-style-type: none"> <li>1. Provided sexual and reproductive health information in the school</li> <li>2. Protection and prevention for sexually active persons</li> <li>3. Practical services for sexually active individuals</li> <li>4. Lower sexual and reproductive health needs</li> </ol>	<ol style="list-style-type: none"> <li>a) Participants had high knowledge of SRH services and contraceptive methods</li> <li>b) Recognised importance of contraception for sexually active persons</li> <li>c) The clinic could be a more reliable, professional information source to reduce unwanted events resulting from sexual acts</li> <li>d) Disavowal of taboo regarding contraception</li> <li>e) Least level of SRH needs, due to abstinence</li> </ol>	<p><b>Practices</b></p> <p>Abstinence, no contraception use, not taking any services of the clinic, asking help from friends and limited communication about sexual issues with family members and relatives.</p>	
'I may need them after marriage'	<ol style="list-style-type: none"> <li>1. SRH services only as after-marriage commodities</li> <li>2. SRH services perceived as being intended for future use</li> </ol>	<ol style="list-style-type: none"> <li>a) Contraception regarded as being for married individuals</li> <li>b) Clinic's services considered irrelevant at the current time</li> <li>c) Importance placed on knowledge relating to sex education, although it would only be of use after marriage</li> <li>d) Participants did not think about contraception since they did not require it</li> </ol>	<p>Knowledge about the SRH services</p> <p>Attitudes towards and perceptions about the clinic and its services</p>	
Sensitivity regarding SRH services	Participants' discomfort relating to sex education classes	<ol style="list-style-type: none"> <li>a) Sex education delivery methods considered inappropriate</li> <li>b) Expressions of awkwardness surrounding sex education</li> <li>c) SRH is a private topic</li> </ol>		
Valued resources	<ol style="list-style-type: none"> <li>1. Friends for seeking SRH information</li> <li>2. Preference for online sources</li> <li>3. Preference of conventional help provider</li> </ol>	<ol style="list-style-type: none"> <li>a) Confidentiality regarding SRH needs</li> <li>b) High value placed upon anonymity when seeking SRH information or aid</li> <li>c) Clinic too unconventional, so more mainstream providers preferred</li> </ol>		



## **The clinic could best serve sexually active individuals**

### **Provided sexual and reproductive health information in the school**

The majority of the participants possessed a higher level of knowledge regarding the sex education services of the clinic. They were enthusiastic that the information would be beneficial in the future with regard to sexual consent and the prevention of disease. Rushana thought this knowledge would give the opportunity to avoid unwanted situations related to sexual activity:

*“It’s [sex education] important as you have seen a lot of TV shows with teen pregnancy, I think it’s important to get to know about it and not to have the consequences [of having sex], and if you get the knowledge then it helps to not to get them [unwanted events] or the diseases [STIs], or like a teenager actually gets pregnant, what to do then, it’s very difficult if there is not enough information and stuff, like where to go and what to do next.”*

According to Lina, sex education is the most important service of the clinic as it gives a person knowledge about preventive measures and STIs while they are in an intimate physical relationship. As she said:

*“First [important service of the clinic] sex education about the prevention methods, what is available out there, what are the side effects, info of them [contraception]. About pregnancy, how do they [individuals] get pregnant, what to do not to get pregnant and finally if somebody is pregnant what to do, how to get an abortion and what is next. Knowing about the diseases, how actually people get this [STIs], like chlamydia or HIV or hepatitis.”*

Lina also added that sex education could help people to be responsible and to prevent the spread of disease, as well as unintended pregnancy resulting from unprotected sexual activity. She spoke about the services offered by the clinic:

*“We need to know information about health, mainly prevention from the diseases, prevention of pregnancy, diseases, prevention of spreading.”*

The participants mentioned that the clinic could also be a more reliable source for professional information, as opposed to potentially random information from other channels. Habiba, although she had never taken one of the counselling sessions, expressed her opinion about the information services of the clinic:

*“Well having proper knowledge is always important. I mean there are so many information around which one to rely on is difficult, if there is someone responsible to give proper information then it’s good. And free counseling helps to understand more.”*

In general, the majority of the participant thought that the services of the clinic could best serve those who were sexually active.

### **Protection and prevention for sexually active persons**

The majority of the participants knew about contraceptives and their usefulness for a sexually active person. At that point, none of the participants used contraceptives. Nonetheless, they possessed a high level of knowledge regarding contraceptives, especially condoms and oral contraceptive pills (OCP). The majority of the participants knew that contraceptives could prevent unwanted pregnancy and STIs/STDs. Moreover, Sara, a 19-year-old participant, expressed concern over the advent of unexpected events in a person’s life due to sexual activity, which could be prevented via use of contraception:

*“As I said you do not want any surprises! You do not want any unnecessary event in your life. You desire to have control of your life as much as possible. And not end up with something you don’t expect like children or so.”*

Participants were aware about the clinic’s contraceptive services for preventing an individual from contracting STIs. They also displayed higher knowledge about the transmission of STIs. In this way, according to the participants, the use of contraception is a responsible choice on the part of young people. Lina thus commented on the useful effects of contraception:

*“It [to use contraception] is very important as they [who are sexually active] get the option to prevent pregnancy and to prevent diseases, it affects the community, they*

[individuals who have STIs] *spread the diseases to others and next generation can get the diseases.*”... *“Diseases remains in the body for ages and so damaging for the future. It [STIs] is on your health and also can go to others and to the baby.”*

For young adults who are sexually active, the use of contraceptives could provide the opportunity and time to effectively prioritize life events so that they could look forward with a degree of certainty. In Sara’s words:

*“It’s [use of contraception] very important, you have to be cautious and if you know your actions [engagement in sex], and it can provide safety. If you are sexually active and you do not planning to have kids you need to take the appropriate measures. Not to become pregnant it’s [contraceptive] a must have thing.”*

In addition, participants disavowed any controversy relating to contraceptive use. Lilian was open to acquiring more knowledge of what she considered positive aspects of medical innovation as regards reproductive and sexual health, such as contraception. She mentioned that the thought that there is a taboo related to contraception is a misconception. Furthermore, Lilian stated that such a taboo has no contribution from Islam. She explained her perspective, and her family’s perspective, on contraception:

*“like about many minorities in Oslo, people think that they [contraceptives] are forbidden but no, there is nowhere in Islam that it is said that contraception is forbidden. It is not. And it is not an issue or taboo. It has nothing against our religion.”*

The majority of the participants exhibited a high level of knowledge regarding the contraceptives, the provision of and education about which is a prominent service of the Sex and Society clinic.

### **Practical services for sexually active individuals**

Participants' knowledge regarding the emergency services offered by Sex and Society was evident. Lilian held a high degree of knowledge regarding the importance of the drop-in sessions provided by the clinic; however, she stated that their emergency services were not of use to her or her friends:

*“I would say—if you have like unprotected sex then as soon as possible. Which is certainly not in my case. Usually getting a doctor takes a lot of time so they have a long line... In that clinic you can get them right away. I mean if I have to wait for one week to get a doctor may be some unfortunate things can happen in the meanwhile. In unprotected sex it is a definite choice to go. You need definite care so, that clinic can serve on time.”*

Participants commented that the clinic's services would be helpful for sexually active persons in emergency cases. Furthermore, they could be of benefit if an individual was confused or doubtful about the state of their health, or any conditions they had or believed themselves to have as a result of sexual contact. In that case, drop-in hours and free counseling sessions could prove especially effective in aiding them and relieving their anxieties.

As Noora thought, the free testing for STIs could remove uncertainty about the health state of an individual:

*“I think free testing is a good thing. It gives the opportunity to be sure if you get any diseases or not.”*

Their knowledge about the clinic's other free services, which include the provision of free condoms and STI testing for sexually active individuals, were also found in conversation with the participants. Like Noora, Sabin thought that immediate assistance from the clinic could remove uncertainty for an individual who is sexually active:

*“It's good for young people to come and check so they know whether they have diseases or they are pregnant.” ..... “It is important because, people, they are wondering if they are pregnant or they have diseases, when they come here, they get an answer [by the services of the clinic].”*

Habiba displayed knowledge of the benefits of the STI testing services of the clinic, since it was a practical solution to prevent such diseases:

*“They [adolescents who might test positive for STIs] can get treatment if they need from the clinic also. If there is a chance to get them [STIs] it’s best to be sure. To be responsible and not to spread to others [through sexual contact].”*

Considering the above comments, the majority of the participants could be said to have held a high level of knowledge about the SRH services of the clinic regarding the prevention of STIs among sexually active individuals.

### **Lower sexual and reproductive health needs**

On the other hand, the majority of the participants had low SRH needs. Their sexual and reproductive health needs amounted to only sex education in general, due to absence of sexual activity on their part. Their primary SRH need was gaining knowledge about their health for the future. Halima believed she did not need to talk with anybody about her health, or the services of Sex and Society:

*“I have no special health need, seriously. I never felt any need of that sort [relating to SRH].”*

For Jebin, her SRH needs constituted attaining information about the menstrual cycle (MC):

*“I want to know what to do if I get pain in periods [menstrual cycle], that’s all. I don’t have much need at the moment.”*

Participants understood the importance of being knowledgeable about their health. However, they did not need the SRH services of the clinic at the moment as they were not sexually active. As Lilian, a 20-year-old participant, said:

*“I am not sexually active, so I don’t have any SRH needs.”*

The majority of the participants had very low SRH needs, although they had gained a high level of knowledge regarding SRH services such as sex education, counselling, contraception, and STIs testing of Sex and Society clinic. They thought these could be useful to prevent unfortunate health events consequential to sexual activity. At present, they did not need anything other than some basic information regarding MC.

### **“I may need them after marriage.”**

#### **SRH services only as after-marriage commodities**

The majority of participants rationalized the use of contraception with sexual activity. They associated their personal need of contraception with marriage. Turin thought that if someone was married, then the contraceptive services could be of use to him or her:

*“If they [any adolescent] are married then they can go together [couples] and ask for the services [contraception and counselling at Sex and Society].”*

In a conversation about contraceptive use, Maria, aged 18, related the action to a certain relationship status:

*“It is [contraceptive] important if someone has a boyfriend and married.”*

Noora was explicit about the use of contraceptives, also citing marriage or a similar intimate relationship as being appropriate contexts for contraceptive use:

*“After marriage they can use pills or condom whatever they like.”... “If you are in a relationship then it [contraceptive] is important.”*

Shabnam was clear about her need of contraception after marriage:

*“I want it [contraceptive or family planning] after marriage.”*

From Amal’s perspective, contraceptives would be useful for the prevention of pregnancy and STDs, but not for those who were currently unmarried and not sexually active:

*“Contraceptives can be helpful for the future prevention.”... “They [contraceptives] are necessary after marriage.”*

The services of Sex and Society were determined by the participants as being useful for those who are married or in a relationship. However, they did not need them because they were not married and therefore sexually active. Therefore, the participants’ needs at present did not match the services that were offered by the clinic, and thus the services were perceived as being irrelevant to them; but they did consider such services, especially those relating to contraception, as a key need in the future.

In this regard, Lina said that she did not need any other services of the clinic, as she was not currently sexually active. This notion was seconded by Jebin, who confirmed that she did not need to know about the services of the clinic currently, as she was not married:

*“I don’t want to know that [SRH services] now, I shall pay attention after my marriage. Not very necessary for me.”*

Halima, also, would look for those services after her marriage; in line, as she claimed, with other Somali females:

*“For Somali girls it is [the clinic] not a very important service actually.”... “Like me I may need them [services of the clinic] after marriage.”*

Another participant, Lilian, stated that she and her friends did not need the contraceptive services at all at present, as they were unmarried and had strong belief in their Muslim faith:

*“I am quite in doubt about that how it [contraceptive services] can be necessary for me and my friends. I am quite religious and my friends too, so it [contraceptive services] has no special need for them”*

Prior to marriage and ensuing sexual activity, the SRH services offered by the clinic were deemed to be largely irrelevant by the participants, since they perceived the services were primarily associated with sexual activity, and its practicalities and possible consequences.

### **SRH services perceived as being intended for future use**

The importance of sex education in the lives of the participants was perceived as being for the future, when they would likely be married and engaging in sexual activity. According to Habiba, aged 20, her health needs differ to those of males. Knowledge about her body would help her to make necessary decisions in future. She expressed why sex education is of particular importance in this regard:

*“I would say information about my health. My body is different than a boy, so information [about general health] is important for me”... “Sex education can give me a clear idea about my body, also important for future. If I decide to be sexually active then I definitely want to know what to do when and which one [contraceptive] is good for me.”*

Another participant, Amal, aged 18, emphasized the importance of knowledge about sex, especially with regards to consent prior to sex in future:

*“It [sex education] can let a girl know what does she want. And the consent she is going to give to other sex in the future. It also let me know about all those diseases that can be transferred from person to person. Also all those diseases which I did not know.”*

Nearly half of the participants expressed that they did not think about contraception, its use, or where and how to acquire it. They did not consider it to be of particular use in their lives at the moment. Jebin, aged 20, reported:

*“I did not think about it [contraception]. I don’t need them [contraceptives] at all.”... “I never needed to think about contraceptives.”*



Kareena, aged 18, seconded this opinion:

*“I never need them [contraceptives] in my life.”*

Rushana considered contraceptive services (such as information and counseling) to be of importance, although having more relevance to her life in the future:

*“Like it [sex education] helps for me to be informed about it [contraception], like what to know more about, in future.”*

Kareena believed these professional services, such as counseling, would be helpful once she was married and considering having children:

*“My boyfriend and I was talking some idea.” ... “if we get married how it will be and the children, how old I will be, this kind of stuff.”*

Participants’ attitudes towards contraception dictated their SRH needs. They wanted to know more about contraceptives and birth control primarily for future use, considering them appropriate only for the situation where they would be married and sexually active.

## **Sensitivity regarding SRH services**

### **Participants’ discomfort relating to sex education classes**

The participants expressed a further negative opinion about the services of the clinic due to the manner of the delivery of private health information in school, which was considered too open and was therefore highly uncomfortable for them.

Most of the participants considered the delivery of information in sex education classes conducted by the clinic to be inappropriate, since it contained a range of sexually explicit material. According to Rushana:

*“We also watched some videos, there was a presentation, that was, that, it was so awkward” ... “I think was, the total thing was awkward, we were in the back of the class, sitting down in the back to get it over with it and laughing the whole time,*

*some of my classmates made some jokes”... “It was [the lecture in the school] so embarrassing and not cool to see.”*

Participants did not wish to be present in sex education lessons. Therefore, lengthy lessons about this sensitive subject, were particularly awkward for them. Halima forgot most of the information about the services of the clinic, as they were discussed in class; a situation in which she did not feel particularly at ease. Shabnam shared similar sentiments:

*“I don’t remember. I was not quite sure that I should be in the class or not.”*

Kareena thought that such classes should be optional for students if they felt it to be unnecessary at that time. This was corroborated by Rushana:

*“But it [sex education] can be optional [elective course in school]”... “Who do not wish to be in the class, they can leave the class.”*

Participants of this study expressed the opinion that sex education did not have particular relevance to their lives at present, although it would be of use when thinking about having sex in future. As Halima commented:

*“This service [sex education] need basically when they are grown-ups [sexually active adults].”*

For the participants, sexual health was a private topic, and they did not wish to discuss it, or see it being discussed, as it would not be relevant for them at that time. Therefore, the delivery of sex education lesson by the Sex and Society clinic at designated times in the school environment was regarded by the most of the participants as an unnecessary attempt of learning about SRH.

## Valued resources

### Friends for seeking SRH information:

Whenever the participants were asked about the source of their awareness about the clinic, knowledge of the services of the clinic, or people they would like to talk about their SRH needs, they cited friends as a dependable and comfortable choice. As Lina said:

*“I shall talk to my friends like all young people.”... “Friends are more comfortable to talk with. I prefer to talk to them [friends].”... “So I just ask them and talk to them. I get all the information about my basic health needs [from my friends].”*

Sabin also preferred to ask for help from her friends:

*“They [friends] will tell me, you can go here or you can go there and do that. So it’s good to have friends who can tell, and guide, and you can talk freely with them.”*

Shabnam’s comments solidified this as the norm:

*“Who I want to talk to, well friends like close close friends, no parents no nurse nothing.”*

All of the participants expressed their deep satisfaction over getting help from friends besides internet resources. Shabnam looked for information about MC from a friend, then searched online for further information which was her only SRH needs at that moment:

*“When I get period [menstrual cycle, MC], I asked a friend. We went online.”*

Halima thought that the clinic was satisfactory, mentioning her friend’s opinion:

*“My friend was satisfied so they [the clinic] are doing good I think.”*

Friends were regarded as the first choice for the participants, if they wished to look for help in terms of SRH. In this manner, the participants expressed their opinion of the irrelevance of the services provided by Sex and Society.

### **Preference for online sources**

In conversation with the participants, the importance they placed upon the availability of online services was remarkable. They expressed their dependency on internet resources to get information regarding their health. Lina searched for answers online to fulfil her curiosity:

*“I get everything [information about SRH] from internet actually, there is something, lommelegen [website for health information]. They have Q&A [question and answer option]. Anything can ask and you get answers.”*

Although the clinic already has a substantial online presence, the majority of participants had never visited their webpage or utilized their online services. Sara recommended the clinic be more present online for adolescents in general, saying that she had never before encountered the website of Sex and Society:

*“I never came across of anything of that sort [the website or YouTube channel of Sex and Society]”... “I think they [the clinic] can be more available online and stuff.”... “Teenagers are online so things are easy to reach there.”*

One participant, Maria, mentioned that she was quite satisfied by the information provided by another Norwegian website for adolescents, which provides all kinds of information ranging from health to diet and aesthetics:

*“I never look out for their [Sex and Society’s website] page.”... “I don’t know what they have. Once we were asking some information from ung.no [Norwegian government website for youth]”... “They [ung.no] have everything, what to eat or how to be confident in any clothes.”*

They preferred anonymous online services when seeking information about contraception, sexuality, and reproduction. For example, according to Sabin, an online student radio could be helpful, if used for live question and answer sessions:

*“Maybe they [the clinic] can have student radio services in the school.”... “Maybe they [the clinic] can have live question answer session once in a week or so, so that can help.”*

Jebin valued this resource for herself, as internet sites could provide confidential services to get answers for her private health needs. She claimed that her knowledge was derived from online resources, along school and friends, regarding health:

*“Online services are good options for getting answers. It’s anonymous, right. That’s all I need.”... “About diseases or any personal question, I check online, It’s good”... “Well I have learn everything from internet and from schools and TV shows.”*

The privacy and anonymity of SRH services were the main concern of the participants. When Habiba explained how to improve the contraceptive services, she specifically mentioned anonymity as a key criterion:

*“I suppose online services can be easy. They [sexually active individuals] can ask it online. Whatever method they need, if they can get it [contraceptives] anonymously online, that will help.”*

The sensitivity of the SRH issues were acknowledged, whereas the participants’ first introduction of the clinic was an open platform such as school lessons. They were cited as being easy to access, as well as being anonymous, which was an important concern for the participants.

### **Preference of conventional help provider**

The majority of the participants mentioned that the younger generation could go to a school nurse or general physician for their health needs which is not exclusive for sexual health only. Maria emphasized that she did not need SRH services during school. However, other individuals who were having sexual contact could get help from a nurse, general physician, or a local pharmaceutical store, unless it was an extreme situation such as requiring an abortion.

Maria found the clinic's services important for emergencies, although she thought that young people would rather go for other options than the clinic:

*“These services [of the clinic] are nice, like not everybody need to come here [the clinic]. If someone needs help they can go to helsestasjon [municipal clinic], in school [school nurse], or fastlege [personal doctor].”... “They can go to store [Apotek- pharmacy] for getting the products [contraceptives].”... “Ok, it [the services of the clinic] can be helpful for emergency situation [after having unprotected sex].”*

Another participant, Sara, stated that she would prefer to go to her school health nurse or her doctor for her health needs, if she required any information, especially regarding the MC:

*“So it is as I said before, would be school helsesøster [school health nurse] or my doctor.”*

The value placed by the participants on sources other than the clinic for their SRH needs was evident. The clinic's exclusivity regarding services related to sexual activity, which was absent in their life, was not desired during the current life period.

Following is the figure summarizing the findings in correspondence with the HBM:

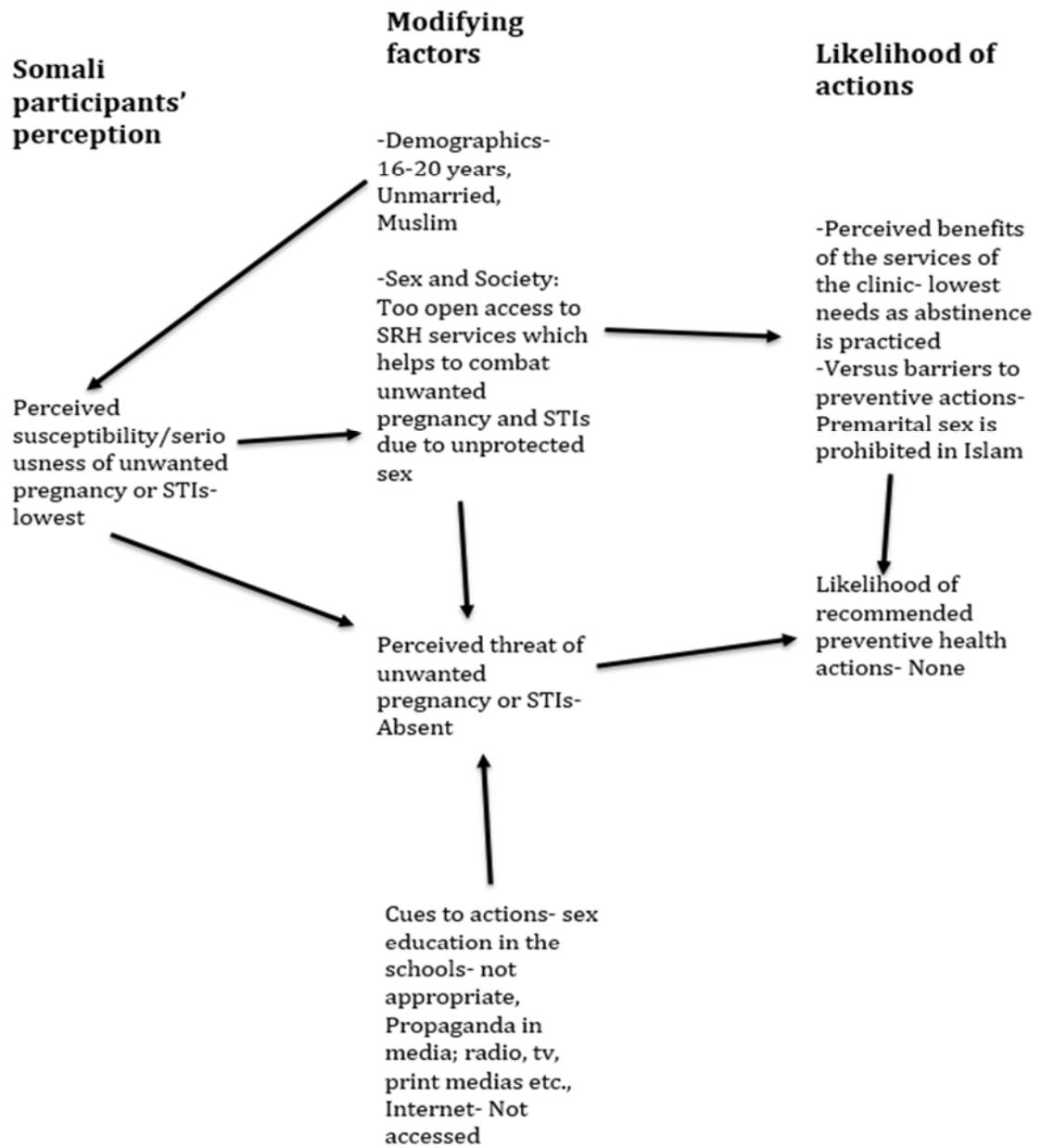


Figure 8: Findings of the research corresponding to the Health Belief Model (HBM)

In conclusion, although the participants had higher knowledge regarding SRH, the delivery of information by the clinic was perceived as not necessary. The clinic's services had no relevance for those participants, as they were not sexually active. The fact that the clinic's representation platforms did not apparently consider the sensitivity of SRH issues, as befitted the Somali females' perspectives, was considered in a negative light. It should be mentioned

that the high refusal rate of 70 per cent as indicated in the demographics table, also indicates that the individuals in this cultural demographic found that the talk about the clinic's services was unnecessary, and that they thought it inappropriate to talk about SRH with a stranger such as myself. All services of the clinic were irrelevant for them as they were related to sexual activity, while the participants were not engaging in sex (60).

## **Discussion:**

The objective of this study was to explore the knowledge, attitudes and perceptions of the female Somali participants towards the services of the Sex and Society clinic. This was achieved via thematic analysis of four main themes, as stated above.

The findings revealed a connection between the aforementioned views of the participants, and their understanding of the services in the context of their unmarried state and cultural prohibition of premarital sex. Furthermore, recommendations about how the services should be delivered to Muslim female adolescents were made in accordance with such views.

Evidence was also found of participants holding negative towards the Sex and Society clinic and its services.

## **Cultural contradictories regarding SRH of the Sex and Society:**

Participants' understanding of sexual and reproductive health was closely connected with their cultural background. Their knowledge, as well as their attitudes towards the subject, were intricately linked to familial values and cultural norms surrounding it (76). The perspectives and views on adolescents' sexual health present in the host society, including healthcare and education systems, present a challenge as they cultivate a lack of interest in the offerings of the clinic on the part of the participants. This is due to its contrasting with their personal views and beliefs, and could be significantly affected by the established image of Sex and Society, which is connected to the apparent promotion of sex and mitigating the possible consequences of unprotected sexual acts. Ultimately, this creates a negative attitude, and a barrier to use of the clinic's services. The participants' cultural and religious background also played a significant role, constituting a barrier for adolescents if they wished to acquire further knowledge about sexual health, even in school (77). Furthermore,



adolescents are vulnerable to having an especial lack of knowledge about reproductive and sexual health service due to age-influenced tendencies, as they are particularly affected and influenced by current social norms (78). Therefore, the participants might also not prioritize sex education in school or other SRH related services of the clinic, including contraception, if they perceive it as not being the right thing (i.e. considered acceptable by their family and community).

In a similar vein, Iusan, R. stated that immigrants in different parts of the world behave differently in terms of sexual health needs and SRH (53) (42). The absence of discussion about sexual issues before marriage can be attributed in many cases to a cultural barrier that exists due to the sensitivity of the subject, and perceived inappropriateness of premarital curiosity about sex (41). This supports a finding among the participants of this study, where they did not talk about SRH needs or the services of Sex and Society, in order to avoid associating themselves with culturally-prohibited activity (52). The sex education service provided by the clinic was similarly affected (41, 46).

### **Marriage and perceived need of SRH services among participants:**

Religions prescribe certain sexual and reproductive behaviors for their followers (76, 79). In the case of Islam, this is particularly focused on sexual abstinence until marriage. Previous researchers have stated that the desired self-image of Muslim Somali women is, to a significant extent, embodied in their religious identity (80, 81). Therefore, in order to preserve this identity, they adhere to the standard of remaining a virgin until marriage (44, 82).

Participants in this study therefore believed they did not need the services of the clinic such as information about the SRH services, sexual counseling or contraceptive counselling (32, 41, 42, 83).

Another study of Muslim female adolescents found that these individuals also tend to practice sexual norms that are conveyed and approved by their parents, culture, and religion (32).

Consequently, adherence to these norms can constitute a way in which they maintain acceptance by their community on a personal and social level, and avoid being the target of public shame or slander (15). Since there is such controversy surrounding the willingness to discuss sexuality and displaying openly enthusiastic attitudes towards it, as well as seeking out information with regards to SRH and related topics prior to marriage, a substantial barrier is erected between young people in this demographic and the utilization of the services of the

clinic (41). This is indicated on a wider scale, with other studies obtaining similar results with the conclusion that contraceptive and SRH services are not frequently or largely sought out by females from a Muslim background (14, 41).

A study conducted among Muslim youth revealed a prevailing opinion that pre-marital sexual contact, as well as abortion, are considered to be sinful (42). Therefore, unmarried Muslim individuals perceived services related to these actions as completely unnecessary prior to their being married. This view leads to the development of a certain attitude towards sexual activity, and its expression as promoted by the clinic, as it is thought of as being particularly questionable in its appropriateness, and the timing of its provision.

By avoiding the clinic or related topics (not checking the websites, avoiding expressions of interest about their services, and therefore not permitting themselves to become well-acquainted with or knowledgeable about the clinic), the participants sought to circumvent any potential doubt as to their desire to remain abstinent. While the name of the clinic itself (making an explicit reference to 'sex') was already controversial, considering the modest lifestyle these adolescents were accustomed to practicing, its open approach to the provision of SRH services presented an additional barrier to their willingness to seek help from it. The Sex and Society clinic, therefore, eventually works as a barrier in and to itself. This may be heightened through the Somali participants' experience of the clinic's school visits, which has given them the impression that it encourages adolescents to engage in sexual contact via providing what they perceive as too much information on the subject, too early. In addition, this provision of information, which may naturally direct an individual's thoughts towards sexual matters, is viewed as encouraging physical and mental behaviors that are forbidden in Islam (83).

Teenagers' and women's knowledge of contraception can be limited for multiple reasons. For instance, values associated with their cultural background that dictate permissible relations to contraception may advocate the view that its use, or even seeking information about its use and purposes, should not be pursued until an individual reaches a certain status that makes such actions acceptable. In such cases, culturally-acceptable contraceptive use is often confined to sexual activity between members of a married couple. This notion is supported by studies conducted amongst Somali communities in Finland, which state that attitudes towards contraception are highly influenced by traditional views. (50, 84). It should also be noted that

contraceptive use among Muslim women globally is significantly influenced by religious and cultural factors (85). Such cultural and religious influence may be observed amongst the participants of current study, who labelled the use of and the importance of the clinic's services, especially the provision and prescription of contraceptives, as being useful only once they were married.

Furthermore, sex education (41, 46), sexual and reproductive health needs (42) and contraception (59, 86) are the subject of prejudices in many societies worldwide, including those that are predominantly Muslim. This can lead to the opening of significant knowledge gaps, due to individuals' interest in such topics not being fostered, and these topics being the subject of negative culturally-influenced attitudes. As Ussher, J.M. et al discussed, these factors can result in the establishment of intense prejudice, which acts as a barrier against obtaining true knowledge of SRH and related subjects (82). Indications of this were found in the current study, with participants mentioning feeling awkward about SRH services, especially the sex education classes that were provided by the clinic. Apparently, it was difficult for the participants to remember the activities of the clinic regarding young people's reproductive and sexual health in school; however, they developed their knowledge from friends at a later stage. This perceived irrelevance of the services, as well as the views thus displayed, may also be attributed in part to the fact that this type of aid, specifically tailored to suit the youth demographic, is non-existent in Somalia (54).

Participants expressing the opinion in this study that increasing knowledge could dismantle taboo surrounding contraception is noteworthy. It is indeed evidenced in previous studies that contraception or family planning is not sinful according to Islam (87), and this was also reported by participants in the current study. Additionally, it has been stated that Qura'nic suggestions could encourage Muslim students to talk about SRH, and thus facilitate the gaining of knowledge and reduce misinterpretation of Islamic views. As a result, controversy around such topics could be lessened (88) (89).

### **Lowest level of SRH needs and desire for conventional SRH facilities**

Unmarried Muslim adolescent females believed their SRH needs to be of lower importance prior to marriage, due to their low level of perceived threat of, for example, contracting STIs or having an unintended pregnancy. Furthermore, there was a very low to negligible level of

perceived susceptibility among the participants in relation to the above health risks. Since they were willing to practice sexual abstinence until they were married, they believed that there was no realistic prospect of these conditions affecting them. Therefore, the likelihood of their seeking out the provision of preventative services from the clinic at this stage was extremely low.

It is possible that these perceptions result from the influence of relevant cultural attitudes on the knowledge of the participants connected to these areas, which as aforementioned predominantly revolve around the discouragement of premarital sex and actively searching for information on SRH (85). Dune, T. and associates have suggested that the SRH help-seeking of immigrants with varied cultural background may be delayed, or considered by the individual to be of lesser importance or priority, due to their understanding of SRH, which once again could be shaped to a significant degree by attitudes prevailing in the culture to which they belong (90). The participants' SRH needs being dictated by their marital state appeared to evidence this.

In addition to cultural differences, the exclusivity of the clinic's services (in that they are marketed as being especially for young adults, and focused on providing information and help for matters linked to sexual activity) can prove problematic. Potentially, this is the result of apparent connections being drawn between sex and adolescents, which by extension may be perceived as promoting sex between any individuals regardless of their marital status (55). The female Somali adolescents are thus more likely to use the clinic in future, since they have previously formed the intention of being sexually active after marriage, and preventing unwanted events derived from sexual activity. These intentions appear to derive from negative attitudes relating to the perceived attachment of culturally and religiously-prohibited premarital sex to the established image of the clinic (91).

In consequence, there is a greater likelihood of female Somali adolescents visiting their designated general practitioner, or utilizing another resource such as a school nurse or municipal health station, to obtain any information they require about SRH.

## **Recommendations for the clinic**

The Somali participants' underutilization of the clinic's services can be attributed to a combination of their personal beliefs (influenced by their cultural background and religion),

and perceptions about diseases like STIs and the likelihood of their contracting them. Suggestions for the clinic were made in accordance the participants' perceived barriers: for example, cultural and social barriers. Therefore, the clinic requires redesigned and culturally-appropriate strategies that will increase outreach to members of this demographic, and consequently their further participation in, and use of, their services (60). Following are some examples that could improve the services for adolescents of Somali ethnicity:

- The clinic could initiate common chat rooms designed for adolescents, as the findings suggest that participants preferred anonymous internet services for generating knowledge and fulfilling health needs, where only approved members can post private messages. Through such an anonymous online service, participants could look for information while maintaining the desired privacy and confidentiality. A chat room in which young people can participate and talk anonymously would be an effective platform for them to gain SRHR knowledge.
- The clinic could make a forum, staffed by girls of a similar age with various ethnic backgrounds, who are trained to talk with their peers about sexuality and healthcare. The forum could also involve girls via social media, such as Facebook and Instagram, and school activities centered on events like International Women's Day or Mother's Day. Peer group attachment, in relation to delivering information about the clinic's services and increasing SRHR knowledge, could eventually help to reduce the prominent stigma surrounding sexuality. Furthermore, it would provide more privacy, and increase trust and comfortability.
- An online radio service could be offered, which would run anonymous question-and-answer sessions on SRHR and related topics for young people. With the added security of voice encryption, it would constitute a private and confidential way for individuals like these Somali girls, who place high value upon such concepts, to obtain information. The subsequent increase in knowledge may prove effective in combatting negative attitudes towards sexuality.
- Assessments of culturally diverse classrooms prior to the delivery of presentations on sex education would ensure that the clinic's approach is suitably tailored to produce as comfortable an environment as possible.

- Integrated health initiatives which involve general physicians, school nurses, psychologists, educational advisors, and volunteers from peer groups, may constitute a positive method of reducing young people's fear of social shame, and improving the overall outreach of the clinic's services. Their discomfort could be minimized by initiating such an integrated health service for youth, where they would be able to find SRH services easily in a less daunting environment.

## **Strengths of the study**

There are two key strengths of this study. Firstly, the study process has been explained clearly, so similar research can be done in future. An in-depth interview process was used to generate data, which makes it replicable for other researchers who wish to conduct studies on this sensitive issue. Secondly, the inherent challenges of participant recruitment have been explained fully, alongside the steps necessary to overcome them. Needless to say, there have been no prior studies done on female Somali adolescents living in Oslo in direct relation to this issue; thus, this research can provide some current insight, enabling repeated studies on the sexual and reproductive health needs of Somali women living in Norway, and the effective redesigning of the health delivery system; as being an additional strength of the study.

## **Limitation of the study**

The main limitations of the study fall into two categories. The first covers those that arose during the recruitment process; the second is the language barrier that existed between the participants and the interviewer. As Gabowduale, K. G. pointed out, "The Somali communities have been a subject of a negative media attention" (38). Therefore, my coming from an Asian country, conducting research on Somali girls' perceptions of, and attitudes toward, reproductive and sexual health services in Oslo, was a source of suspicion. Moreover, such suspicion towards the researcher, combined with the inherent sensitivity of the research topic, presented difficulties throughout the recruitment and data collection processes. Thus, the majority of the participants were found during secondary recruitment via snow-balling. As stated earlier, this technique could produce less variability of information.

However, there is a possible weakness, arising from risking recruitment internally from established social networks through use of the snow-ball technique. These networks can be biased due to speculation and assumption, and all members holding a similar mindset. Thus, snowballing can result in less variety, or a multitude of informants providing near-identical information, according to Atkinson, R., & Flint, J. (92). Although, in this case, as the participants were found during the second or third degree of recruitment and hardly discussed the issue with each other, room for bias was limited.

Interviews took place in English, as I can neither speak their mother tongue, nor am I competent enough in Norwegian to conduct lengthy interviews. This limitation was minimized by the second-generation Somali girls' competency in describing and clarifying utterances made in English, and taking linguistic and technical help from Norwegian friends and online resources to understand nuances. Again, cross-checking of interviews was done by participants, either immediately or during later correspondence. As a female Muslim student, I tried to understand and limit relevant cultural and traditional challenges during the research process. Moreover, expert help from a Somali researcher was also obtained to further minimize this limitation. Another limitation could be the use of in-depth interviews to collect data. The interaction between the interviewer (it was my very first experience as qualitative interviewer) and the participants could be especially impacted by this concept. During analysis, different studies conducted on the Somali communities that exist worldwide, especially the Somali population of Scandinavia, were taken in consideration to verify my personal understanding and interpretation.

Married Somali female adolescents were not sought out deliberately. Such participants could have given rich data on perceptions of the services of the clinic, especially those related to contraceptives. Although marital status was not asked for during interviews, it was provided freely by the majority of the participants, and proved a vital contributory factor for understanding the research topic.

## **Scope of further research**

Further research can be conducted to find out more information on the perceptions of contraceptive services among married Somali women; in such cases, the same research procedure can be repeated. This would provide an association between social taboos and contraceptive practice, and factors deterring contraceptive use among married Somali women.

The research, on the association between stigma and sexual and reproductive health services (for example, testing for STIs) among Somali adolescents, irrespective of gender, can also be done to further understand the effects of such stigma on a personal level.

To provide a culturally-sensitive sex education program for Somali adolescents, another study can be done involving both male and female adolescences of this age range. This would enable understanding of their expectations and recommendations for a sex education program, and the mode of its delivery. A comparative study could be done to measure the acceptance of sex education, mode of delivery, among adolescents of both Somali immigrants and other westerners.

Simplified online services and sex education program compliance constitute the topic of another potential study, and can be measured qualitatively or quantitatively.

## **Conclusions**

This study was intended to get an insight into female Somali adolescents' perspectives on the SRH services of the Sex and Society clinic. This knowledge could be used to redesign programs and services for a national population composed of various ethnicities, creating an inclusive and culturally sensitive healthcare delivery system. The influences of culture and tradition were omnipresent in the statements of all participants. The adolescent females constructed perceptions of the factors preventing them from making use of the clinic's services, and perceptions of their current and future SRH needs. Such perceptions were found to be mainly cultural. Significant barriers to using contraception and visiting Sex and Society included: their being considered inappropriate and irrelevant at the current time by those of a modest Somali background, execution and promotion of the services in a manner labelled as contravening Somali culture, and potentially promoting sexual activity which is absent in the unmarried female participant's lives. A confidential and culturally sensitive method of integrated healthcare delivery from the clinic, in collaboration with school health centers, is recommended, with effective use of online services and peer groups. Further accounts of sexual health within this particular population would be beneficial, in order to understand the unique sexual health challenges adolescent females of Somali background face.



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# Appendix

## Appendix (A) Interview guide

### **Interview Guide for research, Knowledge, attitudes toward and perceptions about the services of the Sex and Society clinic held among female Somali adolescents in Oslo.**

#### **Knowledge about the contraceptive services of the clinic:**

- a) Have you ever heard about the clinic? (If yes then from where and when?)
- b) Which services are most important?
- c) Why are they important? (Please rank in order of usefulness.)
- d) When is the best time for you to visit the clinic?

#### **Participants' own perception about the contraception and contraceptives:**

- a) Have you heard about family planning/ contraceptives?
- b) What does the word 'Contraception' or 'Contraceptives' mean to you?
- c) From where did you learn about contraceptives?
- d) How do you want to have access to the contraceptive?
- e) How important it is for adolescents (or your friends) to use and have access to contraceptives?

#### **Suggestions to improve the contraceptive services:**

- a) Which is most important method to prevent the STIs?
- b) Which is more important to you -prevention of conception or prevention of Sexually transmitted diseases?
- c) Which services need to be changed or improved? Why and how?
- d) What should the clinic do to make sure that all individuals have access to services who need them?

#### **Their peers and family members point of view about contraceptives:**

- a) Whom would you like to talk to about sexual and reproductive health needs?
- b) What do you think about what your sexual and reproductive health needs are?
- c) What do your family members/ friends/relatives/ classmates think about the clinic?
- d) What are their views on contraceptives?

## Appendix (B) Informed written consent

### **Informed written consent**

**As adopted from the Norwegian Research Ethics Committee's (REK) informed consent template.**

#### **Request for participation in the research project**

##### **Background and purpose:**

This is a request for you to participate in a research project that aspires to increase understanding of perception and understanding of adolescent health needs of the young adults of Somali origin living in Oslo.

Tamanna Afroz, a University of Oslo master's student, in association with Sex and Samfunn Clinic, is conducting this study. You have been selected as a participant based on your background origin, and as someone who expressed interest in participation. If you wish, final results of the study will be provided to you upon completion.

##### **What does the study entail?**

In this study, you will be invited to participate in one or more interviews conducted by the researcher. Interviews will last, in general, between 20 to 50 minutes. With your permission, the interviews will be audio recorded. The researcher will accommodate your availability and preferences with regard to the timing and location of the interviews.

##### **Potential advantages and disadvantages:**

Disadvantages- Sensitive and personal practices regarding sexual and reproductive health may be discussed and may cause some discomfort among the participants.

Advantages- You may find discussing your experiences may contribute to the better understanding of your needs as a young adult. The information you share may help improve the services that can be provided by the clinic.

##### **What will happen to the information about you?**

Your information will only be used in accordance with the purpose of the study as described above. All of the information will be processed without names or other directly recognizable information. A code number links you to your

information through a list of pseudonyms, and only the researcher will have access to the list of names and be able to identify you. The list of pseudonyms and code numbers, audio recordings, and other non-anonymous project information will be stored for five years and then deleted upon project completion. Your confidentiality will be respected throughout the research process and it will not be possible to identify you in the results of the study when they are published.

**Voluntary participation:**

Participation in this study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. This will not have any consequences. If you wish to participate, please sign the declaration of consent on the final page. If you agree to participate at this time, you may later withdraw your consent. If you later wish to withdraw your consent or have questions, at any point in time, concerning the study, you may contact the researcher. In addition, if you have further questions about the research, the researcher will be happy to discuss these with you prior to your decision about whether or not you would like to participate.

**Consent for participation in the study:**

I am willing to participate in the study.....

Proxy consent when this is warranted, either in addition to or in place of the participant's consent.....

I confirm that I have been given information about the study.....

Signature

Location/Date

**Research contact**

Tamanna Afroz

MPhil Student, University of Oslo.

Rolf E Stenersens Allé 22, H0209,

Sogn studentby, 0858 Oslo.

Mobile-(+47) 46576310, Email-[tamanna.afroz@studmed.uio.no](mailto:tamanna.afroz@studmed.uio.no)



## Appendix (C) The letter from NSD giving the permission to collect data for the research



Viva Combs Thorsen  
Institutt for helse og samfunn Universitetet i Oslo  
Postboks 1130 Blindern  
0318 OSLO

Vår dato: 05.12.2016

Vår ref: 50753 / 3 / AGH

Deres dato:

Deres ref:

### TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 25.10.2016. Meldingen gjelder prosjektet:

50753	<i>Knowledge, attitude and perceptions of health services among ethnic female Somali adolescents in Oslo, Norway</i>
Behandlingsansvarlig	Universitetet i Oslo, ved institusjonens øverste leder
Daglig ansvarlig	Viva Combs Thorsen
Student	Tamanna Afroz

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

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

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

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

Personvernombudet vil ved prosjektets avslutning, 21.05.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Agnete Hessevik

Kontaktperson: Agnete Hessevik tlf: 55 58 27 97

Dokumentet er elektronisk produsert og godkjent ved NSD's rutiner for elektronisk godkjenning.

## Appendix (D) Ethical clearance exemption letter from REK.



**Regional Committee for Medical  
& Health Research Ethics**

**South East Norway, Section A**

Postbox 1130 Blindern

NO-0318 Oslo

Norway

Phone: + 47 22 84 55 13

E-mail: [a.s.kavli@medisin.uio.no](mailto:a.s.kavli@medisin.uio.no)

Webportal: <http://helseforskning.etikkom.no>

Our ref.: 2016/1645a  
IRB ref: IRB00001871

Date: 24<sup>th</sup> October 2016

To whom it may concern,

### **Re: REC Letter of Exemption**

I am writing in reference to a request from Viva Combs Thorsen, regarding a Letter of Exemption in English.

#### Review

The Chairperson for the Regional Committee for Medical & Health Research Ethics, Section A, South East Norway, reviewed the Remit Assessment Form received on the 25<sup>th</sup> of September 2016 for the Research Project "Knowledge, attitude and perceptions of health services among ethnic female Somali adolescents in Oslo, Norway" (*Norwegian title: Kunnskap, holdninger og oppfatninger av helsetjenester blant etniske kvinnelige somaliske ungdommer i Oslo*). The Project Manager is Viva Combs Thorsen and the Institution Responsible for Research is The University of Oslo. The Review was carried out on behalf of the Committee on the 24<sup>th</sup> of October 2016.

The application was assessed in accordance with the Norwegian Research Ethics Act (2006) and Act on Medical and Health Research (2008).

#### The Decision

The Chairperson for the Regional Committee for Medical & Health Research Ethics, Section A, South East Norway, found the Research Project to be outside the remit of the Act on Medical and Health Research (2008) and therefore can be implemented without its approval.

#### Ethics Committee System

The Ethics Committee System in Norway consists of seven Independent Regional Committees with authority to either approve or disapprove Medical Research Studies conducted within Norway, or by Norwegian Institutions, in accordance with the Act on Medical and Health Research (2008).

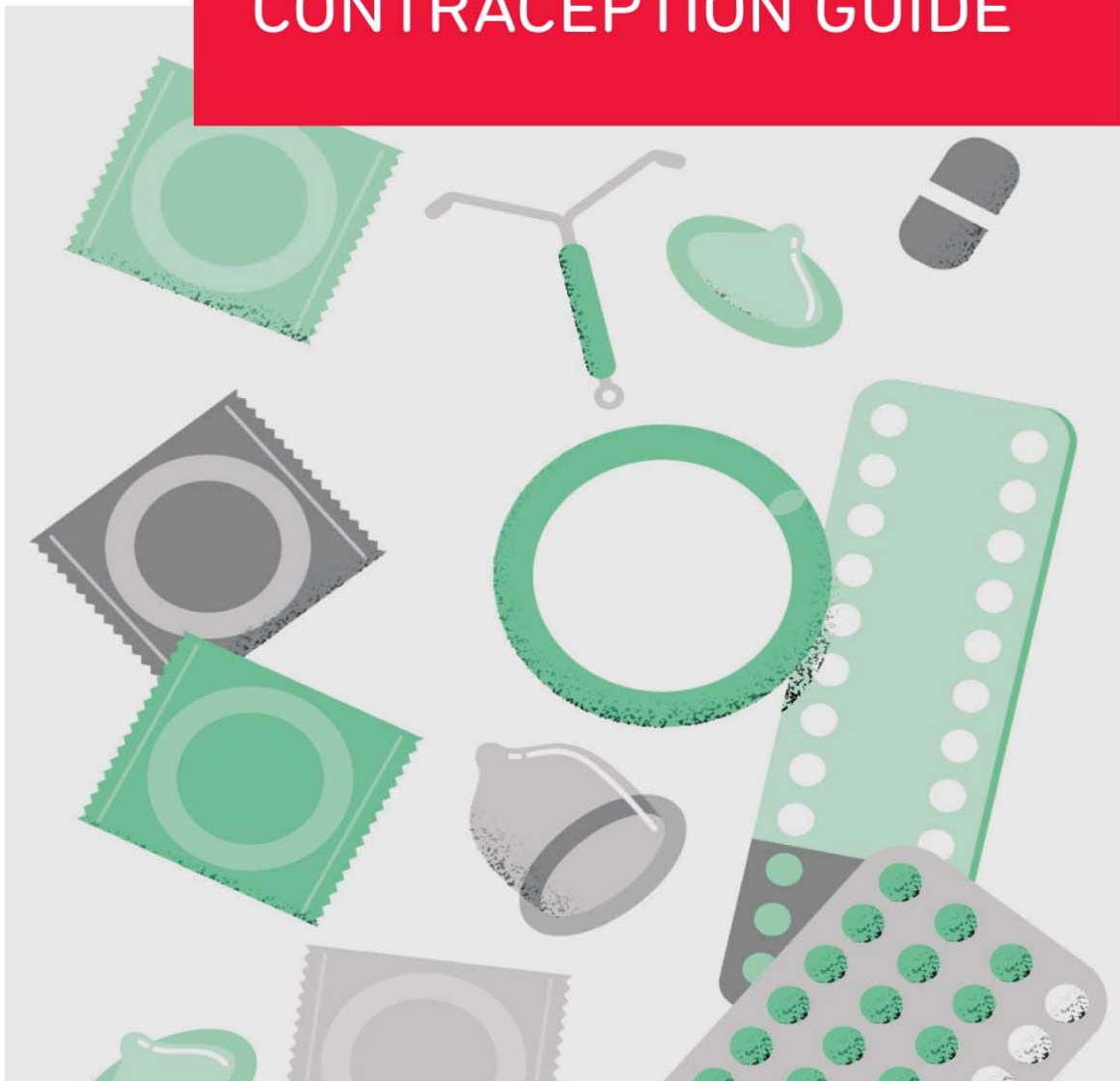
Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics Section South East A (REK Sør-Øst A) if further information is required, as we are happy to be of assistance.

## Appendix (E) Contraception guide of the Sex and Society in English

<http://www.sexogsamfunn.no/wp-content/uploads/2016/03/Prevensjonsguide-engelsk-versjon-Sex-og-samfunn-desember-2016.pdf> ---The downloaded version from the website:



# CONTRACEPTION GUIDE



# CONTRACEPTION GUIDE

## INTRODUCTION

Since there are many varieties of contraceptives, we've created this brochure to give you an overview of the different types. This will make it easier for you when making a choice about what contraception is best for you. It helps to know more about what they contain, how effective and expensive they are, and how long you have to take them for before you choose.

It is important to remember that only condoms protect against sexually transmitted infections. Even if you use another method of contraception, we recommend that you use a condom as well if you have sex with a new partner. You can order free condoms from [www.gratiskondomer.no](http://www.gratiskondomer.no).

If you have any questions, you can chat with us on our website [www.sexogsamfunn.no](http://www.sexogsamfunn.no).

All the information in this brochure has been quality-controlled by Sex og samfunn and University of Oslo employees.

Oslo, November 2016

## TYPES OF CONTRACEPTIVES

### NON-HORMONAL CONTRACEPTIVES

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### HORMONAL CONTRACEPTION WITH PROGESTERONE ONLY

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3 years	Birth control implants	Nexplanon	Page 14
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### HORMONAL CONTRACEPTION WITH OESTROGEN AND PROGESERONE

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# DIFFERENT TYPES OF CONTRACEPTIVES

## Benefits and disadvantages

There are benefits and disadvantages to all contraceptives. The advantage of hormonal contraceptives, of any kind, is that they often reduce bleeding and pain during menstruation. An important difference between the methods is how long they have to be taken for.

### **NON-HORMONAL CONTRACEPTIVES**

Non-hormonal contraception does not affect ovulation, so it does not alter your regular menstrual cycle.

The advantage is that you do not need to think about the side-effects hormones can cause. In addition, condoms protect you against sexually transmitted infections. The disadvantage is that you cannot control your menstruation, and copper-based IUDs can give you heavier bleeding and worse menstrual cramps than before.

### **HORMONAL CONTRACEPTION WITH PROGESTERONE ONLY**

These contraceptives contain hormones similar to the female hormone progesterone. Progesterone prevents ovulation, making it harder for sperm to enter the uterus and making the lining of the uterus thinner so as to prevent any fertilised eggs from attaching.

Your ovulation cycle will quickly return once you stop taking the contraceptive. The only exception is the birth control shot: with this, it often takes a long time before your ovulation returns to normal. The advantage of contraceptives that only contain progesterone is that they do not increase the risk of blood clots, cardiovascular disease or breast cancer. Therefore, women who should not take oestrogen can use contraceptives only containing progesterone.

Many stop menstruating after using contraception for a few months, and this is nothing to be worried about. The disadvantage is that you cannot control your bleeding, and some may experience irregular bleeding or spotting.

### **HORMONAL CONTRACEPTION WITH BOTH OESTROGEN AND PROGESTERONE**

These contraceptives are called combined oral contraceptive pills because they contain a combination of hormones similar to the female sex hormones oestrogen and progesterone. They protect against pregnancy by preventing ovulation and making it harder for sperm to enter the uterus. The effect is temporary. Your ovulation cycle will quickly return once you stop taking these contraceptives.

The advantage of combined contraceptives is that they give you good menstruation control, meaning you can decide when you want to menstruate. If you follow the instructions by taking a break from the hormonal pill one week each month, you will menstruate every month. You can also 'skip' your menstruation by not taking a break. The disadvantage of contraceptives containing oestrogen is that they can cause a slight increase in the risk of harmful side-effects such as blood clots (especially during the first six months), of cardiovascular disease and of breast cancer.

#### ***Harmless side-effects***

***It is normal to experience side-effects, no matter what contraceptive you choose.***

***These events are harmless. Luckily most side-effects stop after 1-2 months of use, so please try to bear with them when you start taking a new contraceptive. The most common side-effects are headache, nausea, mood changes, disturbances in menstrual bleeding patterns, pimples and decreased sex drive.***



*It is important for you to be satisfied with whichever contraceptive you choose. If these side-effects do not stop after a while, it may make sense to switch to another brand or another type of contraceptive. You are the only person who can assess how bad you find the various side-effects.*

## CORRECT USE IS MOST EFFECTIVE!

Most contraceptives are very safe, but for them to work properly, you must be careful to use them exactly the right way. The risk of unplanned pregnancy is largely related to how good you are at remembering your contraception, whether that be taking a pill daily or changing to a new patch or vaginal ring at the right time.

Taking other medicines, such as anti-epileptic medication, may reduce the effectiveness of your contraception. For those taking the pill, other conditions such as vomiting and diarrhoea can also affect their effectiveness.

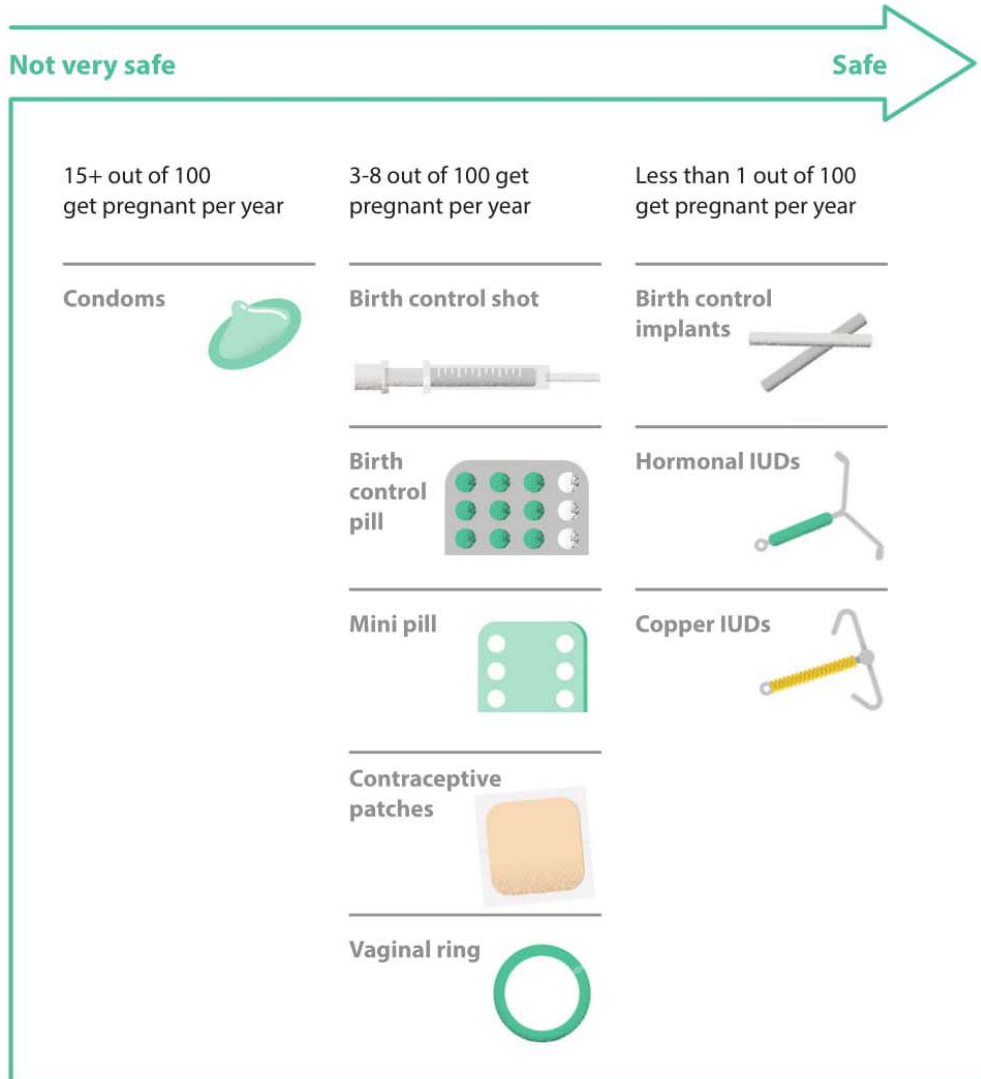
The safest contraceptives are the ones that make it impossible to forget anything or do anything wrong. So the lowest likelihood of an unplanned pregnancy is with long-acting contraceptives such as implants and IUDs

***Some contraceptives require you to remember more than others. The less you have to remember, the less you can do wrong!***



*Sex og samfunn client, aged 17*





**We recommend using hormonal contraception for protection against pregnancy.**



*If you have sex with a new partner, we recommend using a condom as well.*

## COPPER IUDs

### Non-hormonal contraceptives

Copper IUDs, also called coils or copper Ts, are made of plastic, with a soft copper wire wrapped around part of the plastic. Copper IUDs prevent pregnancy without using hormones. The copper IUD is approximately 3 cm long. You still ovulate as normal, but the copper in the IUD destroys sperms' ability to fertilise an egg. Once the IUD is inserted, there is nothing more you need to remember for it to work properly.

If you use a copper IUD, your menstruation pattern will stay the same. Some bleed a bit more, and for a bit longer, than they would normally without the IUD. Using a copper IUD does not impair your ability to have children, no matter how long you use it for.

#### **BENEFITS**

Copper IUDs are one of the surest contraceptives. Copper IUDs save you hassle. You only have to think about contraception once every five years. Most women can use copper IUDs – even those who have never given birth. Copper IUDs give you none of the hormonal side-effects, and no harmful side-effects either.

#### **DISADVANTAGES**

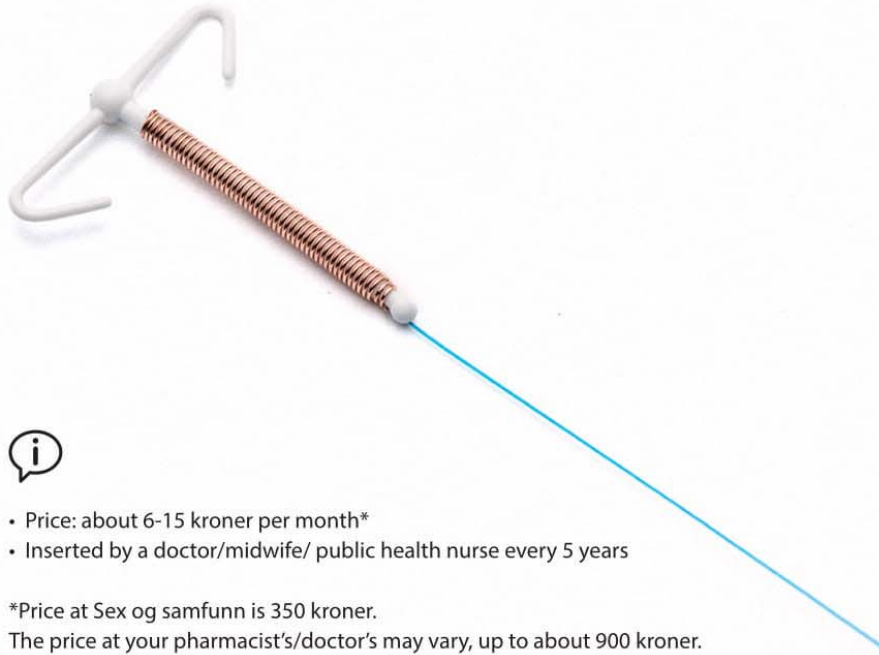
You might find that your bleeding and menstrual cramps are a bit heavier and last longer than your normal menstruation. This can be particularly unfortunate if you already suffer from menstrual pain or heavy bleeding.

#### **WHERE DO I GET A COPPER IUD?**

Copper IUDs can be purchased from most doctors. You can also purchase them at a pharmacy. The coil is inserted by a doctor, public health nurse or midwife. Since the IUD is placed inside the uterus, neither you nor your partner can feel it. The coil has a thin wire hanging down through the cervix, which you can feel at the back of your vagina if you put one or two fingers right in.

#### **WHAT NEEDS TO BE CHECKED BEFORE I CAN HAVE A COPPER IUD?**

- Checklist for your own health & safety (see page 27)
- Pregnancy test, if there is a possibility that you might be pregnant
- Testing for sexually transmitted infections before, or at time of, insertion
- You must undergo a gynaecological examination when you insert a copper IUD



- Price: about 6-15 kroner per month\*
- Inserted by a doctor/midwife/ public health nurse every 5 years

\*Price at Sex og samfunn is 350 kroner.

The price at your pharmacist's/doctor's may vary, up to about 900 kroner.

Free for 16- to 18-year-olds, and 19-year-olds pay about half price.

#### HELPFUL HINTS:

- You are advised to take painkillers one hour before insertion (2 Paracetamol 500 mg tablets plus 1 tablet of Ibuprofen 400 mg).
- Some people dread inserting an IUD, and are worried about it hurting. Think of it as an 'investment'. It doesn't take long to insert an IUD, and after that you do not have to think about contraception for the next five years!
- Schedule an appointment with a doctor, midwife or public health nurse 1-2 months after IUD insertion to check that the IUD is in place.
- Never use a menstrual cup if you have an IUD.
- If you wish to continue with the IUD after 5 years, you can have the old one removed and a new one inserted



# CONDOMS

## Non-hormonal contraceptives

Most condoms are made of latex, which is a type of rubber. Condoms come in different sizes, colours and flavours. Condoms are rolled onto an erect (stiff) penis before sex and are kept on until you have finished having sex. Anyone can use a condom. Latex-free condoms are also available, so that people allergic to latex can use a condom.

Condoms are the only contraceptives that protect both against pregnancy and against sexually transmitted infections.

### **BENEFITS**

Condoms are a sure and effective way of protecting against both pregnancy and sexually transmitted infections, provided they are used correctly. Practice makes perfect. If you are in the habit of using a condom every time, it becomes a very effective contraceptive. Condoms do not contain any hormones, so they do not give the side-effects that hormones do. Condoms may slightly reduce sensation in the penis, so they can be an effective way of making sex last longer. Most condoms are covered with lubricant, and this can make sex more comfortable.

### **DISADVANTAGES**

Some find it a disadvantage that condoms reduce sensation. Having to 'stop what you are doing' to put the condom on before sex can also be disruptive.

### **WHERE CAN I GET CONDOMS?**

You can order free condoms by mail, sent in discreet packaging, from [www.gratiskondomer.no](http://www.gratiskondomer.no). You can also get free condoms at Sex og samfunn. Condoms are sold in most grocery stores, supermarkets and kiosks. Vending machines can also be found in some public toilets, clubs etc.

### **WHAT NEEDS TO BE CHECKED?**

No check-up is necessary to use a condom. Feel free to try out different sizes, smells, tastes and designs.



- Price: free from [www.gratiskondomer.no](http://www.gratiskondomer.no); otherwise about 60-100 kroner for a pack of 10.
- Needs to be put on before sex.

#### HELPFUL HINTS:

- Check the date stamp and make sure that the wrapping is intact.
- Open the wrapping carefully so that you do not damage the condom.
- Your penis needs to be stiff when you put the condom on.
- Pull your foreskin back when you put on the condom, unless you are circumcised.
- Squeeze the tip of the condom (air bubbles can cause the condom to break).
- Hold at least one finger width on the tip of the condom while rolling down the rest of the condom, making sure not to damage the condom with your fingernails. Roll it right down to the base of your penis.
- Hold onto the condom at the base of your penis when you pull your penis out. You must use the condom the entire time you are having sex.
- Condoms must only be used once.
- Throw away condoms in your household rubbish bin after use, not in the toilet.
- Make 'dressing' the penis part of the fun!



## HORMONAL IUDs

### Hormonal contraceptives with progesterone only

Hormonal IUDs, or coils, are made of soft plastic and is about 3 cm long. The hormonal IUD is active for three to five years, but can be removed earlier, for instance if you want to get pregnant. Once the IUD is inserted, there is nothing more you need to remember for it to work properly. Most people who use hormonal IUDs will stop menstruating after a while. Some retain their menstruation pattern, while others may experience irregular bleeding or spotting. Although this may seem bothersome, it is harmless.

When you stop using hormonal IUDs, your normal menstruation will quickly return. Using a hormonal IUD does not impair your ability to have children, no matter how long you use it for.

There are three different brands:

- Mirena: Can stay in for up to five years.
- Jaydess: Can stay in for up to three years.
- Levosert: This is new on the market and is currently only approved for use for three years. The approved use is likely to be increased to five years.

### **BENEFITS**

Hormonal IUDs save you hassle. You only have to think about contraception once every five (or three) years. Most women can use hormonal IUDs – even those who have never given birth. They have no harmful side-effects.

### **DISADVANTAGES**

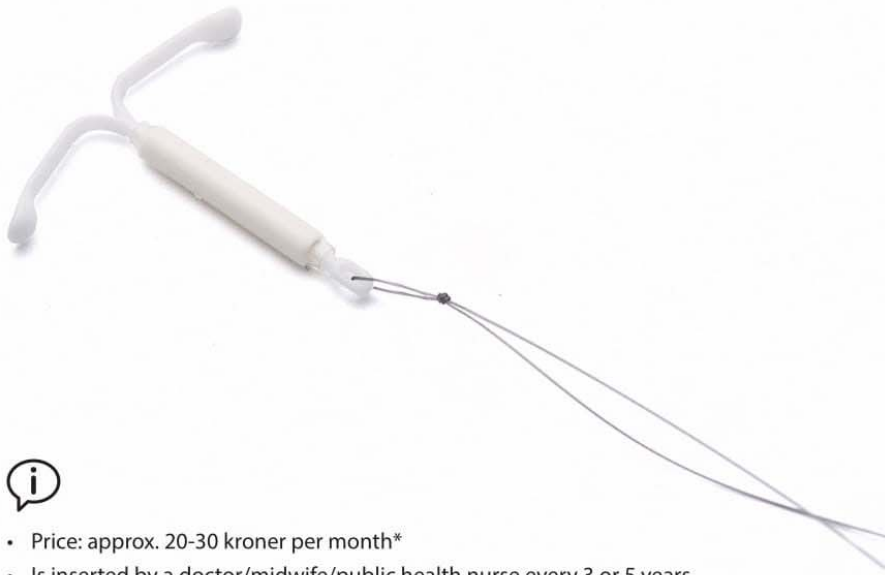
You do not know beforehand how your menstruation pattern will be.

### **WHERE CAN I GET A HORMONAL IUD**

Hormonal IUD can be purchased at pharmacies. A doctor, public health nurse or midwife can write you a prescription for an IUD, and insert it. Since the IUD is placed inside the uterus, neither you nor your partner can feel it. The hormonal IUD has two thin wires hanging down through the cervix, which you can feel at the back of your vagina if you put two fingers right in.

### **WHAT NEEDS TO BE CHECKED BEFORE I CAN HAVE A HORMONAL IUD?**

- Checklist for your and your family's health and safety (see page 27)
- Pregnancy test, if there is a possibility that you might be pregnant
- Testing for sexually transmitted infections before, or at time of, insertion
- You must undergo a gynaecological examination when inserting the IUD



- Price: approx. 20-30 kroner per month\*
- Is inserted by a doctor/midwife/public health nurse every 3 or 5 years

\*A hormonal IUD costs 935-1225 kroner, and can be used for 3-5 years. Hormonal IUDs are free for 16- and 17-year-olds. If you are 18 you have to pay about one third of the price, and 19-year-olds pay about two-thirds of the price.

#### HELPFUL HINTS:

- You are advised to take painkillers one hour before insertion (2 Paracetamol 500 mg tablets plus 1 tablet of Ibuprofen 400 mg).
- Some people dread inserting an IUD, and are worried about it hurting. Think of it as an 'investment'. It doesn't take long to insert an IUD, and after that you do not have to think about contraception for the next 5 (or 3) years!
- Schedule an appointment with a doctor, midwife or nurse 1-2 months after IUD insertion to check that the IUD is in place.
- Never use a menstrual cup if you have a hormonal IUD.
- If you wish to continue with the IUD after 5 (or 3) years, you can have the old one removed and a new one inserted



# BIRTH CONTROL IMPLANTS

Hormonal contraceptives with progesterone only

Birth control implants or contraceptive implants are a soft plastic stick that are 4 cm long and 2 mm in diameter. Birth control implants contain only the hormone progesterone.

The implant can stay in for up to three years, although it can also be removed earlier. Once the implant is inserted, there is nothing more you need to remember for it to work properly. Most people with a birth control implant will either stop menstruating completely, or their menstruation will basically stay the same as before. Some people experience irregular bleeding or spotting. Although this may seem bothersome, it is harmless.

Once the implant is removed, you will soon start ovulating again. The implant does not affect your fertility, no matter how long you have it in for.

## **BENEFITS**

Birth control implants save you hassle. You only have to think about contraception once every three years. Most women can use the implants. They have no harmful side-effects.

## **DISADVANTAGES**

You do not know beforehand how your menstruation pattern will be.

## **WHERE CAN I GET A BIRTH CONTROL IMPLANT?**

Birth control implants can be purchased at pharmacies. A doctor, public health nurse or midwife can write you a prescription for one, and insert the implant. The implant lies just under the skin of your upper arm, meaning that you can feel it but not see it. You get a small scar about 3 millimetres long at the implant insertion site. You will be given a local anaesthetic before it is implanted, so the procedure does not hurt at all.

## **WHAT NEEDS TO BE CHECKED BEFORE I CAN HAVE AN IMPLANT?**

- Checklist for your and your family's health and safety (see page 27)
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required





- Costs about 32 kroner per month\*
- Is implanted by your doctor/public health nurse/midwife every 3 years

\* A birth control implant costs 1141 kr. and can stay in for up to 3 years. Birth control implants are free for 16- and 17-year-olds. If you are 18 you have to pay about one third of the price, and 19-year-olds pay about two-thirds of the price.

#### **HELPFUL HINTS:**

- The implantation does not hurt at all – you will be given a local anaesthetic beforehand.
- After implantation, you will have a small scar about 3 millimetres long where the implant was inserted.
- If you wish to continue to have an implant after 3 years, you can have the old one removed and a new one implanted.



## BIRTH CONTROL SHOTS

Hormonal contraceptives with progesterone only

Birth control shots or contraception injections contain only the hormone progesterone. For the birth control shot to be effective, it is important for you to get a new injection no more than 12 weeks later. Most people who use birth control shots will stop menstruating after a while, while some may experience irregular bleeding or spotting. Although this may seem bothersome, it is harmless.

Once people stop taking contraceptive injections, it often takes a long time before they start ovulating again. So you may find that it can take 6-12 months for you to regain your normal menstruation pattern. However, birth control shots do not affect fertility after that point, no matter how long you were taking them.

### **BENEFITS**

Contraceptive injections save you hassle. You only have to think about contraception four times a year. Most women can use birth control shots. Contraceptive injections have no harmful side-effects.

### **DISADVANTAGES**

There may be a correlation between the use of birth control shot among girls who are not fully developed and subsequent osteoporosis in later years. Some also find it a drawback that it can take a long time for them to regain menstruation and ovulation after they have stopped getting birth control shots.

### **WHERE CAN I GET BIRTH CONTROL SHOTS?**

Birth control shots can be purchased at pharmacies. A doctor, public health nurse or midwife can write you a prescription, and administer the injection.

### **WHAT NEEDS TO BE CHECKED BEFORE I CAN HAVE AN INJECTION?**

- Checklist for your and your family's health and safety (see page 27)
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required.



- Costs 29 kroner per month\*
- Is injected by your doctor/nurse/midwife every 12 weeks

\* One Depo-Provera birth control injection costs 86 kr., and lasts for 12 weeks. If you are aged between 16 and 20, birth control shots do not cost you anything.

#### HELPFUL HINTS:

- If you experience a lot of irregular bleeding or spotting, it can help if you get a new injection after 8 weeks. For most people, the bleeding will stop.



# PROGESTERONE PILLS

Hormonal contraceptives with progesterone only

Progesterone pills contain only the hormone progesterone. For progesterone pills to be effective, it is important for you to take them at the same time every day, and without any break between the packs of pills. Many people who use progesterone pills will stop menstruating completely after a while. Some retain their menstruation pattern, while others may experience irregular bleeding or spotting. Although this may seem bothersome, it is harmless.

Once you stop taking progesterone pills, you will soon start ovulating again. Progesterone pills do not affect your fertility, no matter how long you take them for.

## **BENEFITS**

Most women can use progesterone pills. The pills have no harmful side-effects.

## **DISADVANTAGES**

You must remember to take the pill every day. Also, you do not have any certainty beforehand as to what your menstruation pattern will be like.

## **WHERE DO I GET PROGESTERONE PILLS?**

A doctor, public health nurse or midwife can write you a prescription. Progesterone pills are only available from pharmacies.

## **WHAT NEEDS TO BE CHECKED BEFORE I CAN TAKE PROGESTERONE PILLS?**

- Checklist for your and your family's health and safety (see page 27)
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required.



- Cost between 29-60 NOK per month\*
- Taken daily without a break

\*One pack of 3 rounds (3 months' supply) costs between 88-181 kr. If you are aged between 16 and 20, you get a 111 kroner discount every three months, meaning that you get some of the progesterone pills for free.

#### HELPFUL HINTS:

- Take your pills in the morning – then that gives you a full 12 hours to remember in case you have forgotten a pill (except for Concludag, where you have to remember within 3 hours).
- Keep your pills with your mobile phone, and set an alarm or download an app that gives you a daily reminder to take the pills.



## VAGINAL BIRTH CONTROL RINGS

Hormonal contraceptives containing oestrogen and progesterone

Vaginal rings contain two hormones, oestrogen and progesterone. Vaginal rings are a soft rubber ring. You squeeze the ring between your thumb and finger and insert it into your vagina. As long as the vaginal ring is correctly inserted, you will not notice it, and won't feel it during sex either.

When you stop using a vaginal ring, you will soon start ovulating again. Vaginal rings do not affect your fertility, no matter how long you have them in for.

### **BENEFITS**

The advantage of vaginal rings is that they give you good control of your menstruation pattern. You can choose to skip periods. If you keep using a ring without any break in between, you'll eventually start to bleed. You then take a break for 4-7 days, and then insert the next ring.

### **DISADVANTAGES**

You must remember to change rings. If you have problems with thrush or bacterial vaginosis, these conditions can be harder to treat while you are using a vaginal ring.

### **WHO CAN USE BIRTH CONTROL VAGINAL RINGS?**

Most women can use vaginal rings. Due to a slight increased risk of harmful side-effects, some people are recommended not to use vaginal rings or other contraceptives containing oestrogen.

### **WHERE CAN I GET A BIRTH CONTROL VAGINAL RING?**

A doctor, public health nurse or midwife can write you a prescription. Birth control rings are only available from pharmacies.

### **WHAT NEEDS TO BE CHECKED BEFORE I CAN USE A VAGINAL RING?**

- Checklist for your and your family's health and safety (see page 27)
- Blood pressure measurement
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required.



- Costs about 113 kroner per month\*
- Needs to be changed every 3 weeks

\*One vaginal ring costs about 113 kroner and lasts for three weeks. If you are aged 16-20, the government will cover 111 kroner of the cost every three months.

#### **HELPFUL HINTS:**

- You can easily insert and remove the ring yourself by squeezing it to make it smaller and inserting into your vagina or pulling it out of your vagina.
- The ring can stay in the vagina during sex.
- The ring can be taken out for up to three hours a day, then reinserted. You will still be protected against pregnancy.



# BIRTH CONTROL PATCHES

Hormonal contraceptives containing oestrogen and progesterone

Birth control patches or contraceptive patches are skin patches 4.5 x 4.5 cm in size containing two hormones, oestrogen and progesterone. For a birth control patch to be effective, it is important for you to replace it every week.

Once you stop using birth control patches, you will soon start ovulating again. Birth control patches do not affect your fertility, no matter how long you use them for.

## **BENEFITS**

The advantage of patches is that they give you good control of your menstruation. You can choose to skip periods by skipping the weeks without a patch. If you keep skipping the patch-free week you'll eventually start to bleed. If you start to bleed, then you can take a break for 4-7 days before the next three-patch cycle.

## **DISADVANTAGES**

You must remember to put on a new patch every week.

## **WHO CAN USE BIRTH CONTROL PATCHES?**

Most women can use birth control patches. Due to a slight increased risk of harmful side-effects, some people are recommended not to use patches and other contraceptives containing oestrogen.

## **WHERE CAN I GET BIRTH CONTROL PATCHES?**

A doctor, public health nurse or midwife can write you a prescription. Birth control patches are only available from pharmacies.

## **WHAT NEEDS TO BE CHECKED BEFORE I CAN USE BIRTH CONTROL PATCHES?**

- Checklist for your and your family's health and safety (see page 27)
- Blood pressure measurement
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required.





- Costs 29 kroner per month\*
- Needs to be changed every week

\*One packet of 9 contraceptive patches (3 months' supply) costs 276 kr. If you are aged 16-20, you get a 111 kroner discount every three months.

#### **HELPFUL HINTS:**

- The patches are water-resistant and do not lose effect after swimming, showering or sweating.
- The patches can be put on any area of unbroken, clean and dry skin – except for your breasts, where you must not put them. The most common place to stick the patch on is the upper arm.
- You might like to change area when you put on a new plaster, to avoid any skin irritation



# BIRTH CONTROL PILLS

Hormonal contraceptives containing oestrogen and progesterone

Birth control pills or contraceptive pills contain two hormones, oestrogen and progesterone. For birth control pills to be most effective, it is important for you to take them at the same time every day. Once you stop taking the pill, you will soon start ovulating again. The pill does not affect your fertility, no matter how long you take it for..

## **BENEFITS**

The advantage of birth control pills is that they give you good control of your menstruation. You can choose to skip periods by starting a new pack of pills and skipping the break in between packs, or by skipping the placebo pills. If you keep skipping the period you'll eventually start to bleed anyway. If you start to bleed, then you can then take a break for 4-7 days before starting a new pack.

## **DISADVANTAGES**

You must remember to take the pill every day

## **WHO CAN USE BIRTH CONTROL PILLS?**

Most women can use the pill. Due to a slight increased risk of harmful side-effects, some people are recommended not to use birth control pills or other contraceptives containing oestrogen. RELIS (independent medicine information centre) recommends Microgynon or Oralcon (21-pill tray) and Loette (28-pill tray) as the first choice in oral contraceptives.

## **WHERE CAN I GET BIRTH CONTROL PILLS?**

A doctor, public health nurse or midwife can write you a prescription. The pill is only available from pharmacies.

## **WHAT NEEDS TO BE CHECKED BEFORE I CAN USE THE PILL?**

- Checklist for your and your family's health and safety (see page 27)
- Blood pressure measurement
- Pregnancy test, if there is a possibility that you might be pregnant
- No gynaecological examination is required.



- Costs 25-118 kr. per month\*
- Has to be taken daily, break optional

\*Prices vary. The cheapest pills cost 75 kr., and the most expensive 354 kr., per package. Each package contains 3 rounds of pills (3 months' supply). If you are aged between 16 and 20, you get a 111 kroner discount every three months, meaning that you get some of the pills for free.

#### **HELPFUL HINTS:**

- Take your pills in the morning – then that gives you a full 12 hours to remember in case you have forgotten a pill.
- Keep your pills with your mobile phone, and set an alarm or download an app that gives you a daily reminder to take the pills.



## FORGOTTEN TO USE A CONTRACEPTIVE?

If you have forgotten your pills, ring or patch and are not sure what to do, you can go to [www.sexogsamfunn.no](http://www.sexogsamfunn.no) where we have a chat service available.

There are three different emergency contraception options for preventing pregnancy after unprotected sex. Two of these methods can prevent ovulation.

Although certain emergency contraceptives still work up to 5 days after unprotected sex, we recommend taking them as soon as possible. The sooner you take them, the more effective they are. You should also take a pregnancy test 3 weeks after having unprotected sex to rule out a pregnancy.

### HORMONAL EMERGENCY CONTRACEPTION

**Type: EllaOne**

Can be taken up to five days (120 hours) after unprotected sex

Prevents pregnancy in about 3/4 of cases if taken within 12 hours. After that it is less effective.

Can be purchased at a pharmacy – you do not need a prescription.

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**Type: Norlevo**

Can be taken up to 3 days (72 hours) after unprotected sex

Prevents pregnancy in about 2/3 of cases if taken within 12 hours. After that it is less effective.

Can be purchased at a pharmacy – you do not need a prescription.

*These tablets contain the hormone progesterone. It works by postponing ovulation for a few days. Take a pill as soon as possible after having unprotected sex. If you throw up less than 3 hours later, you should take another pill.*

### COPPER IUD AS EMERGENCY CONTRACEPTION

**Type: Copper IUD**

Can be taken up to 5 days (120 hours) after unprotected sex

Prevents pregnancy among over 99 percent women if it is inserted within 5 days.

You have to contact a doctor/midwife/public health nurse who can insert it.

*IUDs do not stop ovulation, but prevent any potentially fertilised egg from attaching to the uterus, thus preventing pregnancy. Read more about copper IUDs on page 8.*

**PERSONAL DECLARATION FORM** Name: \_\_\_\_\_

Please bring this page to your appointment Soc. sec. no. (11 digits): \_\_\_\_\_

I would like a doctor/ public health nurse/midwife to tell me more about these contraception methods (please tick):

- Copper IUD     Condoms     Hormonal IUDs     Birth control implants     Birth control shot  
 Progesterone pills     Vaginal rings     Birth control patches     Birth control pills     Emergency contraception

So that we can be sure that it is safe to prescribe you the contraceptive you want, it is important for you to fill in the points below before your appointment:

	NO	YES	Not sure
I could already be pregnant now (unprotected sex/forgotten to take the pill)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a smoker (regular and/or social smoker)	<input type="checkbox"/>	<input type="checkbox"/>	
I have irregular vaginal bleeding (bleeding between periods)	<input type="checkbox"/>	<input type="checkbox"/>	
I have, or have had, blood clots or a known coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Close family member (mother, father, sibling) had clots before age 45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have had a stroke or heart attack myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have high blood pressure (or am taking blood pressure medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a pre-existing liver or bile duct condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have had breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I suffer from migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I (might) have a gynaecological infection (e.g. chlamydia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I gave birth less than six weeks ago/I am breastfeeding now	<input type="checkbox"/>	<input type="checkbox"/>	
I take medication	<input type="checkbox"/>	<input type="checkbox"/>	

If yes, what medication (please put what you take them for if you can't remember the name):

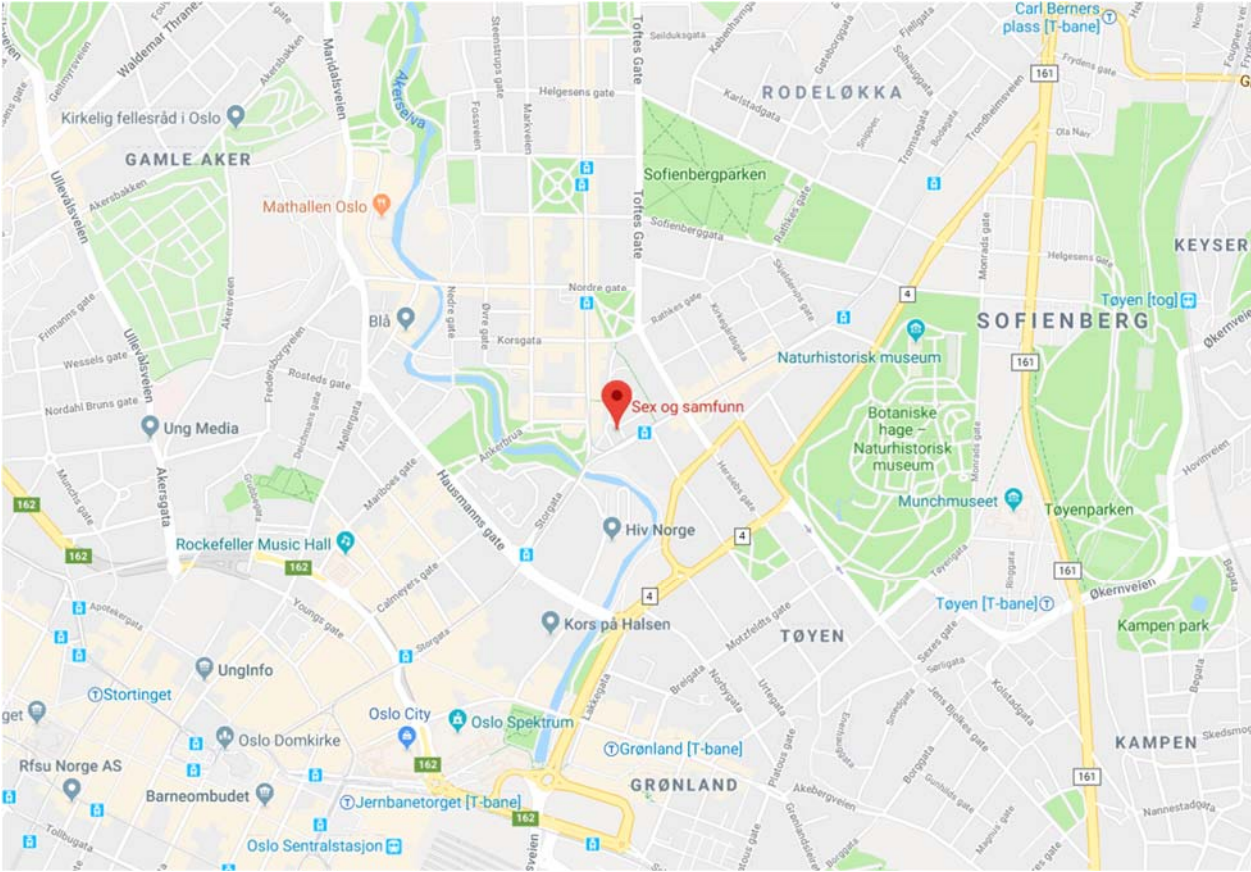
**To be filled in by the doctor/public health nurse/midwife:**

Date: \_\_\_\_\_ Contraception chosen: \_\_\_\_\_

Pat. informed: in writing  verbally  Sign: \_\_\_\_\_



Appendix: (F) Sex and Society clinic's establishment in Oslo showed on map



Courtesy: Google map.

**Appendix (G) The Sex and Society clinic's office near Heimsdalsgate  
stoppage, Oslo.**



*Courtesy: Google photos*