

**SEXUALITY, SEXUAL AND REPRODUCTIVE HEALTH:
AN EXPLORATION OF THE KNOWLEDGE, ATTITUDES AND
BELIEFS OF GREEK-CYPRIOT ADOLESCENTS**

**A THESIS SUBMITTED TO MIDDLESEX UNIVERSITY
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ABSTRACT

The study examines the knowledge, attitudes and beliefs of Greek-Cypriot adolescents regarding sexuality, sexual and reproductive health in Cyprus and is based on the concepts of culture, gender and sexuality under the general scope of health promotion and health education. The study reviews international and local literature on the theory and practice of these ideas and their influence on health, focusing on sexuality. Since culture and society are thought to influence health and sexuality, an extensive discussion is presented on the history of Cyprus and its development in contemporary years.

This is a Pan-Cyprian study of 697 third grade students (13-15 years old) in public general secondary (high) education schools (gymnasium) in Cyprus. A close-ended questionnaire was designed including 51 questions. Three axes were taken in consideration: Knowledge; resources and needs; attitudes and beliefs. With the application of statistical analyses such as factor and cluster analysis, several results were drawn. Among other things the findings reveal that socio-cultural determinants such as religion/church, do have enormous impact on Greek-Cypriot adolescents' attitudes and beliefs. Although young people do have some knowledge about sexuality, limited resources and services exist to support and reinforce that. In the Cypriot society of the 21st century some conservatism and taboo still exist. Gender differences are apparent. Greek-Cypriot society at some point seems to have different expectations, roles and even a 'code of ethics' among males and females.

Researching sexuality issues is a challenge since up until recently sexuality was very much a taboo area. Contemporary Cypriot society is becoming more sensitive and open about it even though a degree of conservatism still exists. However, there is limited scientific evidence on sexuality matters. This study

aims to provide some evidence. When a shift in attitudes take
noticed among adolescents.

Based on the literature review and the results of this study a theoretical
explanatory model was developed. At the end, the study highlights
conclusions and several recommendations are made for future investigation
and progress in the fields of health and education.

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CHAPTER 1
INTRODUCTION

"No Knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved"
(Ernest L. Boyer in Marx et al., 1998:43)

1.1 Background of the study

Health promotion has rapidly acquired a significant role within the field of health and health care. It is an important and vital force in the public health movement (Bunton and MacDonald, 1992). Health promotion involves the population as a whole within the context of their everyday life (WHO, 1994). It is a mediating strategy between individuals and environment, synthesizing personal choice and responsibility in health to create a healthier future (WHO, 1986). Yeo (1993), added that health promotion is a reform movement that advocates the shifting of priorities and resources to align with a broader way of thinking about health thus it can be seen as a powerful social intervention for protection and maintenance of health.

A vast number of health promotion campaigns, prevention projects or programmes have been focusing on different health related matters, such as smoking, alcohol, heart disease. After the HIV/AIDS epidemic people began to think more seriously about sexual matters. Almost two decades after the need for more information, re-shaping attitudes and beliefs regarding sexuality still challenges many societies. Sexual preparedness while it is also so crucial to saving lives (e.g. from HIV/AIDS, unsafe abortions) remains most of the times a controversial issue (Gomez, 1995). Even though the picture of sexual and reproductive health in the world appears to be gloomy, there is much ground for optimism about health development due to the growing respect for human rights particularly for women (Nakajima, 1992).

Globally, most people become sexually active during adolescence and thus, many adolescents are bearing children (Safe Motherhood, 1998; FPA, 1998). Additionally, the use of emergency contraception has increased in recent years (FPA, 1998). Arguably, it seems that there is lack of knowledge or misinformation related to the use or misuse of emergency contraception. There is also an increase of unsafe and casual sex. According to the Alan Guttmacher Institute (AGI, 1998a), seven in ten young girls in America, who had sex before the age of 14 and six in ten of those who had sex before the age of 15, reported having had sex against their will. Adolescent girls may lack self-confidence and decision-making skills to refuse unwanted sex. Girls who experience sexual abuse or rape can suffer from serious physical and psychological consequences (Safe Motherhood, 1998).

Each year, worldwide, girls aged 15-19 undergo at least five million induced abortions, thus being exposed to the possibility of having an unsafe one. Usually the reasons for an abortion are the fear of life change that one can have with a baby, the feeling of immaturity and financial problems (AGI, 1998a). In addition, it is estimated that worldwide, one in twenty adolescents every year contract a Sexually Transmitted Infection (STI) including HIV/AIDS (Safe Motherhood, 1998).

Adolescent development emerges from an interaction between the socialization processes of childhood, physical maturation, the socio-cultural pressures associated with adolescence itself and the active self-agency of the individual (Hendry et al., 1995). Adolescents have to go through and adjust to a biological, psychological, emotional and social development. Although adolescence is considered to be a healthy stage of the lifespan, it may be the genesis of behavioural patterns, which are carried into adulthood with possible health risks (Hendry et al., 1995). Sexuality is one of the factors that is very much affected during this stage. Even though sexuality is

experienced by everybody, it is an area that is least discussed and understood. Many adolescents get mixed messages (from parents, peers, media etc.) and they might pass through their adolescent years not understanding the monumental changes that they are experiencing (Alvarez, 1995).

Many factors such as family, education, culture, religion, attitudes, beliefs and values (these will be explored in the following chapters) influence adolescent sexuality. Many sexually related practices are deeply embedded in various cultures and may be considered as physically harmless or even beneficial to a young person, such as male circumcision for Jews; others can be harmful, such as the practice of female genital mutilation that many women are experiencing. In Catholicism and Orthodoxy contraception is considered a sin; in some countries polygamy is the norm whilst in others is a crime. It can be argued that changing any cultural practice might probably be unacceptable or even unethical for any society. However, reshaping, transforming, re-evaluating some aspects of cultural behaviour that might be harmful to people's health can prevent illness, promote well-being and improve quality of life. Cultural and socio-political structures have enormous power in understanding and expressing sexuality or health in general.

Sexuality education is considered, especially for adolescents, to be one of the major aspects of promoting health through adopting healthier life styles. There are arguments, though, that education for sexuality has limited or no effect in delaying the initiation of sexual intercourse (DiCenso et al., 2002). However, all research studies acknowledge that there is improvement of knowledge and almost all mention that the focus should be on socio-cultural determinants (DiCenso et al., 2002; Pastore and Diaz, 1998; Villaruel, 1998).



The International Planned Parenthood Federation (IPPF)/Youth Manifesto (2001a:3) summarizes the importance of sexuality for young people setting three goals:

- Young people must have information and education on sexuality and best possible sexual and reproductive health services;
- Young people must be able to be active citizens in their society and
- Young people must be able to have pleasure and confidence in relationships and all aspects of sexuality, by having more choices than those imposed by society's gender roles, choices that they can decide and feel happy about.

Cypriot society has European and Middle Eastern cultural characteristics. According to Kalava (in Mylona et al., 1982), the patriarchic nature of Cypriot culture - meaning that the male is the breadwinner, the leader of the family, the main figure in socio-political events - has restricted major changes or transformations to cultural norms, traditions and values which relate to sexuality, reproductive health and gender roles. However, in recent years socio-cultural changes seem to be taking place. This is mainly due to an increase in inward migration, which inevitably requires social and political adjustments to be made including changes in attitudes to gender roles.

In Cyprus, every year, there are on average 24 new HIV/AIDS reported cases. During the year 2001 twenty-three (7 Cypriots and 16 Foreign Nationals) new HIV/AIDS cases were reported. According to the World Health Organization (WHO) the number of HIV infected people currently living in Cyprus is estimated at 300-500. This corresponds to a rate of 0.06%-0.1% in the population between 15 to 49 years of age. In relation to world estimates these numbers are the 0.1 of crude world rate, 0.25 of rate of the Eastern Europe and 0.5 of the rate of Middle East (Ministry of Health, 2001). During the year 2001, 88 cases of genital warts have been reported of which

56% were young people 17-30 years old. In addition, 27 cases of syphilis have been reported of which 48% included young people 20-30 years old; and from 141 cases of genital herpes 11% included young people 15-30 years old (Ministry of Health, 2002). The numbers might seem to be small compared to other countries, but for such a small country (estimated population of Cyprus in 2001 was 762,887) and keeping in mind the socio-cultural influences this is gradually becoming a serious problem. Some of the factors that bring about such changes may be: the loosening of family ties currently being witnessed, reaction to previous strict sexual code of behaviour, improved financial affluence, a more contemporary interpretation of Christian values and beliefs, the influx of foreign artistes and new immigrants, and the increase in tourism. Further, Cypriots that are traveling abroad (for business, study or vacation) may engage in casual sex or intravenous drug use. Before 1993, only 14% of all known HIV cases were infected in Cyprus; by 1999 50% of the cases were infected in the island (Ministry of Health, 2001).

Sexual assault, sexual harassment, rape and other types of abuse have been increasing in recent years. According to the Association for the Prevention and Handling of Domestic Violence (2000) during the year 2000 (January-November 2000), 590 victims (492 women, 38 adolescents, 47, children, 13 men) of physical and/or sexual violence asked for help in terms of psychological support, counseling and/or shelter.

The Greek-Orthodox church has enormous power on the Cypriot society's norms and values. Sexual issues are considered as taboos by the church. Sex is something expressed within marriage. Premarital sex and contraception are considered as sins. Premarital sex was the main reason that in 1999 the Cyprus church abandoned the 'engagement' ceremony. Church representatives felt responsible of encouraging the tradition of young people living together after their engagement. The influence of the Cypriot

church is such that even people who do not consider themselves to be very religious are deeply affected by the moral codes advocated by the church. Having an illegitimate child is severely frowned upon by the Cypriot society that marginalizes both the women and the children involved. The woman is considered to bring dishonour to her family and is therefore also excluded and marginalized by them too. In order to preserve the family honour (Loizos and Papataxiarchis, 1991) the family will do its utmost to conceal the pregnancy and will put enormous psychological pressure on the woman to abort the foetus. However, the church also holds the view that abortion is a sin even in the case of rape. The Cypriot law permits abortion under certain circumstances, usually medical reasons (see chapter 5). Cypriot families and young people who find themselves in such dilemmas may often choose abortion as the social stigma of having an illegitimate child will last longer and have more profound consequences than the sin of abortion— for which they can be forgiven by the priest upon confession.

Twenty-eight abortions were performed in public hospitals for the year of 2000 (Cyprus Statistical Service, 2000a). There is no available data for the private hospitals or clinics. A small number of cases of young women who either tried to self-induce abortion or give birth whilst alone at home have recently been reported (Fileleftheros, 2001a).

In contemporary Cyprus, more people are becoming aware and sensitive to gender and sexuality matters. Women are very slowly gaining their equality within society, since most of them are working outside the home and are more independent, not only financially but also psychosocially. In 1980 sixty-five (65) children were born outside wedlock; in 1990 seventy-seven (77) and in 2000 one hundred and ninety-seven (197) (Lambraki, 2002). Notwithstanding this level and type of change, many Cypriots still hold very traditional and conservative attitudes towards these issues. For example, it is acceptable or even exhortative for boys to have premarital relationships,

while the urge for the girls is to preserve their virginity. Furthermore, since Cyprus is a small country, personal reputation is important. Most of the times people pay attention to and pass judgment on the female sexual behaviour whilst male sexual behaviours are taken for granted and pass unnoticed. This can create an enormous psychological pressure for many young women that sometimes may be harmful to their health.

The scope in promoting adolescent sexual health is to prevent or minimize any unwanted conditions, and to identify choices that young people may have when in a serious dilemma. Sexuality education has been included since 1992 as a unit of the secondary school health education programme. It can be argued that for several reasons, such as the sensitivity of the topic, the high level of privacy about it within Cypriot society and the limited resources available for its implementation has resulted in this not being effective. However, there is no research evidence to support this. In recent years there has been an on-going debate regarding the benefits of sexuality education in schools and how this can best be implemented and accepted within the Cypriot culture. A pilot programme that was planned to start in December 2001 was postponed to commence in the academic year 2002-2003. It is anticipated that its evaluation will be of great interest to both the general public and to many health and education professionals. The Cyprus Family Planning Association (2003) believes that in parallel to an effective school programme the support services for young people must be improved.

The rationale for this study arose from all these concerns, as the researcher views sexuality as a crucial part of health. It is the researcher's assumption that many professionals in the fields of health and education usually ignore this aspect of health. Further, it is assumed that cultural beliefs and attitudes influence the sexual health of Cypriot adolescents as they influence their

knowledge and awareness in issues regarding sexuality. It is also believed that there are gender differences in understanding sexuality among Cypriot adolescents.

Politics might be of equal importance in promoting sexual health. Decriminalization of homosexuality in 1998 was probably the most 'liberal revolution' of the Cypriot parliamentarians. However, most of the politicians do not usually publicly express their opinion about sexuality issues. Politicians though can often be successful agents of change through their conveyance of health messages as well as in influencing the implementation of health promotion programmes.

This study will try to offer thought and challenge to Cypriot people, especially young people, in understanding their own sexuality and sexual and reproductive health needs within the context of culture.

1.2 Concepts and Definitions

It is essential to define and discuss how some ideas/ concepts are used and understood in this study. All of the following terms have been given a variety of definitions. Some will be explored in more detail throughout this study.

Health is a fundamental human right, a precondition of well-being and the quality of life (WHO, 1998). It is a resource for everyday life, not an objective of living (Ewles and Simnett, 1992). Health is the foundation for achieving a person's realistic potential; it is about empowering people, enabling them to become all they are capable of becoming (Seedhouse, 1986). The meaning of health for each individual is influenced by one's own beliefs, values, gender and culture. For example, slimness in Western societies is a culturally defined standard for female beauty and health, while among the Enga people of the New Guinea Highlands a 'fat body' was rewarded as the most important physical asset of a woman (Helman, 1994). In either case one's health may be influenced. In extreme cases some young women can have anorexia nervosa due to obsessive slimness, or cardiovascular problems as a complication of obesity.

The ability to adapt to constant changing demands, expectations and stimuli is a characteristic of a healthy person. Some people view health as the absence of illness or disease. However, others have a more holistic view of health based on one's psychosocial, cultural and physical well-being. For example, a single parent consults a physician because he/she feels depressed. The physician may be tempted to prescribe medication that induces a state of well-being; the alternative may be to refer him/her to a peer support group where life-skills and autonomy can be promoted (Tannahill et al., 1990).

In the first International Conference on Health Promotion, in Ottawa in 1986, a Charter for action to achieve Health For All by the year 2000 and beyond was presented. The Charter (1986:1) stated that *health promotion* is the "...process of enabling people to increase control over, and to improve their health". Health promotion is a multi-factorial process operating on individuals, communities through education, prevention and protection measures (Tannahill, 1985). Some health professionals believe that they have to apply persuasive strategies; others aim in assisting people to learn and apply healthier lifestyles. One can argue, that if people cannot understand the primary purpose of a specific prevention act (e.g. for unwanted pregnancies) and the personal and social consequences, then it will be very difficult to use techniques or methods to alter behaviour. Applying a persuasive strategy alone can probably be successful in short term.

In promoting health, emphasis is given to the concept of positive health. This means a 'true well-being', where the individual and society are of significant value. It entails a balance of physical, mental and social ingredients (Tannahill et al., 1990). All three components are of equal importance and any alteration on anyone will affect health. The health promotion knowledge base is multi-disciplinary and this alone is a strong asset in effectively preventing unwanted or ill-conditions. Nevertheless, organization, collaboration and cooperation will enhance the effort in the promotion of health. The World Health Organization (WHO, 1984) identified certain principles of health promotion that are comprehensive, clear and useful in understanding and practicing health promotion.

Thus, *health promotion*:

- involves the population as a whole in the context of everyday life
- is directed towards action on the determinants or causes of health
- combines diverse but complementary approaches which include education, legislation and community development

- aims at effective and concrete public participation, which will lead to the development of problem-defining and decision making life skills
- is an activity in health and social fields

In 1998 within the context of Health21 the WHO, enriched and explored in more depth the above principles. As to ensure scientific, economic, social and political sustainability four main strategies for action were chosen:

- multi-sectoral strategies to tackle the determinants of health
- integrated family and community-oriented primary health care
- a participatory health development process that involves partners for health at home, school, work and at local community and country levels and that promotes joint decision-making, implementation and accountability
- health-outcome driven programmes and investments for health development and clinical care

Tones (1991) referred to health promotion as an umbrella term, which includes any activity and sector that is designed to improve health; and health education is one of the most important activities that influences health.

Health education is "...communication activity aimed at enhancing positive health and preventing or diminishing ill health in individuals and groups, through influencing the beliefs, attitudes and behaviour of those with power and of the community at large" (Smith, as cited by Tannahill et al., 1990:28). Effective health education can produce changes in ways of thinking; it may influence or clarify values; it may shape a belief or an attitude; it may even affect changes in behaviour or lifestyle (Tones and Tilford, 1994). Education is not a panacea but is a useful tool in promoting health. Nevertheless, philosophers of education highlighted the autonomy of the individual as the central goal of education. Health education itself is a valuable tool and thus,

educational methods that promote autonomy and empowerment must be of a priority. Furthermore, the primary aim is to educate people in such a way as to enable them to develop the ability, skills and confidence to make healthy choices. However, teaching and learning is still largely about acceptance of the rules of others (Bunton and MacDonald, 1992). Educational institutions such as schools should try to promote autonomy not only at personal level but at societal level too. Effective health education involves adopting active and participatory methods and spiral integrated curricula, starting where people are, cognitively, emotionally and developmentally (Bunton and MacDonald, 1992).

Health education is concerned not simply with raising individual competence and knowledge about health, but with raising awareness about social, cultural, political and environmental factors that influence health. Education is for the individual to develop the theoretical and practical background as to understand and respect different ways of thinking and practicing within the diversity of people and societies (Green and Tones, in Wilson and McAndrew, 2000).

Health promotion and health education are seen as having a symbiotic relationship. The aim through these processes is to improve health. Therefore, empowerment is an ultimate goal at personal and communal level. "The self-empowered person is more likely to possess a high internal locus of control" (Tones, 1985:79), meaning that one is likely to have developed a firm conviction that is not controlled by fate or someone else (Apostolidou, 1999). Significant association has been reported between internal locus of control and different health measures (e.g. reduction of alcohol consumption). If one respects and values one self, it is more likely that he/she will look after him/herself (Tones, 1991). The development of healthy attitudes and behaviour can be encouraged by education. However, motivation, ability and responsibility rest with the individual primarily, as well as the health educator

(Jamieson et al., in Wilson and McAndrew, 2000). Emphasis must be given in doing things *with* people and not *to* people.

Despite one's own idiosyncrasy, many times one's cultural background can reinforce or restrain possibilities of empowerment, meaning that within each culture different opportunities and flexibilities exist for the individual to reach empowerment and a healthy state of life. Socio-cultural factors cannot only influence empowerment but health and health promotion too.

Culture is a unique part of one's own personal identity that has been defined by Tylor (1871/1958:1) as the "... complex whole which includes knowledge, beliefs, arts, morals, law, customs and any other capabilities and habits acquired by man as a member of society". According to Leininger (1995:60) "...culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular group in their thinking, decisions and actions in patterned ways". Generally, culture can be seen as that which constitutes humanity or distinguishes a specific society from another (Gausset, 2001). It is the way that life is shared within an environment by a group of people. As societies are becoming more and more multi-cultural, it is necessary to understand the beliefs, attitudes and behaviour of other people as to achieve a harmonious relationship between cultures, societies and individuals.

The meaning of illness is influenced by a person's cultural background. The aetiology, symptoms, possible outcomes and treatment, often are distinctive from one culture to another and may reflect peculiar beliefs, customs or tensions that are prominent in that culture (Gallagher, 2000). Regardless of these and far from being static, culture is dynamic and capable of adapting to new conditions (Gausset, 2001). Undoubtedly, culture is a major component in influencing health and consequently in developing and expressing

sexuality. It is also acceptable that there are differences as well as similarities between cultures. People express their sexuality differently in Afghanistan than in Paris or Japan.

Sexuality is "...interwoven with every aspect of human existence. In its broadest sense, it is a desire for contact, warmth, tenderness or love. Humans express their sexuality during daily life" (Poorman, 1988:1). The biological aspect of sexuality is one of its components that cannot be ignored. The continuation of human species is very important. Sex also has its own meaning within the notion of human sexuality. Overemphasis on biological aspect can underestimate the significance of socio-cultural aspect of sexuality.

Sexual matters are of great importance but in many societies they are viewed as 'secrets'. In many societies the everyday language that people use is full of sexual innuendo, slang and joking. This signifies that people think of and may be problematized about sexual matters, but also demonstrates that these cannot be discussed openly without embarrassment (Evans, in Morrissey, 1998). Slang words or joking, may be used intentionally or unintentionally to mask the feeling of being uncomfortable in discussing such issues. Many people today, throughout the world, are deprived of their sexual and reproductive rights (see chapter 4). Being able to freely express sexuality is one of the most joyful and enriching aspects of human experience (Pratt, in Wilson and Mc Andrew, 2000). All these do have an impact on one's health, because sexuality is an integral part of a human being.

Gender also has a strong impact on human sexuality. Gender goes beyond the chromosomal or biological sex of being a man or a woman and tries to understand individuals as male or female figures within their socio-cultural and physical environments. One of the central elements in gender systems is

the taboo against the sameness of male and female (Hess and Feree, 1987). Much literature reveals the uniqueness and commonalities of expressing male or female sexuality. Nevertheless, sexuality and gender are separate organizing features of social relations but intersect by mutually reinforcing, naturalizing and constituting each other (Schippers, 2000).

Sexuality education is challenging wherever or at whatever age might be applied. It is aiming to teach adolescents (preferably even earlier than that), about their physical and psychosexual development. It also aims to develop skills, shape attitudes, beliefs and values. These will cultivate critical thinking, increase self-respect and self-awareness and may change behaviour (Sinanidou, 1997). Sexuality education is not presented here as a 'magic recipe' that will solve or eliminated all unwanted conditions, but it is a useful tool for reducing or preventing those and, thus, promoting health. Sexuality education concerns everyone-parents, educators, policy makers, mass media etc. Strong partnerships will enhance effectiveness of such programmes. Furthermore, a multi-disciplinary team can provide a more open, diverse and comprehensive approach to sexuality issues than a single person (whoever that can be) (Creatsas, 1998). It is important that young people, especially adolescents, not only learn about their sexual health, but become involved in such programmes thus contributing to the programmes' development and control (Thomas, 1996).

Adolescents are "...a diverse group of people and popular stereotypes underestimate their variety and exaggerate their liabilities, as stereotypes tend to do" (Durkin, as cited by Bergman and Scott, 2001:194). The uniqueness of each one adolescent along with the similarities as a group in sexuality matters are some of the reasons that this research is focused on adolescents. Needless to say that sexual maturation, sexual identity and sexual intercourse are some of the issues that can create concern, ambiguity,

experimentation, challenge and fear to most of the adolescents. This is the point where adolescents need to be aware of the right and healthy choices. Therefore, attitudes, beliefs, behaviour, information and knowledge are probably better to be delivered, shaped or formed much before reaching this stage of life. Adolescent development, as previously mentioned, emerges from an interaction among the socialization processes of childhood, physical maturation and the socio-cultural environment. Therefore, within the contexts of health promotion and everyday culture, adolescents and sexuality are of significant concern.

1.3 Aims and Objectives

Aim

The aim of this study is to examine Greek Cypriot adolescents' knowledge, attitudes and beliefs about sexuality, and sexual and reproductive health and to explore the influence of the dynamic interplay of transnational and local socio-cultural norms and values.

Objectives

- To identify the cultural factors which influence sexuality, and sexual and reproductive health attitudes and beliefs of Greek Cypriot adolescents;
- To describe the knowledge, attitudes and beliefs of Greek Cypriot adolescents about sexuality, and sexual and reproductive health;
- To assess Greek Cypriot adolescents' awareness of the existing resources related to sexuality issues; and
- To develop explanatory frameworks based on the impact of local and transnational socio-political and cultural norms and values on sexuality and sexual and reproductive health

1.4 Overview of the Thesis

Following the introduction (*Chapter 1*), chapters 2-5 are composing the literature review. The concept of culture is discussed in the *second Chapter* exploring its complexity as well as its influence on everyday life. Health and well-being are inseparable aspects of daily living and thus culture is very much related with. In this chapter emphasis is given to the relation of culture in the form of attitudes, values, beliefs and sexuality links with health. Discussing the blending of culture and health, their influence on adolescents' beliefs and behaviour worldwide could not have been ignored. Moreover, as gender is part of culture *Chapter 3* analyses the relation amongst them. While many researchers have focused on biological differences, others explored gender as an important determinant of health, including the socio-cultural aspect of it (Wamala and Agren, 2002). This chapter discusses gender and its components such as gender roles, gender stereotypes within a cultural context and this is essential in promoting health. Adding to the discussion, the concept of sexuality becomes more challenging. Sexuality is produced within gender relations. Cultural and social constructions of gender, influences how one understands and expresses his/her own sexuality. Within these parameters adolescent sexuality is also discussed in this chapter in relation to gender and culture, providing evidence from different cultures and societies and their influence on sexual health.

Chapter 4 refers to sexuality in more detail and presents several theoretical approaches on this topic. At the same time a distinction is made on what is sexuality and sexual and reproductive health. As sexuality embraces many aspects of human existence such as political and economic, politics could not be neglected during the process of reviewing the literature and some examples are mentioned such as the reinstatement of 'Mexico City Policy' by George Bush. Furthermore, Chapter 4 extensively discusses the impact of education for sexuality in promoting health. As the study was undertaken in

Cyprus, it was necessary to explore the meaning of sexuality within Cypriot society and culture and how they may affect Greek-Cypriot people's well-being. These issues are discussed in *Chapter 5*, providing a historical and contemporary perspective of Cyprus. Several factors are explored as strong influencing components of the Greek-Cypriot culture such as church/religion, education, mass media. *Chapter 6* describes in detail the methodology used for the implementation of this study including sampling, the instrument, the methods of data collection and analysis. The ethical implications are also discussed. In *Chapter 7* the research findings are presented. It includes simple and advance statistical analyses and tests that were applied for the purpose of this study. The chapter is divided into different sections according to the theme that is being investigated based on the questionnaire given, for example, knowledge, attitudes and beliefs. The interpretation of the results and a critical discussion of them are found in *Chapter 8*. This chapter is also divided in similar sections, according to the responses of the participants in each theme such as knowledge, resources/needs. In the same chapter the development of an explanatory framework/model is presented as to understand sexuality within Greek-Cypriot culture. The overall idea is to prevent unwanted conditions and promote not only sexual health but a holistic view of well-being. The framework is based on the findings and literature review as they are understood and interpreted within the parameters of culture, gender and sexuality. The final chapter of the thesis, *Chapter 9*, presents the conclusions and recommendations of the study, highlighting at the same time its contribution. In addition, a framework of partnerships among existing or new resources on sexual and reproductive health is introduced aiming at a better collaboration and coordination.

CHAPTER 2

CULTURE

Introduction

There are hundreds of definitions on culture. Culture includes ideas, beliefs, language, institutions and structures of power and a range of various practices, encompassing artistic forms, architecture, work and leisure activities, and popular and elite media products (Grossberg et al., 1992). As culture in this study is considered as the principal idea of understanding sexuality, this chapter explores the concept of culture. Within these parameters the relation of culture, health, and sexuality of adolescents are extensively discussed.

2.1 Culture

Culture is a complex concept that needs to be clarified in order to understand health related knowledge, health related practices and health promotion. Researchers from different disciplines and professions, such as anthropologists, sociologists, psychologists and -in recent years- health professionals such as nurses, offer numerous definitions and analyses related to culture. However, many authors also highlight common features of culture.

More than a century ago, Tylor (1871/1958:1) defined culture as a "...complex whole, which includes knowledge, beliefs, arts, morals, law, customs and any other capabilities and habits acquired by man as a member of society". These 'capabilities and habits' seem to include everything (e.g. language, professions or disciplines). Williams (1981:13) stated that culture "...includes not only the traditional arts and forms of intellectual production but also all the 'signifying practices' -from language through the arts and philosophy to journalism, fashion and advertising- which now constitute this complex and necessarily extended field".

According to Leininger (1995:60) "...culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular group in their thinking, decisions and actions in patterned ways". Leininger goes even further to give a more comprehensive and clear definition. It is a holistic view of the individual as he/she inherits a set of guidelines and at the same time transmits these to the next generation. This process is fascinating because is endless. The 'set of guidelines' might change throughout the years, but the transmission will never stop.

Helman (1994:2), viewed culture in similar way as "...a set of guidelines which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation- by the use of symbols, language, art and ritual". Helman and Leininger emphasize the significance of culture in relation to health and health education.

The above definitions imply that each human society has its own meanings and purposes. Culture has two aspects: firstly, the known meanings and directions, which its members are trained to and secondly, the new observations and meanings, which are offered and tested (Williams, in Gray and McGuigan, 1997). These are the ordinary processes of human societies and human minds. Williams goes on to say that culture can be traditional and creative with ordinary common meanings and the finest individual meanings. Therefore, the ordinary is found in the contemporary, conventional, the popular and the everyday culture. It is in everyday objects, everyday talk and in all the daily aspects of each person's life (Silverstone, 1994). Willis (1990) not only agrees that culture is ordinary but goes one step further to say that culture is the extraordinary in the ordinary. The extraordinary creativity that people use in their social practices, personal styles and choices, is a crucial

variable for the individual identity formation. It helps one to find his/her own identity and place, in a sense, by remaking the world for one's self. Most young people's lives are not involved with arts and yet are full of expressions, signs and symbols through which individuals seek creatively to establish their presence, identity and meaning. People are constantly expressing something about their actual or potential cultural significance (Willis, 1990). Symbolic creativity is "...more fully the practice, the making or the essence, what all practices have in common, it is what drives them" (Willis, in Gray and McGuigan, 1997:208). Symbolic creativity helps to produce specific forms of human identity and capacity (Willis, 1990).

Society also has a vital role in forming or transforming oneself or identity. Some argue that the individual is a product of the society and the culture in which one lives. From the moment humans are born and throughout their lives, they have social relations and are part of a network of other people (Burkitt, 1991). These social interactions and meanings include a cultural aspect that influences one's identity and a way of life.

Fiske (in Grossberg et al., 1992), argued that it is difficult to study empirically or theoretically the everyday culture of people. He added that this may be the reason that culture of everyday life is concrete, contextualized and lived. Bourdieu's (1984 and 1977) theory of 'habitus' is a way of thinking through and analyzing the material practices of everyday culture and the difficulty in studying them. Bourdieu argued that 'habitus' produces dispositions and that individuals make choices according to their habitus. Some argue that 'habitus' embodies the attitudes which one inherits; it does not constitute a stimulus which conditions how one should behave (Robbins, 2000). The concept of 'habitus' contains the meanings of habitat, the processes of habitation and habit, especially habits of thought. People live within a social environment (their habitat). This is a product of its position in the social space and of the practices of the social beings that inhabit it (Grossberg et al., 1992).

Bourdieu's theory may be considered to be useful because it relates cultural and textual differences to social and economic ones. There are a variety of ways in experiencing social conditions and their different ways of knowing, thinking and producing culture. The vitality of a culture could be a source of social change (Fiske, in Grossberg et al., 1992). Individuals in different situations have different capacities to generate positions, but all individuals possess some capacity for positional change (Robbins, 2000). Arguably, one may challenge the social environment and provide different 'habitus' and dispositions.

The study of culture is concerned with everything that is meaningful in connection to power relations. "...Power is everywhere; not because it embraces everything, but because it comes from everywhere" (Foucault, 1980:93). Post-Structuralists, like Foucault, are more interested in the way that language is used with other social and cultural practices (Storey, 1993). The use of language and/or messages, are always articulated by social and cultural practices. These power relations need to be considered in understanding culture. Power should not be viewed negatively; it is productive and produces knowledge (Storey, 1993). However, sometimes power may not be used for promoting good. As culture is a multidimensional issue, involving politics and policy making, economy and the wider society negative power relations may occur (Gray and McGuigan, 1997). For example, one could argue that political differences and conflict between countries or even within countries may be due to differing cultural beliefs and values such as in Ireland, Afghanistan and Cyprus. Foucault argues that power could exist without knowledge, while knowledge would have nothing to integrate without differential power relations. He also argues that there is a connection between knowledge and individuality. He goes further to say that true knowledge is defined by the individual, but what is permitted to count is defined by discourse. Discourse associates the organization of social

relations as power relations (Storey, 1993). Therefore, acquiring knowledge about individual's health issues for health promotion is a step towards gaining power. However, since culture may influence behaviour, it can have an impact on one's understanding of a given knowledge of health. Furthermore, culture may acquire power as it contributes to the identity formation, the cultural production and consumption. Nevertheless, one is encouraged to search and find sources of power, as to enable him/her to do or become what he/she can actually do or become.

Even though there seems to be a difference between Bourdieu's and Foucault's analyses of culture, at the same time their ideas seem to have some resemblance too in how they view the cultural environment.

Humans are more similar to one another than they are different (Brown, 1991). Cultural differences still do exist. Triandis (1994:3) supports that "...we are not aware of our culture unless we come in contact with another one". Even after exposure to other cultures, people are most likely to use the framework of one's own cultural background in interpreting the events. For example, among the Karaki of New Guinea a man is 'abnormal' if he has not engaged in homosexual behaviour prior to marriage. In other countries this may be characterized as exactly the opposite (Triandis, 1994).

Cultures are never homogeneous nor static. Thus, generalizations should be avoided; many times there is a difference between the professed 'social norms' of a cultural group and actual cultural practice. Cultures are influenced by other cultures around them. For example, there is a difference for Muslims living in United States of America and the Muslims living in Saudi Arabia. Muslims living in the United States have multicultural interactions. Their daily stimuli differ from Muslims living in Saudi Arabia. They include non-Muslim or non-Islamic beliefs, attitudes or behaviour. Therefore, the culture of Muslim's living in America is arguably less static than the culture of those living in

Saudi Arabia due to the numerous exogenous factors which impact on their cultural beliefs and practices.

Helman (1994) argues that there is a continuous adaptation process to culture and a constant change. Despite this, certain beliefs, values and practices do persist (Kottak and Kozaitis, 1999). Bauman (1999), highlighted that cultures become inter-dependant and all are diversified. Some cultures have similarities in their beliefs and/or common practices. Interacting with other cultures may or may not bring about changes in one's value system (Watson, 1992). Culture is absorbed unconsciously. Many times people do or say things that they have not really thought about, but have acquired or learned from their everyday life within their culture. 'Social spacing', for example, is not actually taught. It is a gradual process of observation. How far or close North Americans, Russians, Greeks or Italians stand from each other, is learned as a part of their culture (Kottak and Kozaitis, 1999). Thus, hugging, kissing or talking are strongly influenced by culture.

Whether inherited or acquired culture is an inseparable part of human beings. During enculturation people internalize meanings and symbols of their culture. It is the process by which someone learns his/her culture (Kottak and Kozaitis, 1999). Environment, as product of group of individuals, with its own culture -norms, beliefs, values and habits- challenges the individual as to reject, change, adjust or adopt his/her culture. Helman (1994) argued that the culture into which one is born or in which one lives, is not the only influence on his/her life. Gender, personality, education and social class are some of the factors that may influence one's life and health as well as their cultural background.

Cultural habits persist only as long as they satisfy people's needs. Gratification strengthens habits and beliefs (Kozier et al., 1991). It could be argued that this is not applicable to everyone or everything. Cultural habits

and/or norms may not only be unsatisfying to certain people or circumstances but even harmful in some cultures such as female genital mutilation, early age arranged marriages and the burning of widows. Thus, forms of cultural expression reveal power relations within groups; for some people the same practice may offer satisfaction whilst for others may be a negative experience.

Gray and McGuigan (1997) argue that people should learn to think globally while acting locally, developing concepts and forms of writing which will create the links between knowledgeable communities and larger systems. Nowadays, there is a considerable interest in exploring the cultural implications of groupings such as the European Union (E.U.). The dynamics of globalization are more complex than people may think or imagine (Gray and McGuigan, 1997). Belonging to a politically or economically powerful group, one shares this power. For example, each country wishing to be part of the E.U. must meet certain criteria and make specific constitutional changes, which inevitably have socio-cultural ramifications, while at the same time keeping its own cultural identity. It seems that this is not an easy task. Certain people or communities want to preserve the uniqueness of their culture without allowing any transformation or change. Arguably, with globalization cultures may no longer be seen as separate from one another. Either way, some elements of culture do diffuse from one culture to another (Triandis, 1994).

Theories related to biology, ecology and social structure are more likely to be universal (Triandis, 1994). At the same time, each phenomenon has also its cultural specific aspect. Thus, one may respect, accept or apply certain aspects of universality, but retain unique parts of one's own culture. Globalization, acculturation and multiculturalism offer the opportunity to exchange cultural practices, values, attitudes and beliefs, broaden people's horizons, acknowledge and understand people from other communities and cultures and share what is considered to be useful and beneficial for each

culture and community. It is possible that positive interactions among individuals or groups of people may occur. For example, occupational groups, genders, social movements and corporations can become the bases of specific subcultures (Triandis, 1994). Adolescents, health professionals, educators, males and females may consider being the bases of specific subculture. Subculture "...is closely related to culture and refers to a group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes and ways of living with some distinctive features of its own" (Leininger, 1995:60). Unfortunately, cultural interaction is not always positive or beneficial. People may adopt attitudes, behaviours, practices or even values harmful to them or 'culturally inappropriate' within their community. For example, whilst in some countries cohabitation, multiple sex partners or same sex families are acceptable, these are not so in Cyprus where even premarital sex may inhibit a person from receiving the Holy Communion.

The tendency to judge the behaviour and beliefs of people from a different culture based on one's own cultural standards, probably only creates difficulties among people. Ethnocentrism is better to be avoided; and instead one should learn to appreciate the best that humans have produced, no matter where it was developed (Triandis, 1994). Cultural relativism may be more beneficial, if it is used appropriately and not in the extreme. This implies that it is not possible to judge one culture as objectively superior to another (Taylor, 1997). Human diversity must be respected as well as certain international standards of justice and morality (Kottak and Kozaitis, 1999), as long as they do not intervene with the authenticity of the cultural identity of a particular community. Ethnocentrism is not the only barrier for intercultural or transcultural communications and relations, stereotypes are equally inhibiting.

Stereotyping means "...assuming that all members of a culture or ethnic group are alike" (Kozier et al., 1991:745). Once a stereotype is in place, it

influences one's processing of information and behaviour to that person or group. When there is a contact with a person or group that one has a stereotype this is activated immediately (Trandis, 1994). For example, one may assume that all Italians express their pain volubly (Kozier et al., 1991). The more contact there is with a person, group or culture, the more acceptant one is likely to be. Nevertheless, each individual is unique. Stereotypes will be discussed in more detail in chapter 3.

The beliefs and concepts one has regarding race and ethnicity are another two important parameters that can influence one's understanding of other people's cultural practices or beliefs. Race "...is characterized by physical appearance, determined by ancestry and perceived as a permanent genetic state" (Fernando, 1991 as cited by Papadopoulos et al., 1998:2). Since all people are equal, no race can be considered as superior or inferior to another. History reveals that race inequalities existed within or among cultures. Even in contemporary years, in some countries, certain races are not treated as equals. Ethnicity "...is the basis for defining groups of people who feel themselves to be separated in multiracial and multicultural societies. It implies a sense of belonging" (Fernando, 1991 as cited by Papadopoulos et al., 1998:2) and belonging is an important human need. Ethnicity is perceived as partially changeable, while race is perceived as permanent (genetic/biological), (Papadopoulos et al., 1998). Whatever approach one may adopt for ethnicity, all of them agree that it is related to the "...classification of people and group relationship" (Eriksen, in Guibernau and Rex, 1998:34). Misconceptions or stereotypes that exist for a particular race or ethnic group affect the attitudes and behaviour towards others. Since many societies are becoming multicultural and more diverse, such obstacles must be minimized or eliminated.

Nowadays, with the traveling, migration, resettlement, mass media and technology universality cultural blending, challenging and problematizing occurs.

Health is very much related to the individual's experience, identity and culture. In comprehending health, it is important to understand one's own culture (Helman, 1990). Culture guides each person's thinking, doing and being. Therefore, exploring health within each person's culture could reinforce the individual's potential, knowledge and power and thus promote health. Attitudes, values, beliefs and behaviour are shared parts of culture and therefore, are directly linked with health. One may argue that these may be viewed as a form of guidelines (among other factors) that lead the individual to form an opinion, make decisions and take actions in certain matters.

As one of the aims of this study is to describe the attitudes and beliefs of adolescents regarding sexuality and the influence of socio-cultural factors on these, it is necessary to discuss, comprehend and relate attitudes, values and beliefs to health and sexuality.

2.2 Attitudes, Values, Beliefs and Sexual Health Behaviour

The relationship between attitudes, beliefs and behaviour has been the object of study of social scientists for many years.

The origin of the idea of attitude goes back in the fourth century B.C. in Aristotle. His treatise on "Rhetoric" described the principles that generated persuasion- the ways people change others' attitudes (Brewer and Crano, 1994).

There is a number of definitions of what an attitude is. **Attitude** is "...a relatively stable tendency to respond consistently to particular people, objects or situations" (Roediger et al., 1984:587). Since attitudes are 'relatively stable', they may change. Moreover, one's own behaviour does not always

provide an indication of his/her attitude. An attitude must be towards something (Tannahill et al., 1990).

More specifically attitudes are based on three components:

a) A cognitive component concerned an individual's belief about the object or attitude. This belief may be biased, untrue or inaccurate.

b) An affective component concerned with feelings, likes and dislikes and emotions (Tannahill et al., 1990). For example, a young adolescent boy may believe that alcohol can damage his sexual health. Nevertheless, because of the enjoyment and the feeling he experiences, when drinking, he does continue to do so.

c) A conative component, which is the behavioural component of an attitude (Tannahill et al., 1990); it is the disposition or intention towards action (Fishbein and Ajzen, 1975).

Identification of attitudes may be carried out directly (by questioning) or indirectly (by behavioural observation) (Tannahill et al., 1990). However, the link between attitudes and behaviour is not automatic. As the La Piere study showed attitudes may not influence behaviour (Brehm and Kassin, 1996). Ajzen (1991), argued that attitudes influence behaviour through a process of deliberate decision making (theory of planned behaviour). Attitudes towards a specific behaviour or the expression of self combine subjective norms and perceived control to influence a person's intentions. These intentions guide but do not completely determine behaviour or how one expresses his/herself within a specific context such as sexuality. This theory has been used successfully to predict behaviour, such as using condoms, smoking, attending church, making moral and ethical decisions (Brehm and Kassin, 1996). Ethnic identity and acculturation influence attitudes (Gurung and Mehta, 2001) and therefore sexual behaviour and sexuality in general. American Indians with a strong cultural background and identity are more able to adapt in Western culture and not be threatened by it (Gloria and Kurpius, 2001).

Related to attitudes and influencing behaviour are values. **Values** are also expressed in behaviour based on beliefs about objects, persons or situations and are accompanied by feelings of approval or disapproval. For example, some people may judge that conduct likely to risk the spread of AIDS is wrong. Therefore, if one has a certain belief, he/she chooses one mode of behaviour than other and disapproves others who act differently. Values are preferences that express attitudes and affect attitudes (Tannahill et al., 1990). Schwartz (1992:2), defined values as "...concepts or beliefs that pertain to desirable end states or behaviours, that transcend specific situations, that guide selection or evaluation of behaviour and events and are ordered by relative importance". Therefore, values become an important issue in improving health, since health promotion is concerned with changing attitudes.

Rabinowitz and Valian (2000), reported that women's desire for older mates with high earning capacity and men's desire for younger mates (with good domestic skills) are based on the value individuals place on domestic work. These situations are moderately to strongly correlated with indices of gender equality in society. Social-role theory states that the division of labor by sex within a society drives mate preferences. In modern or equal societies women do not need rich and older men. It seems that there are also other social or cultural factors that a woman, in a modern society, may choose to do that so. Unmarried women (over 30 years old) may purposefully marry a much older man as to avoid gossip (for being an 'old-maid' or for different male friends) within a conservative society.

Values are shown by consistent patterns of behaviour. Once an individual is aware of one's values, they become an internal control of behaviour (Kozier et al. 1991).

Beliefs are formed from experience. They are judgments about truth or probability of propositions, which are statements of reality (Tannahill et al., 1990). They are based more on faith than on fact. Family traditions are beliefs

passed from one generation to another (Kozier et al., 1991). Thus people's beliefs may or may not be true. A strongly held, dogmatic belief and resistance to change may be harmful for one's health. In a study at Okanagan College in Canada, students refused the possibility to believe that AIDS may strike people like themselves. Most of them, whether monogamous or promiscuous believed their partners could not possibly be infected. This belief was not so realistic because they had reported high number of partners in their past (Netting, 1992). Moore et al. (1996), in their study showed that young teenage girls beliefs about contraception, before and after they became sexually active, influenced their intentions and eventual use of the pill. One's own religion, culture, taboos, fear of sexual activity and the personal meaning of sexuality may form these beliefs.

It has been also found that sexual self-beliefs are an important factor related to the virginity status, level of sexual risk-taking, numbers of sexual partners and casual sex (Rosenthal et al., 1999). Sexual self-beliefs "...examine individual's sexual perceptions of themselves with respect to physiology (arousal), the externalization of desire (exploration), interpersonal priorities (commitment) and reaction to sexual situations (anxiety)" (Rosenthal et al., 1999:322). Culture influences self-belief and belief system guides everyday behaviour. It is a usual phenomenon that people will hold a belief that is mainly convenient to them. Most of the smokers believe that smoking is harmful, but also believe that by continuing smoking would make no difference to their future experience of illness (Tannahill et al., 1990).

It is obvious that beliefs involve values, but not always though. Generally, attitudes offer justifications for feelings, give emotional meaning to beliefs and provide purpose for actions. Thus, attitudes, values and beliefs are influencing parameters in one's expressing his/her sexuality, preserving and promoting his/her own sexual health.

2.3 Culture and Health

The different cultures around the world have their beliefs about health, illness and healing. In everyday life health is so important and a great deal of human effort has gone into the creation and establishment of beliefs and practices concerning health (Weller and Baer, 2001). There is considerable evidence that culture is related to health status of individuals and communities. Some common factors that may be affected by culture are alcohol consumption, diet and sexuality (Triandis, 1994). In understanding health and illness in relation to culture, it is important to avoid 'victim-blaming'; meaning seeing culture as the only reason for people's poor health.

Health behaviour may be conscious or unconscious by an individual and is directly related to the individual's culture and meanings of health. Since cultural background has a significant influence on many (if not all) aspects of life, culture has important implications for health and health care (Helman, 1994). Thus, understanding culture is essential for explaining 'unhealthy' or risky behaviours such as smoking, unsafe sex and so on. However, what is important for one individual may not be important to another. There are differences among people's health beliefs and behaviours (Helman, 1994). Therefore, individuals or subcultures may need a different approach to health promotion, prevention and protection.

Worldwide, people have a variety of beliefs and practices used for promoting health, preventing and curing illness. Some of these have been proven to be helpful over the years, some are questionable or even harmful. In Latin America many people believed in the 'Hot-Cold Theory of Disease'. 'Hot and Cold' is used as a symbolic power contained in different substances, such as food, herbs etc. They believe that heat and cold should be in balance as to maintain health. For example, menstruation is considered to be a 'hot' state, thus is treated by the ingestion of 'cold' food, medicines or procedures. Some Latin American women may avoid some fruits and vegetables that are liable

to clot menstrual blood and this may cause deficiency in certain vitamins (Helman, 1994). The Chinese believe that health is a balance between negative and positive forces (yin and yang) (Kozier et al., 1991). The Cypriot monk Filaretos (1924), has written extensively about the healing procedures used in Cyprus such as the use of alcohol or dog milk in the ear to relieve pain and the drinking of parsley with vinegar to cure haemoptysis. Some of these remedies are still used today, mainly by older Cypriot people. Jews from ancient years practiced male circumcision for religious and hygienic reasons. In China acupuncture is a mode of treatment, in the United States the chiropractic approach is used for certain conditions such as headache and chronic pain (Helman, 1994), while other cultures may find these as inappropriate approaches to health and illness.

Although a variety of definitions for health have been described throughout the years (see chapter 1, section 1.2), culture is a parameter that should not be ignored. As discussed above, culturally constructed health and health beliefs result in a wide range of unique patterns in health seeking and maintenance behaviours in different societies; therefore, illness and health are directly related to culture (Torsch and Ma, 2000).

Although the importance of the cultural dimension of health has been recognized by a number of 19th and 20th century anthropologists and gained recognition amongst health professionals in the 20th century, the 21st century is posing even greater challenges to health policy makers and health providers. According to Papadopoulos (in Daly et al., 2002a), even though multicultural societies are becoming the norm this does not mean that all individuals within them enjoy equal and fair treatment, and have the human rights respected and protected. Probably one of the main challenges for health professionals is to become culturally competent in order to provide effective health care, which is culturally appropriate.

Within the health care system people from minority ethnic groups encounter in addition to cultural barriers, problems with racism, prejudice and discrimination. Therefore, may have poorer physical and mental health. Some barriers of the low use of mental health services are that minority groups are more likely to be mandated to mental health treatment, to receive severe and stigmatizing diagnoses, to be inappropriately diagnosed and to have less positive mental health outcomes. Moreover, cultural and linguistic mismatches may contribute to discrepant termination rates across groups. Compare with Whites, African Americans reported higher levels of negative attitudes, fear of hospitalization related to mental health services. Adding to these, sexual orientation is rarely addressed in African American reports in relation to the use of mental health services (Matthews and Hughes, 2001).

Culture is a complex and global variable that influences behaviour in a myriad ways. Greek-Cypriots living in Britain reported that one of the three most important reasons that cause them high level of stress is family. Greek-Cypriot parents expect to care for their children, who will stay with them until they are married. This is unlike the accepted or even expected practice within the indigenous population (Papadopoulos, in Papadopoulos et al., 1998). Advantages or disadvantages of such attitude or practice will not be discussed here, but it is obvious that this can have an impact on one's health. Nevertheless, this is a culturally 'appropriate' behaviour.

Drinking or even drunkenness are good-naturedly tolerated and somehow accepted by Japanese people. Intoxication allows them to express freely, without any fear of repercussion (Gannon, 2001). On the other hand, most -if not all- of the countries have restrictions about alcohol use. The Japanese behaviour could be harmful not only for themselves at long-term, but short-term to others (e.g. accidents, violence) as well.



Individuals in each community share and are subject to cultural values that have been adapted to their specific community, using multiple strategies to adopt their health status, limitations and capabilities to their settings (Torsch and Ma, 2000). Caplan (1993), mentioned that a quite large proportion of Mathare, Kenyan women (20% of 63 women) reported that sex is needed to keep them healthy. In Kikuyu society there is no word for celibacy or orgasm. Abstention from sex is physical and psychological impossibility. However, this attitude and behaviour exposes people to Sexually Transmitted Infections (STI's) and HIV/AIDS, particularly when sexual intercourse takes place without the use of condoms.

Traditions, cultural practices and other factors influence a community's absorption of health knowledge. People will not accept modern knowledge unless those offering it show an understanding of local knowledge and sensitivity to their cultural norms. Therefore, an integration of modern and traditional practices may improve public health, by increasing the acceptability of modern health related knowledge and harnessing the curative power of traditional knowledge (WHO, 2000). These are not easy to apply especially in certain deep-rooted sensitive beliefs, cultural norms and practices, such as female genital mutilation.

Cultural idiosyncrasy of a country is reflected in its system of health and the promotion of health practices. When someone is hospitalized in Cyprus, frequent and large family visitations are expected, while for White Americans individual visitations normally occur. Furthermore, cultural systems have the capacity to shape health perceptions and behaviours (Torsch and Ma, 2000). Kotchich et al. (2001), mentioned that Black female adolescents are more likely to report having multiple partners than White or Latina adolescents, among teenagers who were either currently pregnant or had already children (in U.S.A.).

Mass media play an important role on culture. It projects people's desires, dreams or needs. Media enables the development of diffuse and ambiguous lifestyles and images; youth, beauty, fitness, luxury (Featherstone, in Featherstone et al., 1993). Messages and more specific health messages need to be clear and directed at achieving better health status (Lupton, 1994). Advertisements use symbols and metaphors to link a meaningless product with desirable cultural values. For example, a soft drink advertisement, which uses young attractive people pass on the value of youth and sexual attractiveness. When such advertisements are used on a global scale, as in this case, they have the power to influence the development of universal cultural values. Research indicates that ethnicity plays an important role in media viewing choices. Young African Americans spend more time watching television than White youths. The fundamental notion is that the greater the exposure in the media, the greater the possibility that young people will adopt the values, beliefs and behaviours that are portrayed (Gruber and Grube, 2000). Repetitive advertisements, for example, such as luxurious cars showing the easiness of sexual attractiveness or easiness to have sex, is challenging for youth. These advertisements 'sell' in addition to the products they promote attitudes, beliefs and behaviours. These may have an adverse effect on one's health. However, mass media such as television also delivers a variety of programmes in people's homes. Many young people may become familiar with abortion, divorce, prostitution and sex through television. Creatsas (1993) suggested that media can have a positive influence on teenage attitudes, when they watch informative programmes on sexual or any other health issue.

As human societies persist with their complexity modes and meanings of social interaction exist together. Modes of social interaction include concepts (such as norm, role), which call one's attention to the pattern of behaviour that societal members follow and the society's expectations that others should follow these patterns (Luhman, 1989). For example, playing the role of

a married woman it is 'normally' expected to bare children. Meanings of social interaction include cultural elements (e.g. values, knowledge), that direct one's attention to the thoughts that societal members have about their behaviours and the reasons one develops for following them (Luhman, 1989). Therefore, health-related attitudes, values and beliefs are products of social interaction. The avoidance of undertaking the analysis of cultural process may serve as a limitation in some health promotion/ education approaches (e.g. behavioural change model). Health promotion takes place within a culture. There is also an increased recognition of significant role of the social and cultural variables in explaining the adoption of new behaviours and lifestyles (Bunton et al., 1991). The identification and knowledge of one's own socio-cultural practices and beliefs are probably the initial steps in understanding the role of health promotion within everyday culture.

Each person brings to the health care environment a heritage of customs, beliefs, traditions, religious rituals and habits that gives a portrait of one's own identity, individuality and personality (Flarey, 1999). Thus, health promoters, health professionals and educators should consider culture as a vital variable for an effective and efficient promotion of health.

2.4 Culture, Sexuality and Adolescents

For many generations, all over the world, sexuality was largely ignored or it was assumed that all sexuality was covered by the facts of marriage and procreation. Homosexuality was mainly addressed in negative or pejorative terms. Differences between genders, and sexual relations were not so much discussed, until recent years, when the HIV/AIDS epidemic intruded in thousands of people's lives-mainly young people. Moreover, culture was considered as an irrelevant issue in relation to adolescent sexual health or even more generally in relation to sexuality. There is no doubt that taboos on sex in society and science are to blame for this history (Herdt, 1999).

According to Triandis (1994:1) "...culture is to society what memory is to individuals", underlying the power that culture has on the individual. Memory often influences present feelings, attitudes, beliefs and thus behaviour. This is crucial during adolescence, where there is ambivalence and experimentation about one's own personal identity. Since the concept of culture suggests that members of social groups share common norms, values and ways of interpreting the world around them, therefore how one sees oneself (his/her identity), can only be understood in relation to culture (Taylor, 1997). Consequently, there is an important relationship between cultural identity and adolescents. Identity provides a link between one's inner sense of self and the place one occupies in social and cultural world (e.g. within family, workplace) (Taylor, 1997). Interaction with other people, socialization and learning of one's own culture are vital to the formation of identity. Adolescent's sense of cultural identity includes "...race, ethnicity, language and nationality. It is also defined by the groups of people with whom the adolescent shares values, norms, traditions and customs" (WHO, 1999:135).

Adolescence is "...a period of turbulent transformation from childhood to adulthood, where youth undergoes many physical, emotional, cognitive and

psychological changes. It is also a period of experimentation that can involve risk taking" (American Medical Association, 1995:3). However, in order to have a holistic view of adolescence, one must look at it from different perspectives: biological, cognitive and psychosociocultural. Physical changes are more or less obvious and are taken in consideration during puberty, while psychosocial transformations often need more meticulous attention. The emotions of oneself, the development of self-esteem, identity, sexuality and interpersonal relationships are some of the things that adolescents experience. Society, culture and subculture are significant parameters that influence adolescents regarding these challenges or transformations. Although cultural boundaries separating youth from children or from adults are not so clear, adolescents are considered to be the young people between the ages 13-19. The experience of being young is universal, but it takes many different forms- cultural, political, personal. People negotiate cultural processes that are formed by them to some extent. When these cultural processes are formed by young people, this is youth culture. This is a diversified, complex phenomenon (Talai and Wulff, 1995) but a common one. Adolescents many times create their own language, code of communication or dressing. As they try to pass through the childhood-adolescence process, they analyse and challenge their home culture, creating their own, autonomous and unique youth culture.

There are several factors that influence adolescents' attitudes, beliefs and behaviour such as family, culture, religion, race, peer groups. These may have an impact on adolescents' sexual and reproductive health. Adolescents develop subcultures with their own language, styles and value system that are not necessarily approved by adults, but by peers. Adolescents whose peers reported to engage in risk-taking behaviours were more likely to engage in risky sexual behaviours (Scaffa, in Henderson et al., 1998). In contrast to that, there is a view that adolescents reflect adult values beliefs and practices (Rice, 1996) and this is understandable. Adults- parents, family,

adult friends or popular persons- are the role models of young people. They can be either positive or negative role models.

Different studies showed that parents might play a significant role in sexual development, particularly knowledge and attitudes. However, it is difficult to determine which parent factors have the greatest impact and what are the implications of the timing of communication (Somers and Paulson, 2000). In contrast to these, other studies indicated no relation between parental communication on sexuality and adolescent sexuality (Miller and Fox, 1987). In Somers and Paulson study (2000), that was done among adolescents from two suburban high schools in the Midwest (U.S.A.), it was found that younger age and less parental communication were related to less sexual behaviour and knowledge. In the same study it was also found that being younger and female and receiving less maternal communication was related to less sexual behaviour and more conservative attitudes. One may conclude from these findings that parent-adolescent communication about sexuality issues has an impact on adolescent sexuality, since greater parental communication leads to greater sexual knowledge. However, gender differences exist among these relations.

Even though literature suggests that adolescents report wanting to receive information from their parents and parents wanting to provide information, some studies found that only a small percentage have had such interactions with their parents (White and De Blassie, 1992). Furthermore, the stereotype that adolescents (as a group) are in a mass rebellion against their parents and parental values is simply not true (Rice, 1996). Undoubtedly, adolescence is a time that children try to consolidate their independence (Rice, 1996), but this is an essential process of becoming a mature adult.

Parents within their own culture, taboos, knowledge and ignorance may often avoid not discuss sexuality issues with their children. Even when they do, they may usually talk about the biological aspects of a subject such as the

physiology of menstruation. In a telephone survey, among Latino adults living in the United States, more than half of the respondents reported that their mothers had never spoken to them about sex and 58% of men and 82% of women said that their fathers had never spoken to them about sex during youth (Gomez, 1995). This finding is of concern because according to Villarruel (1998), parental communication is a major mean for the transmission of cultural values and probably the most effective one. There is no doubt, that parents are the first to 'implant' values, attitudes and beliefs in their children. Cultural environment, including school and peers, will cultivate and influence this base in a positive or negative form. The influence of the cultural environment naturally extends to matters of sexual health.

Adolescents may feel part of their parents' culture, but they may also feel part of a youth or several youth cultures (WHO, 1999).

It is interesting that American adolescents, whose parents reported to have higher educational attainment, were less likely to ever be engaged in sexual intercourse (Santelli et al., 2000). This may suggest that more educated parents communicate with and transmit more or better quality of knowledge to adolescents. Knowledge can influence values, behaviour or cultural practices within a family. Ignorance of damaging health behaviour, with the lack of insight, stands in the way of providing adolescents with greater opportunity for a healthy behaviour (WHO, 1995).

In spite of this, parental communication about sexuality does not appear to be a sufficient factor to explain adolescents' individual differences in sexual development (Somers and Paulson, 2000). Dilorio et al. (2000) suggested that family based programmes will provide the opportunity for the parents to be able to feel confident that information and knowledge provided to their children are correct and appropriate. Health messages, especially those related to sexuality, are challenging and not easy to be followed by adolescents, but once adopted, they can provide a better quality of life.

For adolescents sexual activity is more than a biological need. It is a key marker to adulthood. In addition, for many young people sexual choice symbolizes the freedom to experiment. Sexual decisions are filtered through at least three culturally determined factors: the meaning of sexuality, the process of male-female negotiations and youths' perceptions of danger (Netting, 1992). In all societies there is a meaning of particular sexual behaviour. What messages each society passes through its people and how people interpret them are mainly products of culture. This implies that parameters that have a strong relation with culture, such as religion, play a significant role in adolescents' sexual behaviour. For example, if monogamy is of high value, within a culture, then an important percentage of its people will probably adopt this. In addition to this, there is evidence that cultural stereotypes and religious taboos influence the age and the reason for initiation of sexual activity (HEA, 1998).

It is also understandable that the meanings of being male or female and therefore, the behaviour of adolescents are influenced by what is considered as 'appropriate' or 'acceptable' in a particular culture. Moreover, youth perception of danger is often minimal. The cultural ideal of youthful sexuality as spontaneous, joyful and loving (Netting, 1992), acts as a 'safety curtain' to ignore possible danger. For example, many young people believe that nothing can happen to them such as HIV/AIDS or STI's. The idea of immortality that youth culture holds in a society can somehow put aside such obvious dangers as mentioned above. In combination with these, personal identity is a factor that can influence one's decisions regarding sexuality matters. Understanding one's culture is an essential part of personal development and personal identity (WHO, 1999). This also enables adolescents to have a better understanding and respect of cultural differences that may exist among other adolescent groups. Therefore, young people can be more respectful and supportive to alternative approaches on sexuality issues. Adolescents themselves may be able to contribute to the promotion of a better adolescent sexual health. No matter how important

culture and cultural differences seem to be in adolescent sexual health, this remains the most neglected area (WHO, 1999).

Data from Youth Risk Behaviour Survey indicated that Latino adolescents were less likely than African American or White adolescents to report condom use or any other contraceptive method the last time they engaged in sexual intercourse (Villarruel, 1998). Religion and gender roles have been linked with sexual behaviours among Latinos. For example, the cultural values and expectations of the female role, the cultural imperative to be a mother have been associated with positive views of pregnancy and childbearing (Villarruel, 1998). Thus, culturally appropriate behavioural interventions enhance the acceptability and effectiveness of intervention to diverse groups (Villaruel, 1995 ; Jemmott and Jones, 1993). In America, gonorrhoea rates are 31 times higher among Black than among White adolescents. Birth rates at the ages 15-17 are 3.2 times higher among Blacks than among Non-Hispanic Whites (Santelli et al., 2000). Naturally these statistics should not only be explained in terms of culture but also in terms of other important socio-economic and political factors. However, as mentioned previously, many minority cultural groups suffer disproportionate levels of poverty and discrimination, both which may be considered as products of the majority culture. There is mounting evidence which links in health to poverty, something that may provide an alternative explanation of the higher level of gonorrhoea and adolescent pregnancy amongst the American Blacks.

Sexual life has private and public manifestations- according to one's own culture. In most American and European countries, kissing and flirting in public are socially acceptable whilst premarital sex is also accepted by many cultural groups in these countries. In other countries, such as Saudi Arabia, these activities are still a taboo (Kottak and Kozaitis, 1999); probably religion influences the acceptability of such practices. For example, the Greek

Orthodox Christianity prohibits premarital sex, even though the Greek society tolerates this for boys but forbidden for girls (Elphis, 1987).

Religion is an important part of culture. However, in most societies there may be differences between religious and cultural values. Each culture has customs or cultural norms related to sexuality that may relate to religion but may not be inherently religious. Personal interpretation of any faith may vary from the most liberal to the most traditional. In North America monogamy is a cultural ideal (Kottak and Kozaitis, 1999), while in Saudi Arabia polygamy is a cultural norm. Furthermore, birth control for Buddhists by means of contraception is not ordinarily a problem. In Islam, Christian Orthodoxy and Catholicism premarital sex is prohibited (FPA, 1997a). In Jewish law, a man cannot use any form of contraception. However, it is assumed that women may do so (Chambers et al., 2001). According to (Chambers et al., 2001; Qureshi, 2001), in Hinduism, a male doctor cannot insert to a female a diaphragm or an Intra Uterine Device (I.U.D.) with his right hand. The right hand is reserved for eating food, shaking hands or counting money. Therefore, even though these methods of contraception are acceptable by Hindu women and they may be suitable and effective contraceptive ways, many women may be denied access to them due to lack of alternatives to right handed male doctors, in other words female doctors or left handed male doctors.

In Catholicism there is the belief that masturbation is something bad and something to feel guilty about. A number of studies reported that young people (15-19) whose religion was important to them and attended church frequently were less likely to report having sexual intercourse during adolescence (Rosenthal et al., 1999 ; Gunatilake, in Henderson et al., 1998). In Nettings' research on young Canadian students (1992), 29.6% reported religion as the main reason for celibacy. Savona-Ventura (1995) reported that the Maltese Catholic church objected to the health authorities, about the

promotion and use of barrier methods of contraception, even though the AIDS epidemic is still a major health danger. The church also objected to sterilization as a method of contraception. In contrast a research study among Nigerian secondary school students found that religious affiliations did not appear to play a role in their level of sexual activity (Amazino et al., 1997). The hypothesis that some religions may be less restrictive and more permissive on sexuality or sexual activity than others needs much more investigation.

Pregnancy in adolescence is frequently unwanted (Jejeebhoy, 2000). Most of the times contraception is not used due to several reasons, such as lack of knowledge, religion or lack of money. For some adolescent girls unwanted pregnancy precipitates marriage and for some may result in abortion. Few of them may become teenage mothers. About 12% of all Colombian adolescents had experienced abortion. In Cuba, 21% of 13-19 year old girls reported to have had an abortion during the last twelve months (Jejeebhoy, 1999). The fear of stigmatization and ostracism may lead to clandestine sexual liaisons. In China, unmarried women are 'ashamed' to purchase contraceptives due to the risk of disclosure. In many countries pregnant adolescents are expelled from schools (Jejeebhoy, 1999). Some adolescent girls may try to self induce abortion due to the fear of consequences of socio-cultural 'inappropriate behaviour'. Data from several studies worldwide show a higher risk of maternal death among teenage girls compared with women aged 20-24 years (WHO, 1993) In Jamaica and Nigeria pregnant girls under 15 are four to five times more likely to die during pregnancy and childbirth than those aged 15-19. Common complication of early childbearing include hypertention leading to eclampsia, obstructed labour (especially if pregnancy occurs soon after menarche), vesicovaginal or rectovaginal fistula may follow obstructed labour, low birth weight etc (WHO, 1993). These complications are all life threatening.

Another cultural sexuality issue, which is relevant to pre-adolescents and adolescents, is that of female genital mutilation. In several countries, such as Middle East and Africa, girls are subjected to female genital mutilation. Over a 100 million of women alive today have been affected by this, which may have immediate and long-term effects on reproductive and general health, such as infections, haemorrhage, sterility, difficult menstruation and coitus and psychological problems (IPPF, 1994). According to Alan Guttmacher Institute (1998a), 87.3% of young girls aged 15-19 in Sudan and Mali and 36% of those in Central African Republic and in Cote d'Ivoire have had female genital mutilation. The girls have little or no choice undergoing this procedure. In Egypt about three fifths of women that have undergone this experience in adolescence, intended to perform or had already performed female genital mutilation to their daughters (Jejeebhoy, 1999). Egyptian women may be 'trapped' within their own culture and may feel powerless to rebel against a practice, which many would consider unnecessary and inhumane. This confirms the concept of culture (Leininger 1995; Helman, 1994) as a set of guidelines that one inherits and transmits from generation to generation. Literature reveals arguments that circumcision is relatively advantageous to women as a form of birth control. There is no evidence though that limiting the number of one's own children is its actual purpose. Paradoxically, many of these girls and women have been six or seven times pregnant and most of these pregnancies tend to be miscarriages or stillborn infants (Boddy, in Lancaster and Di Leonardo, 1997). Female genital mutilation is part of traditional cultural practice. It is a way of life. In these cultures it is believed that female genital mutilation will prevent girls from having premarital sex and thus ensuring marriageability (Haddad, 1993). Arguably, it is challenging to find any rational reason for female genital mutilation.

Another important aspect of sexuality, which needs to be considered in cultural terms, is that of sexual orientation. Historically and cross-culturally sexual behaviour reflects sociopolitical and economic conditions. In classical Athens, there were homosexual unions between elite men, including teachers and students and this was viewed as an acceptable behaviour (Kottak and Kozaitis, 1999). The great Hindu sage Vatsyayana wrote and illustrated the Kama Sutra, celebrating sexual expression and sexual diversity without shame (Pratt, in Wilson and Mc Andrew, 2000). Some societies continue to practice and accept sexual diversity. For example, Dahomey girls of West Africa are prepared for marriage by having homosexual relations with older women (Kottak and Kozaitis, 1999). In New Guinea, as mentioned previously, homosexual relations are somehow obligatory for boys (Kottak and Kozaitis, 1999 ; Triandis, 1994).

Nevertheless, sexual diversity is a taboo in many communities all over the world. Some cultures are strongly 'gender-polarized' and hold highly traditional ideologies. They strongly differentiate roles for boys and girls, men and women. Thus, sexual orientation is directly linked to cultural definitions of masculinity and femininity in most, if not all, cultures (Lippa and Tan, 2001).

In Britain homosexuality was a criminal offence until 1967 and was also listed as a mental disorder until the late 70's. Comparisons between different cultures showed that there is no universal consensus about normal sexual behaviour (Green and Tones, in Wilson and Mc Andrew, 2000). Cross-cultural studies underlined that non-Western societies may recognize same sex activities as integral and necessary to the overall social structure (Herdt, 1997).

Cultural codes of sexual expression dictate whether an act is legal, normal, deviant or pathological (Kottak and Kozaitis, 1999). It is obvious that some forms of sexual expression are valued more in some cultures than in others. This affects sexual health as well as self-esteem and self-awareness. It also influences the communication between partners and health professionals

about one's own sexuality, sexual preferences or practices (Wilson and Mc Andrew, 2000). This is even more significant for adolescents. During their experimentation, ambivalence and search for their sexual identity, their self-esteem and self-awareness are challenged.

Adolescents have the highest risk for many negative health consequences related to sexual risk taking behaviour, including HIV/AIDS, Sexually Transmitted Infections and unwanted pregnancies (Kotchick et al., 2001).

Adolescents' sexual health problems may not be able to be eradicated but they can definitely be reduced. No country can claim that had managed to maintain the sexual activities of adolescents planned or safe from health complications (Jejeebhoy, 1999). There is no doubt that age, race, ethnicity and culture are determinants of one's own health behaviour. The enhancement of transcultural concepts seems to be of immediate need. Cultural and social beliefs affect the individual attitudes, behaviour and beliefs (Papadopoulos and Alleyne, in Papadopoulos et al., 1998). Therefore, a culturally sensitive sex education is of an obvious need (Ip et al., 2001). Any programme aimed at people's health should be culturally sensitive and appropriate and delivered by culturally competence health professionals (Papadopoulos, in Daly et al., 2002a).

Every person deserves a unique, holistic, equal and culturally sensitive health care. This not only shows respect to the diversity of cultures and the individual but it also makes sense.

Summary

Culture, as discussed in this chapter, is an inseparable part of health. One can not understand human sexuality without exploring its relation with culture and its components such as gender (see chapter 3). A holistic comprehension of adolescent sexuality it is likely to view sexuality within everyday culture and how culture influences the expression of sexuality and promotion of sexual health.

Introduction

As previously discussed, adolescents' sexual attitudes and behaviour are influenced by socio-cultural factors and norms. Gender as a social norm affects behaviour within one's own culture. Therefore, it is essential to explore the concept of gender and its association with culture and sexuality (especially adolescent sexuality).

3.1 Gender Versus Sex

Sex and gender are terms whose usage and analytical relations are almost irremediably slippery. Some use these terms interchangeably, whereas others highlight their differences.

Sex refers mainly to the biological categories of male and female. Of course sex is used to designate aspects of sexual behaviour. For most people biological sex is determined "...whether an egg is fertilized by an X or Y bearing sperm" (Crawford and Unger, 2000:151). This is thought to include marked dimorphisms of genital formation, fat distribution, hormonal function, reproductive capacity etc. (Kosofsky-Sedgwick, in During, 1993). In other words, sex denotes "...objective biological capacities and constraints of physical organism" (Wilson, 2000:2998).

Doyle and Paludi (1998:5), argued that biological sex is "...a continuum where reproductive structures, hormones and physical features range somewhere between two end points and not one of two strictly separate biological categories". It was also found that there is no one biological characteristic that always determines sex. The authors continue to argue that androgens, estrogens and progesterone are referred as 'male or female hormones'. In fact all of them are in one's bloodstream. Therefore, an

individual's sex is not determined by the kinds of hormone he/she has, but by the amounts of them.

Sex-differences refer to the biological properties of individuals and are sought among specific biological characteristics or assumed to be known. It is not considered that they need social scientific explanation (Hess and Ferree, 1987). Sexual differences should also be understood as a mode of discourse, one in which groups of social subjects are defined as having different sexual/biological constitutions. "One's sex is genetically determined and biologically maintained anatomy and physiology. One's gender is the enactment of sexual identity in response to socio-cultural learning" (Alt, 2001:9). Sex or chromosomal sex (as seen by some researchers) may be viewed as the relatively minimal raw material in which social construction of gender is based (Kosofsky-Sedgwick, in During, 1993). 'Gender' and 'sex' can be analyzed as modes of discourse but with different agendas" (Yuval-Davis, 1997:9).

Gender is seen as a principle of organizing social arrangements, behaviour and even cognition. One of the central elements in gender systems is the taboo against the sameness of male and female (Hess and Ferree, 1987). Gender denotes subjective features of socio-cultural roles acquired in specific cultural and social milieux (Wilson, 2000; Caplan, 1993).

Gender should be thought of as independent of a person's biological sex (Doyle and Paludi, 1998). Whatever the biological predispositions, people shape gender differences through a complex set of forces. It depends on childhood socialization and structural constraints, such as status or wealth. Therefore, gender is created through everyday interactions within specific historical, social and political configurations (Messner, 2000).

3.2 Gender and its Components

Components of gender include- gender roles, stereotypes, gender norms, gender role identity and vary along a continuum of femininity and masculinity. Gender should be understood "...not as a 'real' social difference between women and men, but as a mode of discourse which relates to groups of subjects whose social roles are defined by their sexual/biological difference as opposed to their economic positions or their memberships in ethnic and racial collectivities" (Yuval-Davis, 1999:9). The concept of gender can be analyzed and rationalized as an entity in itself. Thus, it means much more than 'social differences' between men and women. However, by each gender comprehending their differences, it results in an understanding of their similarities; their needs and capacities for change (Rhode, 1997).

Gender differences can be explained through socialization, gender identity construction, as well as existing power inequalities between men and women (Bergman and Scott, 2001). With the customary norms of everyday behaviour young women and men are helped in different situations. For example, men may receive service priority in department store, whereas women are offered helped for a flat tire. Men usually do not help more than women, when the situation called for empathy and social support (Crawford and Unger, 2000). Somehow society and culture construct the abilities and roles of each gender. Culture as a set of guidelines that are shared and learned from one generation to another (Leininger 1995; Helman, 1994) may guide individuals to adopt given roles. However, these roles may not respond to reality. In some societies differentiation of roles or discrimination begins from birth. If a boy is born there is general rejoicing, whereas if a girl is born, gloom descends on the household (UNPF, 1996). The colours that boys and girls are dressed, the rewards and punishments for each gender are learned within everyday culture also from birth.

Gender differences and behaviour might be related to the 'masculine' or 'feminine' culture one is raised and lived (or still lives). In masculine cultures (e.g. Japan, Austria), emphasis is given on occupational achievements, while in feminine cultures (e.g. Sweden), cooperation with co-workers and job security are valued (Costa et al., 2001). For example, fathers in masculine cultures deal with facts and mothers with feelings, whereas both of them deal with feelings in feminine cultures. In 'feminine' cultures gender relations seem to be more harmonious than 'masculine' ones (Costa et al., 2001). Thus, it can be assumed that sexual relations are more balanced. According to Walby (1990), masculinity entails assertiveness, being active, lively and quick to take the initiative, while femininity entails cooperativeness, passivity, gentleness and emotionality. It may be debatable whether 'masculine' and 'feminine' cultures can be classified. May be this can also creates sexism and gender inequalities. Whatever the case, culture does have an impact on the development of gender-role, gender differences as well as one's personal identity.

Most gender differences resulting from adoption of gender roles, define what is appropriate for men and women (Costa et al., 2001). *Gender roles* are learned through observations. For example, girls who watch their mother's domestic works are likely to pick up similar messages. It is important from young age to recognize stereotypical images and cross gender boundaries. This will allow young people to develop their full potential (Rhode, 1997). Most parents do not consciously encourage gender stereotypes or roles. Culture may influence though some parents more than others, thus to deliberately try and introduce specific gender roles (Rhode, 1997). Undoubtedly, parental support is a key factor that enables a boy or a girl to achieve or do whatever they want to do or achieve or are capable to do (e.g. girls success in science class).

One may argue, that today gender roles are going through changes (e.g. males are more involved with housework), but somehow many times gender stereotypes are still projected within a society in a variety of ways. Throughout the years, *mass media* presented women's physical external charismas or beauty and rarely their professional, spiritual, political or societal role. Playboy magazine published in 1953, promoted pleasures of being a male and blamed women for enslaving men. Arguably, these are reflections of social values, but at the same time they shape values. VandeBerg and Streckfuss (1992), analyzing prime-time television programme episodes found that representation of male to female characters were 2:1. Working women were less likely to portrayed as decision makers, assertive, socially and economically productive. Women in management positions presented that they inherited those from spouse or relatives. Men portrayed mainly as powerful, tough, aggressive and competitive. In United States when birth control pill was approved, a great deal of media discussion was provoked undermining the ideology of motherhood (Staggenborg, 1998).

Cultural phenomena such as television reflect and influence public sentiments about the changing roles of men and women (Staggenborg, 1998). Different movies, songs, famous persons have passed through the years their messages: From the tough masculinity of John Wayne and Elvis Presley who focused on teenage girls, to the 'Breakfast at Tiffany's' featuring new female styling and 'Thelma and Louise' showing the female abuse (rape) and rebelliousness. Although women's passive role has declined over the years, still women are more frequently presented in depicting more passive roles than men. Women in many advertisements are presented as glamorous, young and sexy figures. Adding to this, music videos are the most sexist media in representing women; 78% of the performers are male (Crawford and Unger, 2000). Since socialization also occurs outside family, media have a significant role in promoting specific characteristics of gender roles. For example, 'Marlboro' advertisements for years are presenting the Western

cowboy image, projecting masculinity, independence and power. For Americans, 'Marlboro man' even became a cultural symbol (Keller, in Dines and Humez, 1995). One may argue that 'Virginia Slims' cigarettes project a female gender role. Even if one analyzes the name Virginia- a female erotic name throughout the history and Slim- slimness that is associated with femininity, it reinforces a female gender role. It also builds up an image of beauty and sexuality. There are also 'male' and 'female' magazines such as 'Man', 'Good housekeeping', 'Cosmopolitan', 'She'. Arguably, it may be more practical or marketable to buy a magazine that both genders can find interesting things to read. It seems doubtful that reading a single-gendered magazine is more fulfilling for one's needs. Many people though may find those magazines closer to their gender image, more fulfilling. Furthermore, in advertisements in different magazines (such as Vogue or McCalls) an important 40% are depicting women as sex objects (Crawford and Unger, 2000). A recent Coca Cola commercial showed women's buttocks while working in constructions. The young men were shown to enjoy the scene having their Coca Cola drink. Several advertisements used women's body (part of it or all) to promote a particular product that usually has nothing to do with the actual product that is advertised.

Despite the influence of mass media on gender roles, Crawford and Unger (2000) suggested that more and more young people challenge traditional gender roles, which is leading towards a greater flexibility. They proposed that information and knowledge, personal and gender beliefs and attitudes shape the degree of media influence to one's own ideology.

Arguably, different forms of gender roles exist due to the diversity in gender relations and expectations consequent upon age, class, ethnicity and religion. In countries where economic development occurred and more women became employed outside home (e.g. U.S.A.), gender role ideology became more liberal (Burn, 1996). The issue of equality is still a huge debate. On one hand, many believe that women are homemakers and that is their place.

However, if all women have chosen to follow this concept, then women would never equal men in political and economic power (Staggenborg, 1998). Within a democratic society genders are expected to have equal rights. Some women choose to support feminist views (e.g. reproductive rights) and some do not; some will become political activists and some women will choose to stay at home. Although improvements have been made, there is still space for more. Nowadays, it is more common for women to choose to work outside the home and for young men being much more involved in household tasks. There is evidence though, that women still assume two-third of the domestic work (Rhode, 1997). Although this may differ from culture to culture, the current position of women in many societies is becoming more equal to men than in previous periods.

Whether gender roles are purely cultural creations or reflect preexisting and natural differences between the sexes inabilities and predisposition, is a controversial issue (Geary, 1999 ; Eagly, 1995). Some can argue that what each gender reflects is what it is in its nature. That is how was created and probably it will not change (Yuval-Davis, 1997). Biological theorists consider differences due to natural selection (Costa et al., 2001). Social psychologists believe that gender roles are shared expectations of men's and women's attributes and social behaviour and these are internalized from childhood. Other researchers accept the fact that people naturally have some gender characteristics, but how they are constructed, formed and appeared are due to cultural interactions (Costa et al., 2001).

Another component of gender is that of stereotypes. Walter Lippman noted in 1922, that *stereotypes* are "...culturally determined pictures that intrude between an individual's cognitive facilities and his/her perception of the world" (Crawford and Unger, 2000:37). It may also include the different characteristics that one possesses from birth and through the socialization process (Wilson, 1995). Furthermore, stereotypes are "...generalized beliefs

about what members of an identifiable group are like and operate as schemas, when people perceiving those groups" thus, they influence perception and memory (Burn, 1996:111). All these imply that stereotypes are created and reinforced by the way that one understands the world, which is mainly influenced by one's own cultural background. Whenever individuals are classified by others as having a particular similarity due to the fact that they are members of a specific group or category of people, stereotypes are likely to occur (Crawford and Unger, 2000). This can be unfair or unequal to most people. It can even become a racist characteristic and therefore it may distort reality. Costa et al. (2001) found that gender stereotypes were more differentiated in Western, individualistic cultures.

Stereotypes seemed to be more like forms of social consensus rather than individual attitudes (Crawford and Unger, 2000). Individual beliefs are not the same as stereotypes. For example, one may believe that because a woman wears a very short skirt that she has poor intellectual abilities. This is probably one's own opinion and perception and represents some of the women that he/she knows. There is no evidence to support that there is a relationship between short-skirts or clothing and intellectual abilities. Usually stereotypes lack of variability-most of the people choose a particular characteristic of a young group such as many believe that men are more competent in mathematics than women. This belief may influence one's own ability in mathematics. Stereotypes about males and females appear to consist in virtually all aspects of human beings (Crawford and Unger, 2000). Since gender affects perception (Burn, 1996) gender role stereotypes exist like other stereotypes. Certain role behaviours, such as being the main provider or cooking the meals or even certain occupations (e.g. secretary or taxi-driver), are associated with the male or female roles. Despite that, these examples are seen and lived during everyday life, the ideas/concepts that exist and their interrelationships affect one's perception on gender roles. "Stereotyping involves making value judgments rather than seeing realistic expectations" (Charon, 1989:202). For example, being a teacher is

anticipated to meet the expectations of a teacher position, but if one believes that all teachers are over-demanding of or punishing the children this can be stereotyping.

If one goes to a toy store, it will be clear which toys are intended for boys (e.g. cars, building tools) or girls (e.g. dolls, coffee set), but rarely for both (Burn, 1996). Gender segregation serves to reinforce gender stereotypes throughout childhood. Boys celebrate heroism, dominance, competitive activities and aggression and girls romanticism, domesticity and personal appearance activities (Rhode, 1997).

Continuous emphasis on gender differences can prevent people from seeing gender similarities. Work/occupation is often a debate associated with gender stereotypes or inequalities. Fathers who are devoted to their careers are viewed as 'good providers', while women are viewed as selfish (Rhode, 1997). In addition to this, many women may sacrifice their own career for their families or for their partner's or husband's career and most of the time no one notices.

Yuval-Davis (1997), argued that women's oppression is endemic and integral to social relations with regard to the distribution of power and material resources in the society. However the notion of 'patriarchy' is highly problematic. According to Walby (1990:20), patriarchy is viewed as "...a system of social structures and practices in which men dominate, oppress and exploit women". Walby clearly explains that she rejects the notion that every man is in dominant position or that every woman is in a subordinate position. It is also important to note that Walby highlighted different structures of patriarchy operating within different domains such as employment, culture, sexuality, violence etc. In contemporary societies gender relations have somehow changed but still need to be improved. Therefore, gender relations (including sex and gender differences) need to be seriously considered in promoting a better understanding of sexuality, culture and promotion of

health. Gender relations are at the heart of cultural constructions of social identities and collectivities as well as in most cultural conflicts and contestations (Yuval-Davis, 1997).

Within multicultural and democratic societies it is obvious that emphasis should also be given in variations in culture, class, race, ethnicity, age and sexual orientation (Rhode, 1997).



3.3 Gender, Culture and Sexuality

Gender is a cultural construct (Caplan, 1993). It detaches the social construction of sexual identities from the 'real' biological differences of sex. Cultures or societies use social categories as explanatory mechanisms of, and a means to social injustice. For example, the United States culture employs categories such as 'gender' or 'race' to privilege or restrict access to important cultural resources and opportunities (e.g. cultural authorities, jobs) and this conception might be analogous to the way of thinking of culture as a 'thing' (Allen, 1996). These categories can influence the way one thinks for him/her self and others.

Sexuality is produced and maintained within gender relations. Sexuality and gender are separate organizing features of social relations but intersect by mutually reinforcing, naturalizing and constituting each other (Schipper, 2000). Sexuality generates wider social relations and is refracted through the prism of society. Sexual feeling and activities express all the contradictions of power relations- of gender, class and race (Ross and Rapp, in Lancaster and Di Leonardo, 1997).

Cross-cultural studies showed that there are similarities in gender roles (and in relation to sexuality) among the different cultures (Burn, 1996), but still they can vary in the way that these similarities are viewed. However, it is difficult to determine whether similarities are indicative of evolutionary factors or whether they reflect common practices or solutions that humans use in a particular culture (Burn, 1996).

According to Williams and Best (1990), men and women in more traditional cultures (that hold their beliefs, customs through-out centuries e.g. Pakistani culture) emphasize sex role differences, but in modern cultures (e.g. Dutch culture) minimize them. Therefore, cultures may vary in the degree to which sex roles are emphasized (Costa et al., 2001). In Kikuyu, Kenya coitus is seen as a necessity for health and sanity and anyone who does not have

regular sex will suffer various illnesses. Wives are not allowed to touch their husbands' genitals and husbands to touch their wives' nipples. The man has to be on top of the woman. Kikuyu men believe that they need a lot of sex and a variety of sexual partners. It is a man's right. Faithfulness is not an issue for men, as it is for women (Caplan, 1993).

Even though Munroe's et al. (1984), research in four cultures about gender understanding and sex role differences is not a recent one, it is interesting to mention some of the findings: The Logoli of Kenya and the Newars of Nepal displayed strong emphasis on sex differentiation in socialization practices and institutional characteristics, while the Garifuna of Belize and the Samoans of American Samoa did not. The Kenyan and Nepal cultures induct young girls into domestic labor force at significantly higher roles than young boys, producing experiences that are sharply sex differentiated. Young males have a transition period to adulthood through various initiation rituals. Females are required to get married and move near the kinsmen of their husbands. Cultural characteristics of this sort have been linked to the development of several elements of sex-appropriate behaviour. In Belize and Samoans cultures girls and boys have nearly equal societal role. The differences of sex roles found in Munroe's et al. (1984) study are due to cultural and cognitive factors.

In some cultures, gender differences may be exaggerated, in others they may be masked (Costa et al., 2001). When people from Argentina, Peru, Ecuador, El Salvador, Mexico, South Africa, Pakistan were asked in Kate O'Neil's study in 1994, what would happen to a child if he/she does not behave as expected of his/her sex, all of them responded that he/she will be punished through ridicule, teasing and even physical punishment (Burn, 1996). This is surprising considering the diversity of the people in the countries, which participated in this study.

According to Caplan (1993), many Muslims' attitude to sexual intercourse follows, the Koran rules- 'women are your tillage'. Sexual intercourse is a pleasure (for men) and should be enjoyed as such. Women are thought to be sexually enthusiastic and irresponsible given the opportunity. Since 'men are in charge of women', they must be confined and ordered by men for sexual intercourse or any sexual matter. Some men also believe that menstrual blood pollutes (Caplan, 1993), therefore any contact should be avoided on those days. An admirable man is a person who supports and controls women and children (Caplan, 1993). Nevertheless, there are many interpretations of the Koran and different Muslim groups may understand or apply it in different ways. Arguably, the woman's societal position/role as subordinate is adopted by many Muslim communities. Different religious groups may interpret religious books (e.g. Koran, Bible) according to their needs and understanding. A similar division of norms has been reported among Greeks in rural areas (Loizos and Papataxiarchis, 1991): Among Greeks 'shame and honor' are very important; it is a matter of prestige. Marriage is regarded as a necessary condition of the continuation of life. Women are perceived as 'mothers', 'house-mistresses' and 'wives' (Loizos and Papataxiarchis, 1991). Somehow, women are called to serve all the needs of their husbands as well as the family needs. There are the extreme cases also- Palestinian women have been murdered by their male relatives because they brought 'shame' on their families and community. Women must have 'proper' behaviour (Yuval-Davis, 1997), in everyday culture, such as clothing, talking, sexual activity. Such 'honor killings' continue to take place in a number of third world and developing countries.

Differences in power relations between women and men influence one's own behaviour for sexual health. For example, whether women can purchase or use a contraceptive and their vulnerability to STI's. In Zimbabwe when a wife learned of her husband's infidelity, a health professional suggested that she should insist that her husband use condoms with her in the future. Her

reaction was interesting. She underlined that this would lead to the end of the marriage or even violence. This emphasizes the husband's dominant power in the marriage (Mafethe, 1995). It is obvious that in many cultures male gender power is so strong that women are willing to be without protection, despite the knowledge of the dangers to their health, even possibly death (HIV/AIDS). Knowledge is power; knowledge unused is not. Power comes with the confidence and ability to use this knowledge (Mafethe, 1995). This supports Foucault's idea of knowledge and power and the connection of the knowledge with identity (see chapter 2). Nowadays, culturally and gender specific knowledge on sexual and reproductive health is a demand especially for adolescents.

Everyday culture includes all these challenges that one should filter carefully and then adopt, if an individual wishes to do so. Sometimes, though, is not a matter of choice. In cultures with strong beliefs and practices is hard for anyone to decline or diverse from them. According to Moghadam (in Parker et al. 1992), in Afghanistan during traditional and tribal arrangements women are regarded as men's property. A woman has to get married since her standing is maintained primarily through bearing sons. Her family chooses for her a close relative or an old man to be her husband. Women never ask men for their whereabouts or expect marital fidelity. These beliefs and practices have a direct effect on women's sexual health. For example, they deny the woman's sexual and reproductive health rights; marriage with close relatives may cause birth defects; domestic violence may be endured by women who are powerless to do anything about it as they are considered the 'property' their husbands.

In all cultures the ceremony of wedding is based on certain beliefs and practices. They may be similar to many societies, but still certain rituals or religious practices can have different meaning or importance to the particular people.

Moreover, in polygamous societies males are encouraged to be 'successful', by having more wives and children (Burn, 1996).

In the case of fraternal polyandry (several brothers married to the same woman), in Northwest Nepal, women have to move to their husbands' land and must work too. Even though people do have the option of monogamy, they prefer polyandry so that their land will not be divided (Triandis, 1994). The inferiority of the woman and the impact on her sexual health is obvious. For example, many concurrent sexual partners may lead to several health problems such as infections (e.g. urinary track infections) or some forms of cancer such as cervical cancer (Pratt, 2000; WHO, 1992). Also, there is increased possibility of many pregnancies and many children to rear (may be from different fathers). This can affect a woman's well-being. One can argue, that women are mainly seen as hard workers and sex objects and not as female entities. In societies where women are viewed as subordinate to men, sexual beliefs and practices incorporate this subordination. This can be expressed through a variety of ways such as images, scientific models of knowledge, pornography and/or law. All these factors produce or develop sexual meanings. Sexual meanings are culturally and historically specific, thus continuities and variations can be expected (Thomson and Scott, 1990).

Research has shown that male gender roles in most cultures may lead men to ignore their health needs and consequently their sexual health needs (Lloyd, 1997). This is due to several reasons: Men are more likely to engage in risk health behaviour such as alcohol, drugs or unprotected sex (Alt, 2001 ; Lloyd, 1997), they utilize health care less frequently than women (Alt, 2001) and rarely follow a preventative health behaviour. One can argue, that all of the above are consequences of the male gender role stereotypes and role models that one has. To demonstrate physical strength traditional masculinity encourages a man to disregard pain or act in hypersexual ways or to demonstrate fearlessness thus exposing themselves to more risk-taking (Alt, 2001). Nowadays, young women are exposing themselves to increased

health risks too. For example, in Western societies there is a gradual increase in smoking and unprotected sex with multiple partners among young girls.

Alt (2001) argued that the present model of male gender in America generates a self-destructive health behaviour. This is because traditional masculine stereotype (as previously mentioned) has to demonstrate presumed superiority characterized by physical strength, fearlessness and self-reliance. Lance Armstrong's (multi-time winner of bicycling's grueling Tour de France) attitude towards his health, almost caused his life. This is a strong example of a typically male health attitude especially to sexual health. Lance Armstrong was diagnosed with metastatic testicular cancer. Even though he married and became a father, he did not seek medical attention until he could no longer ignore serious symptoms (e.g. swollen testicles), (Alt, 2001).

Beyer et al. (1996), argued that in middle and high school sexuality curricula that they had examined, males were represented as perpetrators of sexual exploitation, while females were portrayed as the victims of exploitation, abuse, assault and rape. Beyer et al. (1996) researched fourteen United States school curricula published during the period between 1985-1995. The study examined differences in gender representation in illustrations, photographs, cartoons, drawings and text. It is of particular concern that gender inequalities and inequities may exist in school curricula that suppose to broaden knowledge and promote health. Further, gender role stereotyping in sexuality education curricula was noted by Beyer et al. (1996), in relation to parenting which had a pro-feminine slant. The male role in parenting was omitted. The researchers suggested that qualitative research can enrich their study identifying factors that may contribute to gender differences in sexuality curricula such as gender of authors, gender of instructors and students. Doyle and Paludi (1998) found that gender roles were encouraged by parents who teach their children gender-related behaviours (e.g. boys do not cry, play football, girls do dishes) by reinforcing or punishing the children's gender-related behaviour. Perceptions, attitudes and therefore behaviour is being

recycled. Alix (1995) argued that stereotypes tend to be resistant to change, even when shown by factual evidence to be in error.

It is a major challenge for anyone to develop culturally sensitive prevention messages and thus, enhance the sensitivity to dangerous effects of sex and gender norms within cultures (Gomez, 1995). A deep understanding of health-related beliefs and practices and of human sexuality precedes the need to study each person within his/her own culture and gender.

3.4 Adolescent Sexuality: Gender and Culture

Adolescent sexuality is affected by socio-cultural factors. Values and attitudes of the family, religion and generally one's own culture about sexuality affect one's behaviour. Seventy-five percent of the American girls strongly believe that their personal worth is assessed by the way they look (Ferron, 1997). This is part of one's own sexuality, a search for an identity and gender role due to the body changes during their transition from childhood to adolescence. Bodily changes influence adolescents' health behaviour (Ferron, 1997). A sexy and attractive body is highly valued in American culture. This can be a pressure for adolescents. It may be seen (by adolescents) as a societal expectation. Arguably, self-esteem and self-awareness may be considered as strong assets in resisting temptations and avoiding unhealthy behaviours during adolescence such as having sex just for 'testing' or 'proving' their attractiveness. Seventy-five percent (75%) of American adolescents and a 25% of French adolescents reported that being attractive is extremely important to their social integration, for either friends or lovers. Bergman and Scott (2001), highlighted that British girls reported lower self-esteem compared to boys. They also reported greater unhappiness and more worries. In their research they found that self-esteem, self-efficacy, happiness and worries are more interconnected for adolescent girls than for boys. Failure to attract the opposite sex can create a feeling of negativity (Bergman and Scott, 2001). Adding to these, there is a strong association between gender role conflicts, low self-esteem and anxiety (Lloyd, 1997).

Often young people are influenced by the assumption of the roles that are imposed on them (e.g. a woman does not know how to change a car tire). Maleness conveys more power (Crawford and Unger, 2000). Cultural and social construction of gender influences this attitude. Therefore, adolescents learn throughout daily interactions that being a male is not only different from being a female but also preferred (Hand and Sanchez, 2000 ; Thorne, 1993).

According to Dowsett et al. (1998), even though all seven developing countries that they included in their study reported similar differential in cultural understandings of young women's and young men's sexuality, there was a marked perception that young men are sexual beings and young women ought not to be. With this logic, young men 'as sexual beings' need to find partners. So, if young women are not 'sexual beings', then young women are used as 'tools' or 'means' for sexual pleasure (questioning the men's sexual pleasure). Then, the persons involved seem to have no value. In some societies female stereotypes such as adolescent girls 'let sex happen' or 'trust in love' still exist. Although this view is not widely accepted, it can disempower adolescent girls with their relationships with men. Some people may believe that 'real sex' involves vaginal penetration and male orgasm and this can make some adolescent girls vulnerable in engaging to sexual intercourse without their choice (HEA, 1998). This vulnerability can influence the personal identity of adolescent girls, including their level of self-confidence, assertiveness and self-awareness. These beliefs or attitudes may have serious health consequences such as STI's, unwanted pregnancy; such disempowering values may result some young women to have self-destructive behaviour (e.g. abuse of alcohol or drugs) or 'accepting' violence by men.

Heise (1999) argued that violence is a significant part of young women's sexual lives. One-third of all female homicide victims are killed by a husband or boyfriend (Rhode, 1997). When Michael Tyson defended himself for the accusation of date rape, he said "...I didn't hurt anyone- no black eyes, no broken bones" (Rhode, 1997:122). It could be argued, that boys are socialized to be aggressive and powerful (WHO, 1999). However, this may differ from one culture to another. Latino adolescent females are more likely to be sexually abused, at even a younger age, and the abuser is more likely to be a relative (Pastore and Diaz, 1998). In early ethnographic studies of Latinos it was found that family life promoted the themes of 'machino' of men

and the passivity of women (Doyle and Paludi, 1998). WHO (1999), argued that boys should be empowered to reject 'machino' attitudes. In addition to these, girls may choose to be less assertive in order to be more likeable among their peers (Crawford and Unger, 2000).

In many societies, cultural norms about the meaning of sexual activity for adolescent girls and boys influence condom use. It is more socially acceptable for adolescent boys to desire sex, while girls are encouraged to stay virgins as long as possible (Nahom et al., 2001). Gender differences are obvious even in modern Western societies. Both genders seek and need information and knowledge related to sexual and reproductive health (e.g. STI's, pregnancy). Despite this, adolescent girls reported that were more uncomfortable discussing certain issues such as sexuality and contraception, whereas boys reported that they were more uncomfortable discussing drugs and alcohol use (Ackard and Neumark-Sztainer, 2001). Van den Akker et al. (1999), reported that more adolescent boys than girls did not know what contraceptives were and thus, they were unable to discuss it with their partners. It has been reported that adolescent girls were more likely than boys to ask their mother than their father for any health related issue. Adolescent girls, also, were more likely than adolescent boys to ask another adult female relative or a friend. However, girls tend to believe their friends more than boys and were more concerned about friends' negative opinions of their sexual activities (Van den Akker et al., 1999). Adolescent boys were more likely to consult a teacher, doctor or a nurse or no one (Ackard and Neumark-Sztainer, 2001). This shows that adolescent girls worry and want to know about their health, even though they do not often ask the most appropriate person, whereas adolescent boys seem to seek for a professional opinion. Obviously, parenting has an important impact on gender role development. In addition to these, parents are rated as having more influence on sexual attitudes. Sexual permissiveness and intercourse are related to parental discipline and control (Werner-Wilson, 1998). Adding to these, WHO (1999)

reported that adolescent boys may be consulted by their parents when important family decisions are made, while the same may not be true for adolescent girls. This creates more insecurity among adolescent girls.

Parents also must have the necessary background as to provide knowledge to their children. For example, although Latina mothers wanted to provide information about sexuality to their daughters, they lacked knowledge about it such as contraception (Villaruel, 1998). However, the promotion and use of contraception or the concern of any aspect of sexuality may differ between genders but also from one cultural group to another. For example, the rate of oral contraceptive use of U.S. Puerto Ricans is higher than that of Cuban-American adolescent females and slightly lower than in the Mexican-American adolescents (Pastore and Diaz, 1998). Several factors may influence this cultural phenomenon- health services, availability of oral contraceptives, financial constraints, personal and cultural beliefs and attitudes, knowledge and information.

In some cultures (e.g. Pakistani), parents or other elders in the family choose potential brides and grooms for their children. Many adolescents accept the decision of their family believing that since they are young probably they may make a decision that may lead to an unhappy marriage (Friedman, 1999). This idea is not totally rejected as far as the adolescent boy or girl honestly agrees with his/her parents' decision. It depends on their level of maturity. Adolescents may not have that choice though. Many times the selection of a bride or a groom is based on money, religious beliefs, age (older usually for girls) or relationship of families (e.g. relatives). There is evidence though that divorce and broken families are often seen in societies where parents or family play little or no role in choosing mates for their children (Friedman, 1999). Arranged marriages have also been and are still been practiced in many Western societies amongst the aristocracy and high social classes. The rationale for this is not very different from that being used in some developing countries where arranged marriages are a regular event. One may argue, that may be adolescents with arranged marriages in the developing countries do

not easily decide to have a divorce due to fear of family or stigmatization by society. However, this is not so for marriages in the Western societies, where divorce is much more easily decided because there is minimal fear of consequences and stigmatization.

Adolescents often confront changing cultural contexts, even as they strive to make individual choices between the cultures of parents and peers. Life events become more complicated for adolescents, whose parents differ in their ethnicities or cultural practices (Michaud et al., 2001).

Villaruel (1998) reported that in Mexican- American and Puerto Rican cultures kissing (not French kiss) was an accepted way to show affection to a steady boyfriend. Prolonged 'touching' or 'rubbing' were not acceptable though. When a girl is allowed to see a boy, he has to go to the house, her parents will meet the boy and/or his family and dates will be supervised. This is done as a protection for their daughters from 'culturally inappropriate' influences such as sex.

Virginity is very much highly valued in many cultures such as Mexican-American, Puerto Rican, Middle East, some Mediterranean countries and that is why the issue of virginity arose in many studies. It is a guarantee of the value of a potential partner. The virgin of Guadalupe (the 'brown virgin') symbolizes proper servility and modesty for Mexican women (Zavela, in Lancaster and Di Leonardo, 1997). In Cambodia young men still demand a virgin bride (Dowsett, 1998). The paradox is that it is acceptable for them to be sexually active before marriage. Socio-cultural norms that promote virginity in girls underline girls' ignorance about their bodies. This often compromises their adoption of safer sex options and use of reproductive health services for fear of being stigmatized as sexually active (WHO, 1999). Arguably, the high value that is placed on female virginity can be seen as a form of sexism or gender inequality. It also promotes the stereotyping of females as being subordinate to males. Virginity can be a choice for young women as it is for

most young men. Personal, ethical and moral values can be seen in one's own personhood and behaviour. According to Amazino et al. (1997), among Nigerian secondary school students, it was shown that the proportions of 14 and 15 year olds who were sexually active were lower among girls than boys, and of ages 17-19 (in secondary school) were higher among young women compared to young men. Similar findings were reported by Nahom et al. (2001), related to the age of initiation of sexual activity according to gender. Compared with college women, a greater proportion of young men have had many and multiple partners. They also had greater likelihood of using alcohol or drugs before intercourse. Therefore, there are serious indicators of greater sexual health risk among young men than young women (Forrest, 2001). However, young men may claim different sexual activities or behaviours that are not quite real, since it may be argued that this is considered as a gender norm. Female adolescents are at disproportionately increased risk of developing STI's due to physiological factors (e.g. immature cervix) and social factors (e.g. lack of assertiveness, pressure to agree to sex).

Adolescent males are less inclined to consider affection as a precursor to sexual intimacy than are adolescent females. There is also a positive correlation between expectations of sexual intercourse and length of relationship for adolescent males, but not for females (Werner-Wilson, 1998). Adolescent girls' identity may be more bound up with their relationships with others than in the case of adolescent boys. Adolescent girls' are likely to be more sensitive than adolescent boys to the perceptions of others (Bergman and Scott, 2001). This makes it more essential for adolescents to know and shape attitudes and beliefs for sexuality matters, especially related to gender. Many times, adolescent boys or girls concentrate only to what his/her gender 'suppose' to do/behave and do not consider knowing and understanding the needs or interests of the other gender.

In Van den Akker et al. study (1999) young women reported to be most likely to decide to have sex if they felt in love (93.5%), rather than out of curiosity (23.5%) or because they liked the person (53.2%). Young men reported also

that their decision to have sex was based on being in love (76.3%), rather than curiosity (47.7%) or because they liked the person (69.9%). Adolescents are more likely to behave in gender role stereotyping ways when on a date than when alone (Doyle and Paludi, 1998).

Young men are encouraged to think about sex in terms of their own needs and desires rather than in relation to women's sexuality. Even among intellectually empowered women that know about safer sex, only few of them report to be able to negotiate it in practice (Holland et al., in HEA, 1998). Successful masculinity is linked with the numbers of sexual encounters and sexual performance rather than the ability to be responsible of one's own sexual health (HEA, 1998). This is a major obstacle for the prevention of teenage pregnancy and the understanding of young girls' gender role and needs.

Not all cultures agree with the idea of the existence of two genders- male and female. In North American Indian societies some men are berdache- biological males who adopt the clothes and some other women roles and have sexual relationships with men. These men's behaviour fit no ethnocentric norm such as homosexuals, transvestites or transsexuals. Not all homosexuals are berdaches (Crawford and Unger, 2000). The term berdache maybe used for females too (Roscoe, 1998). In Mombasa, Swahili boys (mixed blood Arab-African), may have their first homosexual experience at puberty, while girls must be married before any adult activities are allowed to them (Caplan, 1993).

Homophobia among adolescents may lead to practice risky behaviours among heterosexual adolescents (Rios-Ellis and Figueroa, in Henderson et al., 1998). Westerman and Davidson (1993) in their study reported that the more homophobic an adolescent is, the more is to believe that HIV/AIDS is a gay disease and feel invulnerable to infection. They also reported (as cited by Rios-Ellis and Figueroa, in Henderson et al., 1998) that the degree of

homophobia positively influences the adolescent's intention to engage in sexual intercourse, after knowing his/her partner for a short time. There is evidence that adolescent experiences have a pronounced influence on adult life (Bergman and Scott, 2001).

Considering sexuality issues within different cultural perspectives in promoting health, empowers each individual in the participation in decision making, developing skills and acknowledges the importance of one's own sexual and reproductive health needs by shaping attitudes, beliefs and behaviours. These may be learned and practiced through health promotion. There is an effort to reach adolescents broadly while maintaining cultural sensitivity (Michaud et al., 2001), by involving adolescents in designing and developing studies related to sexuality, gender and cultural issues. It is essential to avoid discrimination or gender inequalities or inequities and promote cultural pluralism and understanding of health issues related to gender and sexuality.

Summary

Gender is part of culture. It influences and is being influenced by it. As gender roles have an impact on the formation of one's own identity, consequently may affect the formation and expression of sexuality. This chapter has discussed the relationship among gender, culture and sexuality (especially for adolescents). The following chapter will explore the concept of sexuality.