

Learning the Language of Sexual Health and Sexuality

*An exploration of sources of information and adolescent learning
about sexual health and sexuality in Santiago, Chile*

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Abstract

Sexual and reproductive rights include access to accurate and appropriate information, necessary to make informed sexual and reproductive decisions (Committee on Economic, Social and Cultural Rights, 2000). In the current age of media globalization and internet, adolescents are exposed to information about sexual health and sexuality from a myriad of sources. The objective of this study is to explore sources of information and adolescent learning about sexual health and sexuality in Santiago, Chile. The study has a qualitative design and includes four focus group discussions and 20 semi-structured interviews with adolescents 16-19 years old, as well as seven semi-structured interviews with key informants working with adolescents.

On the micro level, the findings indicate that the primary sources of information for adolescents were parents, teachers and friends, whilst secondary sources included health professionals for females and internet for males. Information provided by trusted sources, such as parents, teachers and health professionals, tended to focus on biological 'risk' of pregnancy and sexually transmitted diseases, with less emphasis on broader elements of sexuality such as love, attraction, pleasure and relationships. Information was focused on heterosexual relations, thus excluding sexual minority youth and disregarding the spectrum of sexual behaviours. Adolescents learnt about relationships and sexual acts through friends and, for many males, through watching pornography. The findings show a lack of information on practical skills related to contraception, partner communication and setting personal limits.

On the macro level, the ongoing gender socialization in Chile, highly influenced by various socializing institutions, affects the way adolescents conceptualize gender and sexuality. This was particularly notable in the way they discussed topics of homosexuality, contraceptive responsibility, female pleasure, pornography, and gender appropriate language and behaviour.

This thesis concludes that comprehensive sexual health information moving beyond biological 'risk' is necessary for adolescents to be able to make informed and empowered decisions in relation to their sexuality. Furthermore, they need support in learning practical skills, necessary to build self-esteem and self-efficacy to ensure safe and pleasurable sexual experiences. Working together with adolescents, the current social construction of sexuality and gender needs to be challenged in order to increase gender equality and ensure sexual and reproductive rights for all.

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Chapter 1: Introduction and Structure of the Thesis

Brief introduction to the research topic

Sexuality is an intrinsic part of a holistic framework for human health (WHO, 2006), and there are few aspects of human health and behaviour that trigger more fascination and embarrassment, joy and pain, vulnerability and pride, than sex. Issues surrounding sex and sexuality are moulded within every society, as cultural norms dictate the timing and nature of sexual relations, particularly with regards to adolescents (Breakwell, 1997; DeLamater, 1989). Furthermore, issues relating to sexuality trigger discussions across the public/private divide on what is acceptable sexual behaviour and how deviant behaviour should be punished. From a public health perspective, sex is interesting as good sexual experiences can enrich a person's life, their self-esteem and relationships with others, whilst conversely negative sexual experiences and sexual ill health detrimental effects on a person's physical, psychological and social wellbeing (WHO, 2006).

Adolescence is a time where individuals develop their sexual identity, knowledge, standards and behaviour, all under the influence of different socializing agents (DeLamater, 1989). Although sexual development is life long, healthy sexual health in adulthood is closely linked to adolescent sexual experiences that set the stage for later life (WHO, 2006). Furthermore, young people's sexuality is *"directly connected with the ethics, values and mores, and attitudes towards sex prevailing in the adult world"* (Casas & Ahumada, 2009, p. 89). It is during this time that they are expected to learn a *"lexicon of sexuality"* which involves *"assimilation, ordering and decoding the often conflicting messages"* (Breakwell, 1997, p. 135) received from a range of sources. Furthermore, the information adolescents receive may be obscure, ambiguous, or clouded in secrecy and emotional overtones (Breakwell, 1997).

This exploratory qualitative study investigates how Chilean adolescents learn about sexual health and sexuality in their unique social context. The aim of the study is to explore the sources and content of the information adolescents both actively seek and passively receive, how this information is communicated, how they judge the trustworthiness of the information, as well what words are used. The theme of gender will also be expanded upon since it is intrinsically linked to societal control of sexuality. On a more philosophical level, this study

aims to provide new insights into the personal and social discourses on adolescent sexuality in Chile.¹

Structure of the thesis

This thesis has six chapters. Following on from this introductory chapter, *chapter two* provides background information on the topic of sexual health and the Chilean context, especially introducing the area of adolescent sexual and reproductive health. A brief review of literature will also set the foundation for this research into adolescent sexual health and the chapter will end with the justification for the study, main objective and research questions. *Chapter three* presents the study design and methodology, including detailed descriptions of the study settings, sampling and recruitment processes, data collection and analysis. The trustworthiness of the data is discussed here alongside ethical considerations of the study. In *chapter four* the study findings are presented. *Chapter five* provides a discussion of these findings in relation to theories and previous empirical research. Finally, *chapter six* briefly concludes the thesis with suggested recommendations for practice and suggestions for future research.

¹ In this thesis, *discourse* is understood as looking beyond simply what is being said by different social actors on the topic of sexuality, instead incorporating reflections on the context and implications of what is being said. Drawing on different theorists, Lessa (2005) describes how discourse has often been linked to discussions of power and control, the construction of *truths* and *realities*, and can play a role in both inhibiting and encouraging social change. This makes exploring discourse particularly interesting in relation to sexuality, sexual health and rights.

Chapter 2: Background Information and Literature Review

Background information

The first seeds of this research project were sewn during a course on sexual and reproductive rights. During this course, Chile and other Latin American countries were highlighted in case studies exemplifying varying challenges to sexual and reproductive rights. This prompted further investigation into the state of sexual and reproductive rights in Chile. Before exploring these rights in the Chilean context, the first step is to define the key terms sexual health, sexuality and reproductive rights.

Sexual health, sexuality and reproductive rights

Defining sexual health is a complex task. The World Health Organization (WHO) defines sexual health as not only the absence of disease but “*physical, emotional, mental and social well-being in relation to sexuality*” (WHO, 2006, p. 5). Furthermore, optimal sexual health includes “*the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence*” (WHO, 2006, p. 5). It is notable that the terms pleasure and safety are presented side by side. As this definition illustrates, sexual health cannot be understood without also defining sexuality.

Sexuality is much more than reproduction and can be defined on very broad terms as “*a spectrum of behaviour that extends from the procreative to the erotic, and encompasses ideals, desires, practices, preferences and identities*” (Chant & Craske, 2003, p. 128), incorporating elements of “*sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction*” (WHO, 2006, p. 5). The way in which one’s sexuality is expressed can be multifaceted, including “*thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships*” (WHO, 2006, p. 5). The extent to which an individual can freely express this sexuality, is defined by sociocultural norms, beliefs, morals, taboos and laws. What we believe to be *good* and *bad*, *risky* and *safe* and *healthy* and *unhealthy* sexuality is greatly influenced by our social context. In turn this context is shaped by presiding morals (often religious) and judicial laws (Foucault, 1990). The most obvious example of this is homosexuality, which in some countries is illegal under state law, whilst in other countries where homosexuality is legal, morals may restrict freedom of homosexual expression. Given these global variations, it is possible to view sexuality less

as an intrinsic, essential part of one's being, but rather as a social construction given meaning through the way different societies discuss, define and control sexuality (Foucault, 1990).

The French philosopher Michel Foucault (1990) wrote extensively on this topic. He writes that the concept *sexuality* is a social construct borne out of a "*discursive explosion*" (p. 38) on sexuality in the 18th and 19th centuries. In this "*explosion*", private sexual practices or preferences became increasingly discussed in a public arena. This way of seeing issues such as sexuality as nothing more than a "*discursive construction of reality*" (Lupton, 1999, p. 6) contradicts the essentialists view that sexuality is an essential part of a person's being. A case against social constructivism has been made by essentialists like John Boswell (1989), who claims that the concept of homosexuality can be traced back to Greek times. However, keeping with the Foucauldian social constructivist view, sexuality is not something static, rather a cultural construct made and remade over time, modified by the way we talk about it. In this way our understanding of sexuality is constantly open to change through shifts in cultural norms. In their sexual script theory, Simon and Gagnon (1984) describe this fluid construction of sexuality through the act of facing different *cultural scenarios* that are influenced by different sociocultural institutions.

Several institutions or socializing agents work to socialize, and in effect control the population in relation to sexuality (Atkinson, 1989). These social institutions are religion, family, schools and medicine (DeLamater, 1989). These institutions each have an *ideology* around sexuality dictating the purpose of sexual activity and the role it plays in human life (DeLamater, 1989). These institutions may coincide in these ideologies, or they may disagree. Which of these social institutions is more influential in defining the social discourse, and thus also individual sexual scripts, will depend on historical and current political power and social influence (Atkinson, 1989; Simon & Gagnon, 1984). The degree to which these socializing institutions also have the power to influence judicial law will not only shape individual sexual scripts, but it will also greatly shape social policy (Atkinson, 1989).

In the Latin American context, Shepard (2000) claims that legal norms are greatly imposed upon by religious moral codes, making the "*distinction between immorality and criminality blurred*" (p. 114). A good example of this is therapeutic abortion.² The social institutions of

² Therapeutic abortions are induced terminations of pregnancy. Most commonly this is performed through medication if it is early in the pregnancy or through surgical vacuum aspiration (Grimes et al., 2006)

religion, family, schools and medicine may all hold differing views on what is *right* and *wrong* in relation to therapeutic abortion. However, the institution that holds the position of power in a community, in this case religion, may also have great levels of power over judicial processes and thus social policies. This is seen in the fact that at the time of writing this thesis, only four countries in the world criminalize therapeutic abortion on all grounds,³ all of which are traditionally Catholic countries and three of which are in Latin America.

In response to the wide global variation in social and legal control of sexuality and reproduction, in 1994 the United Nations (UN) organized a conference aiming to develop a universal human rights approach towards sexuality and reproduction (Obaid, 2009). This approach set a global standard for sexual and reproductive rights, regardless of variations in religious, family, educational, medical and judicial *ideologies*. The aim of these rights is to protect the aforementioned holistic wellbeing in relation to sexuality and reproduction.

Historically, these sexual and reproductive rights evolved from the population control policies of the 1950s, 1960s and 1970s, aiming to curb population growth in order to reduce poverty (Pieper-Mooney, 2009). Although positive steps were made in reducing fertility rates in low income settings, the public health motivated approach raised questions as to the place of individual rights in relation to reproductive choices (Pieper-Mooney, 2009). In 1994 at the UN run Cairo International Conference on Population and Development the concept *reproductive rights* was coined (Obaid, 2009). This conference defined reproductive rights as: access to appropriate services in family planning and safe abortion, childbirth and new-born services, screening and treatment for sexual health problems including sexually transmitted diseases (STDs), sexual health education and counselling, and promotion of gender equality and empowerment (Obaid, 2009). By including underlying social determinants of poor reproductive health, such as gender inequality and disempowerment, reproductive rights have both short term aims related to improving access to services, as well as long term goals of social change.

Human rights watch dog organizations such as Human Rights Watch and different UN committees such as the Committee on the Elimination of Discrimination against Women

³The countries where therapeutic abortion is illegal are Chile, Nicaragua, El Salvador and Malta (Center for Reproductive Rights, 2013).

(CEDAW), monitor to what extent countries meet the requirements to ensure the sexual and reproductive rights of their citizens.

Focussing on adolescents

Adolescence is a time of exponential sexual development driven by biological changes entering puberty, coupled with changes in social expectations and interactions (Bearinger, Sieving, Ferguson, & Sharma, 2007; Schutt-Aine & Maddaleno, 2003). Adolescence is also called the time of sexual awakening as adolescents explore their personal sexuality and increasingly begin to experiment their sexuality in a couple. Adolescence is also a time of vulnerability as youth negotiate their self-image, experience peer pressure and are increasingly influenced by media, are impulsive and oppositional in their behaviour and have a belief in their own invincibility (Montero, 2011).

Given this vulnerability, the denial of reproductive rights for adolescents can manifest itself in the form of high teenage pregnancy rates, illegal abortions and increasing rates of STDs (Dides & Benavente, 2009). Health programs to improve adolescent sexual health outcomes focus on prevention of adolescent pregnancies and the transmission of sexually transmitted infections such as Human Immunodeficiency Virus (HIV). The United Nation Population Fund (UNFPA) describes the health impacts of adolescent pregnancy as far reaching, including obstetric complications, unsafe abortions, STDs, increased risk of stillbirth and neonatal death, risk to the mother's life especially if under 15 years and psychosocial stigmatization (UNFPA, 2013). This is coupled with socioeconomic repercussions such as low educational achievement and loss of future economic potential (UNFPA, 2013). Globally, approximately half of the new HIV infections are in young people between 15-24 (Schutt-Aine & Maddaleno, 2003). Chilean statistics related to new HIV infections, show that adolescent males between the ages of 15-19 had the biggest increase in new infections between 2000-2006 (Dides, Benavente, & Morán, 2009).

In 2007, the medical journal *The Lancet* published a series focussing on adolescent health, advocating for an increased global focus on adolescents as a vulnerable group. The series described strategies to reduce the adolescent burden of disease with measures such as delaying early marriage and ensuring reproductive rights such as increasing access to health services including STD treatment and contraception, legalising abortion and increasing

coverage of comprehensive sexual education (Bearinger et al., 2007). Such publications have attempted to bring adolescents to the forefront of the reproductive rights agenda.

Focussing on Chile

Demographics

The Chilean National Statistics Institute (INE) holds a national census every 10 years with the most recent in 2012. According to the 2012 preliminary results, Chile has a population of approximately 16,5 million inhabitants, with approximately 2,6 million adolescents between the ages of 10-19 (INE, 2012). The Chilean population is highly centralized with approximately 6,7 million people residing in the capital city Santiago (INE, 2012). There are numerous indigenous groups in Chile with Mapuche the largest.

Political history

Chile is a constitutional republic with democratic presidential elections every four years. Similar to other South and Central American countries, Chile has a history of political polarization including military coups, the last of which took over the democratically elected socialist government in 1973 (Rector, 2005). Policies implemented during the 17-year military dictatorship drastically transformed the economy, education and health systems, with accompanying restrictions to civil and political rights (Mesa-Lago, 2008). Since the return to democracy in 1990, Chile has made great strides in improving certain civil and political rights of their citizens, visible in the passing of such laws as those related to discrimination and rights of domestic workers (CEDAW, 2006). Chile has also engaged in health care and social protection reforms reducing poverty, however political and economic inequalities still remain (Mesa-Lago, 2008).

Religion

In the preliminary results from the 2012 census, 67,3% of the population defined themselves as Catholic, followed by 16,6% Evangelical Christians, 4,6% belonging to other religions (Jehovah's Witness, Mormon, Muslim, Orthodox or other) and 11,5% whom declare no religion (INE, 2012). These preliminary results show a continued decrease in the number of Catholic followers, increase in the number people declaring no religion and a slight increase in the number of Evangelical followers, especially in younger generations (INE, 2012).

Health

Along with most other public services, the Chilean health system was fully privatized under the military dictatorship creating a dual public-private health system. The public insurance program (Fondo Nacional de Salud or FONASA), generally serves people of lower socioeconomic status and those living in rural areas, whilst the multiple private insurance programs (Instituciones de Salud Previsional or ISAPRE) generally serve those of middle and high social class whom can afford to pay the insurance premiums (Mesa-Lago, 2008). Although social reforms since the return to democracy have boosted healthcare provision to the poorest sectors of the Chilean population, quality of service delivery and waiting times may differ considerably between public and private services (Mesa-Lago, 2008).

Education

Chile has a high percentage of high school participation with an average of 85% of students enrolled in high school education and 99% youth literacy for both females and males (UNICEF, 2013). In 2002, 15% of high schools and 22% of universities in Chile were catholic (Passalacqua, 2006). Although a small number of universities in Chile receive government funding and are regarded as public, in effect all universities are private. In recent years large scale student protests have pushed for free and high quality university education, in order to reduce inequalities in the education system.

Sexual and reproductive rights in Chile

As mentioned earlier, sexual and reproductive policies during the period of the 1950s and 1960s were determined by international policies of population control and family planning. During this time in Chile a new intrauterine device was developed and used widely to counter illegal abortions, described to be occurring in "*epidemic proportions*" (Pieper-Mooney, 2009, p. 45). Pieper-Mooney (2009) argues that subsequent programs promoting contraception and family planning were driven by public health priorities rather than promotion of women's reproductive rights.

During the 1970s and 1980s, under the military dictatorship, social conservatism was maintained even in the face of economic modernization (Pieper-Mooney, 2009). The dictatorship's pro-natalist policies culminated with the final act of the military government: a criminalization of therapeutic abortion in 1989, which had been legal under the health code since 1931 (Haas, 2010; Pieper-Mooney, 2009). In the same year as abortion was

criminalized, Chile ratified the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Although Chile has had some of the most traditional laws in relation to women, it has also had a one of the strongest women's movements lobbying for feminist policy change (Haas, 2010). Therefore, even during the dictatorship of the 1970s and 1980s, a multitude of feminist movements were actively putting women's rights on the agenda. Gender issues such as those related to sexual orientation were also raised, however the primacy given to overthrowing the dictatorship meant that broader gender issues fell outside the mainstream feminist agenda of the time (Chant & Craske, 2003).

The 20 years immediately following the return to democracy saw slow gains in sexual and reproductive rights. This has been linked to the key position of power held by conservative religious politicians whom supported the return to democracy (Casas & Ahumada, 2009; Guzman, Seibert, & Staab, 2010). This slow progress is perpetuated by what Shepard (2000) describes as the *double discourse* in Chilean society. This *double discourse* is defined as maintenance of repressive conservative public policies and laws in the public arena, whilst at the same time tolerating unlawful reproductive decisions in the private sphere (Shepard, 2000). The clearest example of this is clandestine abortions.⁴ Unsurprisingly, the risks associated with these unlawful reproductive decisions, are higher for low income and marginalized women (Shepard, 2000).

In recent years there has been increased political will in Chile to debate controversial issues surrounding sexual and reproductive rights. This is reflected in the passing of a reproductive health law "Information, Guidance and Assistance on Fertility Regulation" in 2010 (MINSAL, 2010b). This law stipulates the right to sex education, access to information and services for the prevention of adolescent pregnancy, including access to emergency contraception and legal responsibilities of health professionals to report suspected sexual abuse (MINSAL, 2010b).⁵ Implementation of the law has been wrought with challenges, however visible advances have been made, especially related to emergency contraception (Dides, Nicholls,

⁴ Clandestine abortions are therapeutic abortions performed illegally often using unsafe techniques and placing a woman at great risk (Grimes et al., 2006).

⁵ Emergency contraceptive pill is a hormonal pill taken within 120 hour of unprotected intercourse that delays ovulation and thus reduces the likelihood of fertilization, but does not interrupt already established pregnancy (WHO, 2012).

Boso, & Fernández, 2013). In the area of sex education, implementation of the law has been slow and hampered by political and institutional road blocks (Dides, Benavente, Sáez, & Nicholls, 2011). Debate around the decriminalization of abortion has been in the forefront of both media and political campaigning, with the newly inaugurated president Michelle Bachelet campaigning for the legalization of therapeutic abortion under certain circumstances.

With respect to sexual minority rights, some advances have been made in recent years. Homosexuality was decriminalized in 1999, however there is still a differential legal age of consent for homosexual sex (18 years) compared to heterosexual sex (14 years) (Ministerio de Justicia, 2013; Movilh, 2013). High profile cases of violence against sexual minorities, such as the murder of the homosexual student Daniel Zamudio in Santiago, sped up the passing of an anti-discrimination law in 2012. This law incorporated "*discrimination based on sexual orientation*" into article 12 of the Chilean penal code (Ministerio de Justicia, 2013). In their yearly report, the non-government organization Movement for Homosexual Integration and Liberation (Movilh) (2014) describe recent advances made in Chile, with the passing of the 2012 law helping address institutional discrimination and an overall decrease in acts of violence based on sexual orientation. However, Movilh (2014) also highlight the increased severity of violent attacks and the new law's inability to bring charges against perpetrators of acts of discrimination. Chant and Craske (2003) describe similar challenges in other Latin American countries, and claim that it largely reflects "*the dominance of heterosexism in the region, which has often equated homosexuality with crime, deviance and other forms of social pathology*" (p. 154).

Adolescent sexual and reproductive health in Chile

Through reading Chilean ministry of health (MINSAL) documents, prevention of pregnancy seems to be the primary focus of government adolescent sexual health policies in Chile (MINSAL, 2012, 2013a, 2013b). Preliminary statistics from 2012 show that the proportion of all live births in Chile born to adolescent mothers 10-19 years of age was 14.4% (34,906 births) (MINSAL, 2013b). Of this number, 0,36% (873 births) were among adolescents between 10-15 years of age (MINSAL, 2013b). Rates of adolescent pregnancy have fluctuated with recent years, with an overall trend in reduction of pregnancies, however, there has been an increase in the proportion of these pregnancies in the age group 10-15 years (MINSAL, 2013b). Furthermore, a study investigating the demographics of those women seeking emergency contraception in Chile in 2010 shows that adolescents aged 15-19 years

old had over twice the rates of referral for emergency contraception compared to women 20-44 years old (Morán, 2013). Adolescent contraceptive needs are primarily covered within the primary health care system in public healthcare centres or private clinics, even though there may still be significant barriers to access (MINSAL, 2010a).

Prevention of STDs seems to be the secondary focus for government adolescent sexual health policies. The predicted total number of people living with HIV in Chile is approximately 39,000 with a prevalence of 0,4% (UNAIDS, 2012). The age group 20-49 years has the highest total number of notifications for HIV, however it is unknown how many may have been infected during adolescence (MINSAL, 2013a; Montero, González, & Molina, 2008). The primary motivation for using condoms in youth population is prevention of pregnancy, which has implications for the awareness and understanding of the implications of STDs (González, Molina, Montero, Martínez, & Leyton, 2007; MINSAL, 2013a). Thus the aforementioned focus on preventing pregnancy also leaves a gap in focus on homosexual, lesbian, bisexual and transgender youth at risk of STDs.

Having introduced the issues around reproductive rights and adolescent sexual health, and related these to the Chilean social, political, cultural and historical context, the next section will explore empirical research in the field of adolescent sexual health.

Literature review

This literature review will be divided into two parts. Firstly, a brief review of literature on factors influencing adolescent sexual health knowledge and behaviours will be presented. Given the large array of available literature, I found it necessary to structure this literature review within a framework. In order to approach adolescent sexual health from a holistic perspective, a framework was needed that could capture the complexity of influences on adolescent sexual health. For this task, Bronfenbrenner's (1979) ecological model was chosen for its holism and simplicity (see figure 1). This model places an individual, their knowledge, attitudes and behaviour, within the context of their social ecosystem. The ecosystem is made up of five layers: individual, interpersonal (microsystem), institutional (mesosystem), community (exosystem) and public policies (macrosystem).

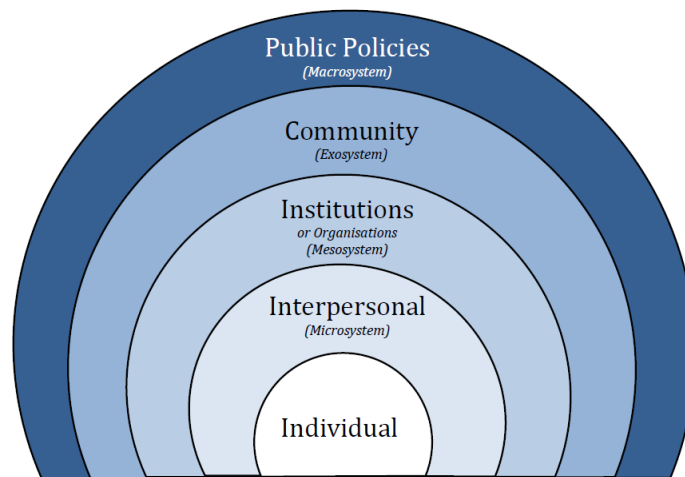


Figure 1: Bronfenbrenner's Ecological Model (1979)

Secondly, this review will explore a topic that incorporates the whole ecosystem perspective, namely the *sources of information adolescents use to learn about sexual health and sexuality*. In the selection of literature reviewed in this chapter, a priority is placed on Chilean and Latin American research, however global perspectives are also included.

Part One: Factors that influence adolescent sexuality

Individual factors

The primary individual factors researched in relation to adolescent sexual health are age, gender, socioeconomic status, family structure, education level, socioeconomic level (using the proxy of attending public, subsidised or private schools), religiosity, civil status of parents, use of drugs or alcohol and personal attitudes to sexuality and adolescent parenthood.

A vast majority of Chilean studies explored individual factors influencing adolescent sexual knowledge and/or behaviour. Pérez, Barrales, Jara, Palma, and Ceballos (2008) performed a cross sectional quantitative study into knowledge of HIV and Acquired Immunodeficiency Syndrome (AIDS) among 480 adolescents in the city of Chillan and found that knowledge of HIV prevention did not correlate to actual condom use. Age, gender and educational level were not statically significant individual factors influencing knowledge on HIV prevention. The only significant factor was educational institution, with adolescents from public schools showing lower levels of knowledge than those in private schools. This socioeconomic disparity is also highlighted in other Chilean studies by Montero et al. (2008) and González et al. (2007).

Montero et al. (2008) present national statistics on adolescent sexual practices and sexual health outcomes, showing higher numbers of pregnancies in youth with lower socioeconomic

level, as well as a gender difference in prevalence of STDs, with females more affected. Like Pérez et al. (2008), Montero et al. (2008) also raise concern about the incongruence between sexual health knowledge and safe sex practices, the reduction in age of sexual debut and the increase in pregnancies in early adolescence (under 14 years).

González et al. (2007) focus more specifically on gender differences in sexually active youth accessing a healthcare centre over a 15 year period. The primary gender differences related to motivation for sexual initiation was that females more often stated love as a motivation compared to males whom stated desire as their motivation. Interestingly, other gender differences diminished over the years, with females reporting age of sexual debut on par with males. González et al. (2007) describe a change in gender roles in Chile alongside a stagnant belief in sexual relations belonging inside a the traditional definition of a stable dating relationship. The authors recommend ongoing efforts to challenge damaging gender roles.

Finally, an earlier cross sectional study by Pérez, Cid, Lepe, and Carrasco (2004) looked into knowledge, attitudes and behaviours in relation to sexuality. These authors found gender differences in knowledge, with females attaining more knowledge about contraception; and differences in behaviours, with females using contraception less and males having more sexual partners. Interestingly, the only statistically significant individual factors influencing knowledge and behaviour were attendance in sex education classes and religion. Increased sex education led to greater levels of knowledge and religiosity was a protective factor in delaying sexual debut.

Interpersonal factors (microsystem)

The main interpersonal relationships most commonly researched are parents, peers and partners. Of the studies reviewed, parenting or family relations are the most common factors researched, with less focus on peer relations. Only one older Chilean article was found that explored specifically the influence of peer relations (Murray, Zabin, Toledo-Dreves, & Luengo-Charath, 1998).

Sanchez, Grogan-Kaylor, Castillo, Caballero, and Delva (2010) performed a quantitative cross sectional study in Chile investigating both individual and parenting factors influencing sexual debut. The only significant influences in the multivariate analysis that increased the odds of initiating sexual debut were increased age, somatic complaints and rule breaking

behaviour. Perhaps unsurprisingly, the initial bivariate analysis showed that better relationships with parents and increased parental monitoring reduced odds of engaging in sexual relationships. A limitation of the study is the difficulty of capturing the intricacies of parental communication in a quantitative questionnaire as opposed to qualitative techniques.

One qualitative study from Namibia explores parental communication through qualitative interviews with 20 youth and 16 parents (Nambambi & Mufune, 2011). This study found that taboos still existed in talking of sexual health, however the HIV epidemic had made communication a necessity. Gender differences were found with parents discussing sexual health issues earlier with their female children compared to their male children. Similarly, the content of communication with each parent was different and it was found that females preferred to communicate with their mothers. Communication was most often one-way with little discussion, even though parents stated that they recognized the advantages in open communication for building trust in their relationship with their child. Parents also believed they were better sources of information than peers and media (Nambambi & Mufune, 2011).

Peer influence on sexuality has received less attention. This is surprising since adolescence is characterised by increased reliance on peers for conforming to socially appropriate behaviours, and for defining adolescent identity and self-esteem (Schutt-Aine & Maddaleno, 2003). Selikow, Ahmed, Flisher, Mathews, and Mukoma (2009) investigated peer pressure in a qualitative study in South Africa. Through eight focus group discussions the authors found that peer pressure negatively undermined health promotion information encouraging safe sex and HIV prevention (Selikow et al., 2009). In comparison, a quantitative approach to peer influences was used in a large Chilean cross sectional study by Murray et al. (1998) looking at gender differences on factors influencing first intercourse in urban adolescents. The authors investigated perception of peers' sexual experience in association with own sexual history and found a positive association between perceived peer sexual experience and sexual debut. A limitation of this quantitative approach is that the results provide no information on the specific context of the sexual interaction, such as whether it was consensual and whether contraceptives were used. This would better help determine the effect of the sexual debut on the adolescent's health. Murray et al. (1998) acknowledge limitations in their study and encourage further research into peer relationships.

Institutional factors (mesosystem)

Schools and healthcare services are the main institutions influencing adolescent sexual health, with schools the most frequently used source of information (Pérez et al., 2004). In an editorial, Chilean gynaecologist and researcher Adela Montero (2011) describes school education and healthcare services as the fundamental pillars of adolescent sexuality. Montero (2011) goes on to describe the legal obligations schools have to provide sex education and presents the current selection of seven sexual health programs available for schools in Chile. Montero (2011) concludes that there is a need for sustainable sex education programs based on scientific evidence rather than religious belief or political motivations.

When reviewing literature on sex education, a distinction is made between *abstinence-only* and *comprehensive* sex education. Abstinence-only programs focus on abstinence as the only safe option and either do not mention contraception, focus on contraceptive failure or mention contraception, but stress abstinence (Kirby, 2001). In comparison, comprehensive programs include messages on abstinence alongside information on safe sex practices (Kirby, 2001). Of the seven programs promoted by the Chilean government, two are designed in Catholic universities and at least one is abstinence-only (Dides et al., 2011). The superior effect comprehensive sex education has on all adolescent sexual health outcomes, such as delaying sexual debut and use of condoms in sexual intercourse, has been firmly established (Kirby, Laris, & Rolleri, 2007; UNESCO, 2009).

Of the seven programs presented, research on only two of these programs was found, analysing the efficacy of the programs. These were the abstinence-only program *TeenSTAR* developed by the Catholic University of Chile (Cabezón et al., 2005), and the comprehensive program *Adolescence: A time of decisions* developed by the University of Chile (Murray, Toledo, Luengo, Molina, & Zabin, 2000). Both studies showed positive results in reducing rates of adolescent pregnancy, however these also have limitations.

Cabezón et al. (2005) describe their study of the program *TeenSTAR* as a randomized controlled cohort intervention study. In this study, 1259 girls were divided into three cohorts according to the year they started school, one cohort received no intervention and the girls in the two other cohorts were randomized to intervention or no intervention. The efficacy of the program was assessed over a two-year period by the sole outcome variable of teenage pregnancy. The authors found a positive effect with lower rates of pregnancy in the

intervention groups compared to controls. The authors recognize the limitations of measuring the success of their abstinence-only program on *actual sexual behaviour* by assessing only adolescent pregnancy, rather than actual sexual experience. The authors also acknowledge that their results may underrepresent pregnancy rates, given the unknown number of unreported pregnancies that ended in spontaneous or induced abortions (Cabezón et al., 2005). The authors fail to acknowledge the effect the high numbers of pupil dropouts might have had on the study results, considering some pupils may have dropped out due to pregnancy. The study also has the limitation of not including males in the study.

In contrast, Murray et al. (2000) measure the effect of their program *Adolescence: A time of decisions* by multiple outcomes: knowledge, attitudes and sexual behaviour (including sexual activity, timing of debut, contraceptive use and source of contraceptive). This quasi-experimental study was designed to evaluate outcomes with a large sample size (4135 adolescents) including both females and males. A limitation of the program was the requirement of specialist staff to be on site at the schools for the intervention period, a design difficult to replicate on a nation-wide basis for financial reasons. Furthermore, the schools worked closely with a specialist adolescent reproductive health centre, which is an ideal, however unrealistic for many schools, particularly those in rural areas. Lastly the actual intervention was conducted between 1994-5 and given the changes undergoing in contemporary Chilean society, especially related to internet, mass media and globalization, an updated review of the program is necessary to evaluate its efficacy with today's adolescents.

When it comes to Chilean primary healthcare services, Williams, Poblete, and Baldrich (2012) performed a multidimensional analysis of adolescent services in Santiago. This mixed method analysis utilized file audits, focus group discussions with healthcare professionals and adolescent user satisfaction surveys. The main results showed that adolescents rated the available services highly, particularly the relationship with the health professionals, technical standards and infrastructure, even though these same health professionals described flaws in the services provided. Given this discrepancy, the authors suggest more qualitative exploration of the adolescent experience and also describe the need to compare healthcare centres in different settings (Williams et al., 2012). As noted earlier, there are inequalities in the accessibility to youth friendly services in rural compared to urban settings.

To investigate these inequities and barriers, the Chilean ministry of health conducted a study into the barriers adolescents face in accessing health services to prevent pregnancy (MINSAL, 2010a). Through their extensive literature review, qualitative interviews and focus group discussions with health professionals, they found multiple barriers on the political, local and individual levels (MINSAL, 2010a). The absence of the *voice* of the adolescent, gained through a qualitative approach, makes it difficult to discern whether the individual adolescent barriers indicated by health professionals actually correlate to the barriers experienced by the actual adolescents.

Community factors (exosystem)

The community exosystem includes cultural values and norms that dictate appropriate sexual behaviour. An international systematic review of 268 qualitative studies by Marston and King (2006) explored factors that shape young people's sexual behaviour, many of which reflect these cultural values and norms. The results of the review indicate that the same themes can be found all over the world with variation in extent to which each theme is present. Of particular interest, the authors state that the theme of gender stereotypes and double standards exist everywhere, as women are made responsible for contraception, and societies encourages male sexual activity and restrict female sexual activity. Other results include the importance of the partner on influencing behaviour, the stigmatization of condoms as a sign of mistrust, the importance of social displays of sexual activity or non-activity, and that social expectations hamper effective partner communication about sex (Marston & King, 2006).

Chile is a predominantly catholic country, thus analysing the influence of religiosity on adolescent sexual health behaviour is important. Pérez et al. (2004) found that individual religious belief was a protective factor for delaying sexual debut. The study results found that 19.8% of the catholic participants and 17.6% of the evangelical participants had initiated their sexual debut, compared to 38% of those declaring no religious belief. A literature review of the English speaking Caribbean also found that in six studies, religiosity was a protective factor in encouraging delay of sexual debut, however only one study utilized qualitative techniques to explore the relationship between religion and sexuality (Pilgrim & Blum, 2012).

Mass media (television, films, advertising, magazines, radio and music) and internet play an increasingly large role in the socialization of youth in many parts of the world. A number of theories have been presented as to the potential influence of mass media messages on

adolescent attitudes and behaviour (Escobar-Chaves et al., 2005). A recent longitudinal study with 1792 adolescents from the United States claims that increased exposure to sexual content in mass media hastens sexual debut in adolescence (Collins, 2004). However, a review of 21 years of research on media deems the current evidence as inadequate (Escobar-Chaves et al., 2005). Sexual health and sexuality messages through the media may come in the form of modelling relationships and sexual behaviour, all of which are defined by cultural values and norms the media wish to portray (Hust, Brown, & L'Engle, 2008). A study into the sexuality messages portrayed in media describe how little media focuses on the *health* aspects of sexuality, information is often erroneous or contradictory, sexuality is portrayed as embarrassing and traditional gender stereotypes are frequently displayed (Hust et al., 2008).

The expansion of internet access globally has increased the accessibility of sexual material on the internet (Döring, 2009). In particular, online pornography has expanded the accessibility of explicit pornographic material to users whom would earlier not been able to access or afford this material in traditional media (for example magazines). Furthermore, the increased accessibility requires internet users to be *internet literate* to avoid unwanted exposure to pornographic material (Döring, 2009). Internet may also function as a source of peer support and conversely bullying related to adolescent sexuality through question and answer forums, anonymous question websites (such as ask.fm) and social networking. There is also much educational material and research on sexual health and sexuality available on the internet through specific websites and academic databases (Döring, 2009).

Public policies (macrosystem)

Research into the effect and efficacy of public policies often fall into the realm of ministry of health evaluations and reports. The Chilean ministry of health publishes a considerable number of reports on adolescent health in relation to public policies. An example is the report mentioned earlier investigating the barriers to adolescents accessing reproductive health services (MINSAL, 2010a).

Laws are also an important aspect of public policy that shape adolescent sexual behaviour as they define legal rights and responsibilities. As described earlier in the introduction, Chile has recently passed a law guaranteeing access to sex education and contraception for the prevention of pregnancy, including the emergency contraceptive pill (MINSAL, 2010b). Laws are an important step in protecting reproductive rights and guiding public health

practices, however research into the implementation of these policies is also necessary. A review of the implementation of the law in relation to the emergency contraceptive pill found that 86.3% of municipalities distribute the pill, with those not distributing stating a range of barriers including lack of human resources (Dides et al., 2013).

Part Two: Sources of adolescent sexual health information

So far this literature review has analysed primarily single factor influences on adolescent sexual health knowledge, attitudes and behaviour from interpersonal, institutional, community and public policy levels. Although these studies each highlight important factors that influence adolescents, they lack a perspective on the multitude of factors influencing adolescent knowledge and behaviour simultaneously. During this review, one area of research was discovered which incorporated a whole ecosystem approach: research exploring the sources of adolescent sexual health information. The following literature review focuses specifically on the topic of where and how adolescents learn about sexual health. This review aims to provide evidence of a research gap and justify the importance of studying the sources of information and adolescent learning about sexual health and sexuality Chile.

As discussed throughout this chapter, adolescents learn about sexual health and sexuality from a multitude of different sources. The extent to which young people understand, trust and put into practice what they learn is greatly influenced by the source of information, as well as the type and quality of information. Even defining what information is becomes a challenge, since information may be seen as an objective, static fact, or conversely information can be seen as a "*highly subjective and complex thing that alludes to ideology, cultural values, symbolic communication and power relations*" (Castañeda, Brindis, & Castaneda, 2001, p. 213). Given this disparity in definition of what *information* is, what one person defines as *sexual health information* may differ greatly from another. Regardless of whether information is defined as something *objective* or *subjective*, it can be communicated in many different ways from both formal and informal sources. For example, it may take the form of lectures, skill development, group discussions, formal debates, informal chats and jokes, myths, legends and also silence (Castañeda et al., 2001). Earlier quantitative and qualitative studies have analysed adolescent learning about sexual health and sexuality from different sources of information.

In El Salvador, Ruiz-Canela et al. (2012) surveyed 2,615 high school pupils to investigate what sources of information influenced sexual initiation. The researchers found that information from parents, siblings and friends influenced sexual debut, however due to the cross sectional design of the study no line of causality between messages and debut could be claimed (Ruiz-Canela et al., 2012).

Another Latin American study from Brazil used a different quantitative approach conducting structured interviews with 383 youth (Borges, Izumi, & Schor, 2006). The authors found that adolescents utilized a diverse and heterogeneous network of sources, with parents the most important sources. A limitation of the study was that teachers and health professionals were combined as “other”, thus their differing and potentially complimentary roles were not explored. In additional sources such as TV and internet were not included (Borges et al., 2006).

Moving away from Latin America, a study from the UK investigated a sample of 2036 adolescents, surveying which sources of information youth found most useful and approachable (Whitfield, Jomeen, Hayter, & Gardiner, 2013). As with the previous two Latin American studies, results showed that friends and mothers were the most useful informal sources, whilst schools were the most useful formal sources. A gender difference was found in use of sources with females utilizing health services more, while males relied more on schools and internet. Due to the quantitative nature of the study, the actual characteristics of the sources, which made them useful or trustworthy, was not explored. The researchers suggested qualitative research, as well as research in other cultural settings should explore this topic further (Whitfield et al., 2013).

One such piece of research, in a very different cultural setting, was conducted in Nigeria (Onyeonoro et al., 2011). In this small quantitative study, 304 high school adolescent girls were surveyed to identify sources of information and likely effect on sexual practice. In this setting where premarital sex, early sexual debut and unprotected sex was common, the researchers found that peers and media were the first and primary sources of information. They also found that these sources had an influence on sexual behaviour by encouraged early sexual debut. The authors underline a lack of competency on the part of parents to talk to their daughters about sex and highlight that family communication about sex is taboo in the Nigerian context (Onyeonoro et al., 2011). This contrasts to both the Latin American and UK

setting where parents were a common and trusted source of useful information. One considerable limitation is that the study does not include male adolescents and the small sample size makes generalization difficult.

Two studies from the United States have explored sources of sexual health information with a qualitative approach, investigating in greater depth the interactions between different sources and the way adolescents negotiate the networks of information around them. Firstly, Dolcini, Catania, Harper, Boyer, and Richards (2012) conducted structured interviews with 81 heterosexual African American youth exploring what sources adolescents used and how useful these sources were to them. In direct contrast to the Nigerian study mentioned earlier, parents and schools were the primary sources of information, with peers found to be a common, but less useful source of information. The content of the communication from these sources focused on pregnancy and STDs with few adolescents receiving messages on sexual abstinence. The detailed nature of the qualitative data collected allowed the researchers to develop a pattern of four types of sexual health information networks: *Rich and consistent*; *sparse, inconsistent*, and *sex negative*. The authors define *sex negative networks* when describing adolescents whom receive consistently sex negative or perceived sex negative messages, and thus form an opinion that sex has only negative outcomes, cannot be pleasurable and is “*unwholesome*” (Dolcini et al., 2012, p. 13).

In another study, Jones, Biddlecom, Hebert, and Mellor (2011) conducted in depth interviews with 58 youth from three schools in two geographical regions that were “*racially and ethnically diverse*” (p. 423). These researchers explored the sources of information adolescents used to find out about contraception and the extent to which they trusted these sources. Like Dolcini et al. (2012), Jones et al. (2011) found that school and family were key sources eliciting high levels of trust. In addition friends were seen as important, although less trustworthy source of contraceptive information. The authors found two emergent themes in their data: wariness about hormonal contraception and a belief in the compatibility of contraception and abstinence messages. This contrasts to the arguments of those opposing comprehensive sex education claiming that adolescents become confused by mixed messages of abstinence and contraception (Kirby, 2008). Unlike Dolcini et al. (2012), Jones et al. (2011) found that many adolescents had been exposed to abstinence messages, however abstinence was defined in different ways, for example as “*waiting until marriage*” or simply “*waiting*”.

In both studies, concerns were raised surrounding inconsistencies in sexual health messages and the subsequent confusion this caused for adolescents. However, both studies included participants with positive experiences regarding their sexual health information networks (Dolcini et al., 2012; Jones et al., 2011). Both studies focus on heterosexual relations, Dolcini et al. (2012) explicitly so by excluding homosexual participants. Jones et al. (2011) state that they assumed participants were talking of heterosexual vaginal sex, however there were four interviews where they suspected the participants were homosexual or lesbian. It is unclear why these studies wished to study only heterosexual relations when homosexual, lesbian, bisexual and transgender youth (hereafter called *sexual minority youth*) also need information on sexual health (Rose & Friedman, 2012).

All the studies reviewed in this part have a number of common traits. They show that adolescents utilise a range of different sources from informal sources such as parents, friends and other media; to formal sources such as teachers and health care staff. Internet may be regarded as both an informal and a formal source, depending on which information is sought. The chosen source of information and the utility and trustworthiness of each source seems to depend specifically on what information is sought. However, as this brief literature review has shown, there are also clear cultural differences in the acceptability of different sources. This implies a dynamic relationship between sources of sexual health information, specific adolescent sexual health information needs and sociocultural context.

Justification for study

Previous research has highlighted that Chilean students also are exposed to information on sexual health from an array of different sources with potentially conflicting messages (Pérez et al., 2004). These conflicting messages are described by Casas and Ahumada (2009) who describe Chile as a society with double standards with sexuality being *sold* to teenagers everywhere through marketing and other popular media, whilst conservative politics maintain a single stance on abstinence and denial of teenage sexuality.

Regarding which sources are the most common in Chile, González et al. (2007) found schools to be the main source utilized by the youth in their large sample, whilst Pérez et al. (2004) found that parents were the main source utilized by youth in their smaller sample. These quantitative studies often include large samples and provide valuable insight into sexual health variables, but they have the disadvantage that the voices of the individual adolescents

are often lost in measuring only pre-defined variables (Silverman, 2010). Although these two studies name the most common sources of information, they do not provide information as to when, what and how the information is conveyed as well as how much the adolescents actually trust this information. To contrast both these findings, it has been claimed that peers and mass media are the main sources of information on sexual health for adolescents in Latin America and the Caribbean (Schutt-Aine & Maddaleno, 2003).

To the best of my knowledge, no qualitative study has been undertaken in Chile specifically exploring how adolescents learn about sexual health, what information they seek and receive and from what sources, how the information is communicated, whether they trust the information and how gender influences their learning. The purpose of this study is thus to fill the gap in the literature on adolescent sexual health in Chile. Focussing broadly on sexual health and sexuality rather than only contraception or pregnancy widens the scope of the study beyond prevention of pregnancy and STDs, aiming to explore wider issues surrounding sexuality and including perspectives of sexual minority youth.

Research objective and questions

Research objective:

To explore sources of information and adolescent learning about sexual health and sexuality in Chile.

Research questions:

1. Where do Chilean adolescents learn about sexual health and sexuality?
2. What do adolescents learn from these sources?
3. How is this information communicated?
4. How do adolescents judge the trustworthiness of the information from these sources?
5. What words are used in adolescent sexual health and sexuality discourse?
6. How does gender influence adolescent learning about sexual health and sexuality?

Chapter 3: Research Design and Methodology

Given that no studies were found specifically exploring sources of information and adolescent learning about sexual health and sexuality in Chile, the objective and research questions of this study are exploratory and descriptive in nature. Furthermore, after critiquing the methods utilised in previous research and seeking inspiration from the theoretical perspectives described in the following section, I believe a qualitative methodology is most appropriate for answering the research questions. Since a number of international studies have explored adolescent sources of sexual health information, including in Latin America, I felt justified in not designing a purely exploratory study. There was no reason to doubt that Chilean adolescents learn about sexual health and sexuality from many of the same sources as youth from other countries.

Theoretical perspectives

This study crosses what Newman (2011, p. 38) describes as the blurred line between descriptive and exploratory studies. Keeping in line with the descriptive aspects of the study design, thematic focus group and interview guides taken into the field have been inspired by previous empirical studies and theories on human development. Throughout the data collection and analysis, unanticipated themes emerged, and new theories were drawn on to aid in the interpretation of the data. Therefore, this study represents what Fangen (2004) describes as an *abductive* approach, starting out with theories and pre-understandings (deduction) and yet being open to themes emerging from the empirical data (induction).

The main theoretical perspective shaping the literature review and design of this research is Bronfenbrenner's holistic ecological model of human development (1979), presented in the previous chapter. Viewing the individual in the context of their wider ecosystem allows for contextualising the individual in their social world, before exploring the interactions between the individual and the layers of their ecosystem, and finally returning to the whole ecosystem perspective again. This reflects the hermeneutic cycle, viewing the whole, then exploring each part, before returning with new perspectives to the whole again (Kvale, 1996).

As described in the introduction, sexuality can be defined as a social construct under the control of social institutions and socializing agents. Following this line of thought, DeLamater (1989) has elaborated a similar multi-level model specifically looking at

institutional and interpersonal control of sexuality. His model includes individual, interpersonal, subcultural and macro factors that control individual sexual beliefs, attitudes and behaviours (DeLamater, 1989). This model further supports this study's holistic, ecological view of adolescent sexual health.

Over the course of the fieldwork and data analysis, new theoretical perspectives have been drawn in to help analyse and interpret the data collected. Most significantly, the emergence of gender socialization as a key theme in the adolescent and key informant discourses led to an incorporation of feminist, as well as gender theories in the discussion (Chant, 2003; Haas, 2010). This was especially relevant in the discussion of gender sexual double standards, stigmatization of female sexuality and the situation of sexual minorities in Chile. Foucault's (1990) theory on social construction of sexuality and institutional (in particular religious) control of sexuality have also been drawn on. Furthermore, theories related to the concept of risk have been utilized to shed light on the "risk" focus of current sexual health discourse (Lupton, 1999). Lastly, Bandura's theory of sexual self-efficacy, has also been considered during analysis of the findings (Bandura, 1992; Breakwell, 1997).

Methods

For this study, qualitative methods of semi-structured interviews and focus group discussions were chosen. These methods have strengths and limitations, which will be discussed here.

Semi-structured interviews

The strengths of semi-structured interviews are that they allow for data collection on an individual's personal and unique beliefs, ideas, attitudes and interpretations of their social world. Ideally the interview setting provides a safe, non-judgmental environment where the participant feels empowered to share their perspectives, experiences and symbolically 'invite' the researcher in to see the world from the their perspective. In this way the participant is both the centre and point of departure of the research (Dahlgren, Emmelin, & Winkvist, 2007).

One limitations of these interviews is social desirability bias, whereby a participant responds in a way that puts them in best possible light (Neuman, 2011). The researcher is the main tool in interview research, and therefore needs to be *calibrated* like any other research tool through critical self-reflection and transparency in presenting their personal influence on data collection and analysis. Formal interviews, like focus group discussions, are artificially

constructed interactions whereby the researcher and participant assume different roles with differing power balances and interact in a more or less artificially structured way (Kvale, 1996). This means the data collected does not accurately reflect genuine interactions from the *real world*, as with more observational and informal interview methods. Although these limitations exist, ways of reducing the power imbalance and potential researcher biases will be discussed in the sections on trustworthiness of the data.

Focus group discussions

Focus group discussions have the strength of providing large amounts of information on how individuals in a social interaction verbalise opinions on a topic of common interest (Halkier, 2010). Furthermore, the social process can help develop knowledge that may not be expressed in an individual interview, and the interaction itself provides valuable data on social discourse (Halkier, 2010). None of the studies found in the literature review of sources of sexual health information utilised focus group discussions, however these discussions are valuable when exploring issues that reflect real social discussions in the wider society, and have been used in other settings to discuss topics of adolescent sexuality (Allen, 2007; Hyde, Howlett, Brady, & Drennan, 2005; Selikow et al., 2009). Discussions around sexuality are highly present in the contemporary Chilean social and political climate, therefore focus group discussions with adolescents can be seen in light of current social and political discourses.

The limitations of focus group discussions include the effect of social control and the group dynamic on individuals wishing to share opposing or controversial views (Halkier, 2010). The group dynamic may be controlled by one or more participants resulting in some participants not taking part in the discussion, leading to either a *consensus* or a *polarising* effect that may not reflect the views of all participants (Halkier, 2010). Another limitation is that although focus group discussions can be analysed for both verbal content and social dynamic, ultimately the discussion is an artificial construct in a non-natural environment. Observation as a method would likely collect more *authentic* data on social interactions in their natural settings. Even given these limitations, focus group discussions were chosen as a method for aiding in contextualization of the interview guide and for triangulation of data collected from interviews.

Key terminology

The three key terms used throughout the interview and thematic guides are *sexual health*, *sex education* and *sexuality*. I have my own definitions of what these terms mean, which are shaped by my nursing education, literature review in this study, as well as my overall human rights approach to health. The challenge was to ensure *intersubjectivity* in the interview situations, in other words that the interview participants and I shared the same understanding of these three key terms. After asking participants in the initial focus group discussions and pilot interviews what their definitions were, it became clear that there were many ways to define these terms, particularly *sexuality*, and the definitions were often far narrower than my own. Therefore, in every interview and focus group discussion, participants were asked to define these three key terms. Through questioning and probing during the interviews, I aimed to bring in elements of my broad definition of *sexual health*, *sex education* and *sexuality* for discussion.

Fieldwork

Study setting – High schools

The core data for this study was collected through semi-structured interviews and focus group discussions with high school students. It is therefore helpful to understand a little of how the Chilean school system is structured. Some schools provide education from pre-kinder to 4th grade of high school (all 17 years), while others are only pre-school (four years), elementary school (eight years) or high school (four years). Schools may be religious or secular and within the spectrum of religious schools there is a range from those run by specific orders (often run by nuns and priests) to those primarily guided by religious principles. Even secular schools may have voluntary religion classes.

Chilean schools can be funded either completely by the state (municipal), partially by the state and partially by parents (particular *subvencionado*) or fully by parents (*privado*). Some schools give the option for students to focus on the sciences, humanities or more technical degrees, whilst others have a solely academic focus.

Chilean schools often have a psychologist and/or *orientator* who work with pupils on an individual and group basis, combining teaching and individual guidance. These psychologists may be involved in coordination and teaching of sex education classes as well as working with topics such as bullying, complex home situations and career guidance.

Study population: Adolescents

The population of this study was high school and university pupils between the ages of 16-19 years, residing in Santiago, Chile. The study includes a sample of adolescents from three high schools with different characteristics in three municipalities, namely Independencia, Recoleta and Las Condes. Three high schools were chosen to capture a diversity of youth experiences as the schools differed by size, socioeconomic status, geographic location, religiosity and curriculum. The sample also includes university students between the ages 18-19 years attending a public university (See appendix 1 for a map of Santiago and brief institutional profiles of the three schools and university).

Study population: Key informants

The aim was to interview key informants who work with adolescent sexual health, either in an active provision of information or in any other way important in influencing how adolescents learn about sexual health. Which key informants would be interesting to interview was defined in the field in response to data collected from the adolescents on which people, organizations or institutions provided them with sexual health information

Sampling

As with all qualitative research, the aim of this sample is not to be generalizable across a larger population, rather that it represents a maximum diversity and variation (Patton, 2002). Sampling techniques used were varied both to ensure maximum variation in the sample and in response to practical constraints of sampling adolescents in school and university settings.

Sampling for adolescent interviews (Patton, 2002):

- ***Maximum variation sampling*** – in this sampling technique a range of different characteristics of a desired sample are developed. In this study these characteristics included gender, age, school, socioeconomic status and religiosity, therefore it made sense to sample in different high schools in Santiago.
- ***Deviant case sampling*** – this sampling technique aims to select cases that are very information rich or in some way different from the main study population. In this study it was desirable to include adolescent parents in the sample as they had experiences that were both interesting and different from their adolescent peers.

- ***Purposeful random sampling*** – this technique is used when more participants are willing and eligible to participate than it is possible to include, therefore of the eligible participants, a random sample is selected. The aim here is for credibility of the results, rather than representativeness (as with quantitative studies). In this study, more adolescents volunteered to participate than it was possible to include, so the interviewees were randomly selected.

Sampling adolescents for focus group discussions (Patton, 2002):

- ***Homogenous sampling*** – this sampling technique aims to collect in depth information on a “homogenous” sub group. It is common to seek a certain level of homogeneity in focus group discussion samples to encourage discussion but not “extremes” of experience that make discussion unfruitful. In this study, homogeneity of the sample was based on age, gender and institution (school or university faculty).
- ***Opportunistic sampling*** – this sampling technique is unique to qualitative research whereby taking advantage of unforeseen opportunities to select a participant even after the fieldwork has begun. In this study, opportunistic sampling was used in the case of focus group discussions when poor participant turn out on the day led to the on the spot decision to sample friends and classmates of the participants present.

Sampling for key informant interviews (Patton, 2002):

- ***Maximum variation sampling*** – the range of characteristics of the sample were different occupations, years and experience working, different occupational settings and different fields of knowledge (for example medical, educational or theological).

Recruitment: Steps in gaining access to recruit adolescents

In order to be able to recruit adolescents through the three chosen high schools, phone or email contact was initially made with each principal to organize an interview. Subsequently my local co-supervisor Dr Montero and I met with each school principal to present the project with a two-page summary of the project proposal, copy of the ethical approval from the Faculty of Medicine, University of Chile, and copies of ethical consent forms relevant for the population to be recruited. Each school principal consented and provided a contact person (school psychologist) to help facilitate recruitment. Together with the psychologists we made a plan for recruitment and I presented the project to either a selection of eligible students or

an entire class. Volunteers under 18 years of age were given a parental consent form to take home, which were later collected by the teachers or psychologists. Finally, a date and time for each interview was coordinated together with psychologists, teachers and pupils.

At the university, my research assistant and I visited the director of the anthropology faculty, presented the project and a summary of the proposal, provided a copy of ethical approval from Faculty of Medicine, University of Chile and a copy of the relevant ethical consent form.

Recruitment: Different strategies and the final sample

Adolescent participants were recruited from three high schools and one university faculty. Age was the only exclusion criteria for participation, however one female twin was excluded after interviewing her sister. Prior to data collection it was unclear how many individual interviews would be necessary to reach saturation in the data,⁶ and how many interviews would be feasible in the given time frame. In the end, 20 high school adolescents were interviewed individually, one female and one male focus group discussion were held at a high school with seven participants each, and finally one female and one male focus group at the university were held with five participants each.

During the recruitment process, it was necessary to rely on support from both the school psychologists, teachers and lecturers to facilitate the recruitment. This presented challenges faced by other researchers conducting school based studies into adolescent sexual health, namely that given the busy work schedules of these psychologists, teachers and lecturers, it was not always easy to make demands or be too directive about the recruitment process (Hyde et al., 2005). Thus a range of different recruitment strategies were utilized, each with their own strengths and limitations. These are presented in the following table:

Institution	Activity	No	Recruitment Strategy
School 1: Indepen- dencia	FGD >18 yrs.	2x7	The psychologist approached classrooms with pupils in fourth grade and with permission of teachers, all eligible students over 18 years of age were asked if they were interested participating in the project. In total 20 volunteers were guided to the library where I briefly presented the project with time for asking questions. Seven males and seven females

⁶ Saturation of data occurs when continuing data collection no longer provides new information on specific research objectives or questions.

			agreed to participate. On the day of the male focus group, only three participants came, thus to be pragmatic the male pupils suggested asking their friends if they wished to participate. Similarly, only three females came so the pedagogy teacher approached four more participants, making a total of seven females.
	Interview	2	Two fourth grade students whom initially volunteered for the focus group discussion but were absent on the day of the discussion were asked by the school psychologist if they would like to participate in individual interviews. These two participants were both adolescent parents (one male and one female).
	Interview	2	To gain a diverse sample and ensure that the participants were not all friends, together with the psychologist we presented the project to four teachers of pupils in third grade, asking for names of two pupils whom they thought might want to participate. I presented the project to the eight pupils with time for asking questions. Four students took parental consent forms home and two pupils returned these (one male and one female)
School 2: Recoleta	Interview	6	Since the previous approach with under 18 year olds in school 1 gave a relatively low participation and may have included selection bias in which pupils the teachers most wanted included in the study, a new approach was applied. The school psychologist randomly picked one class of third grade pupils and I presented the project to the entire class with time for asking questions. 25 students took parental consent forms home and 9 pupils returned these (two males and seven females). The two males and four females were interviewed. The females were randomly selected and it became clear that many of them were friends. Thus given time constraints and saturation of key themes, only four females were interviewed.
School 3: Las Condes	Interview	5	In this school I asked the course coordinator to select 10 students in fourth grade with diverse backgrounds, attitudes and experiences. The course coordinator approached 10 students asking if they would like to participate in a project. In the psychologists office I presented the project to the 10 pupils with time for asking questions. Nine pupils wished to participate and were given an information sheet to give to their parents (this was a special request from the school principal). Four pupils were randomly selected to participate (two males and two females). One

			additional participant was purposefully asked to participate as she is an adolescent mother.
	Interview <18 yrs.	5	As in school 2, the psychologist chose a third grade class and I presented the project to the entire class with time for asking questions. 10 students took parental consent forms home and seven pupils returned these. One participant was excluded after we interviewed her twin sister and one interview was cancelled due to a medical emergency. Five participants were interviewed (three males and two females).
University	FGD >18 yrs.	2x5	With permission from a lecture, the project was presented to first year anthropology students with time for asking questions. In total 13 students volunteered. Due to few male volunteers, the project was also presented to second year anthropology students where three males volunteered. The final focus groups included five males and five females.

The final sample for individual interviews included ten female and ten male participants, two of which were adolescent mothers and one of which was an adolescent father. As for age, nine were 16 years, four were 17 years, four were 18 years and three were 19 years. 11 participants lived with both their biological parents, two males lived with their mother and step father, one participant lived with his sister and grandparents since his own parents lived in another city, and six participants lived with a solo parent. Of these, five were solo mothers and one was a solo father. Four participants described currently being in a relationship with a boyfriend or girlfriend, however multiple participants alluded to previous relationships (current or previous relationship status was not explicitly asked about). No participants described same-sex sexual attraction or relationships. Four female participants described themselves as virgins whilst four female and one male participant referred to being sexually initiated (including the three adolescent parents). Six participants referred to themselves as catholic or evangelical Christians, whilst two described themselves as non-religious but coming from religious families. One participant was active in a catholic youth group that performed missionary work.

Half the participants participated actively in sport or dance activities whilst three described their main interest as music. The participants described varied interest in school with ten participants describing their future plans to study at university (most commonly graphic design, architecture and medicine). Three participants had experiences living overseas with

one or both of their parents, describing through the interviews how these experiences compared to Chile. Finally, the participants showed varying degrees of curiosity and engagement with the topic of sexual health and sexuality, with some describing in depth their experiences learning from the information they had received or sought, with others providing short, non-committal answers to probes on their learning. In general, the voluntary nature of participation means that the sample population may have been more interested in the topic than adolescents in general.

The final sample of focus group discussion participants cannot be described as thoroughly, since in the discussion participants were not asked to introduce themselves in detail. Two notable characteristics are worth mentioning. Firstly, three females in the initial female high school focus group were Peruvian by origin but had lived many years in Chile. It was not initially planned to include participants of other nationalities, however the discussion that developed shed interesting light on their observations of Chilean society in comparison to Peru. Secondly, one male in the university focus group openly shared his homosexual orientation whilst describing his opinion of generational change in Chile. This led to an interesting group discussion.

The number of key informant interviews could not be determined before going into the field. Information from adolescent interviews highlighted the importance of school teachers and health professionals in provision of information. The influence of religion on sexual health discourse in Chile was also discussed, therefore it was decided it would be interesting to also interview a representative of the Catholic Church with experience working with adolescents. In the end, seven key informants were interviewed. These participants were all contacted directly to ask for participation. Recruitment strategies are presented in the following table:

Institution	Occupation	No°	Strategy
Schools	Psychologist	3	After completion of the individual interviews with participants in the high schools, each of the psychologists was asked if she would like to participate in an interview.
Healthcare Clinic	Midwife, Paediatrician, Gynaecologist	3	Two of these participants volunteered to participate after a short presentation of the project to the sexual health clinic staff and one participant was approached specifically.
Catholic	Priest	1	Contact was made with this participant through a shared acquaintance.

Church

Via email I presented the project to this participant and he agreed to participate.

The final sample of key informants included three school psychologists working in the selected high schools. One psychologist was a new graduate in her first year working in the school, whilst the other two psychologist described having many years of experience. One of these two also worked part time as a clinical psychologist. The healthcare professionals all described many years of work experience. One participant had worked 20 years in her profession and thus had interesting reflections on generational change in the adolescent population. Another healthcare professional worked both on the primary care and tertiary care levels, as well as in the public and private health systems, all of which meant she had interesting reflections on both population differences between the preventative and curative levels of health care as well as socioeconomic differences across public and private health services. The final healthcare professional had many years experience working with another age group and had only recently started working with adolescents, which provided more holistic, life span perspectives. Finally, the catholic priest had worked for over 25 years as a priest in a range of different municipalities in Santiago with diverse populations including high proportions of adolescents. Although he did not currently work exclusively with adolescents, he had previously worked for a period of nine years as leader of the section of the church that specifically focuses on young people in Santiago.

Data collection

Prior to starting data collection I employed a research assistant to help with data collection and analysis. My assistant accompanied me to all adolescent interviews and focus group discussions. I conducted all interviews and focus group discussions in Spanish. All interviews were audio recorded and transcribed verbatim in Spanish primarily by myself, while my assistant transcribed two interviews and three focus group discussions. A selection of the transcriptions I had completed were checked by my assistant for accuracy. We discussed the transcription accuracy and concluded together that none of her corrections changed the meaning of what was said during the interview. All quotes used in the findings were translated into English by me and checked by a Spanish native speaker.

As verbal conversation is converted into written text, it becomes decontextualized and valuable data about the social interaction is lost (Kvale, 1996). In order to capture some of

this data, each interview was complimented by observations written down by my assistant during the interviews and observations I wrote after each interview. Since data analysis is an on-going process, which starts in the field, all interviews transcribed by me were completed within 1-3 days of the interview to allow for on-going analysis.

Semi-structured interviews

Interviews were semi-structured to gather data on all six specific research objectives. Flexibility was maintained in allowing for divergences and narratives interesting to the general objective of the research. Different types of interview questions were formulated with a focus on questions being short, simple and non-judgmental, avoiding too many 'why' questions that could make the participant feel interrogated (Kvale, 1996). Techniques in active listening, probing and clarification of answers were key to improving therapeutic communication (Kvale, 1996). Given the sensitivity of the subject matter, a particular focus was placed on building rapport and trust with the participant both before and throughout the interviews. The possibility of conducting follow up interviews at a later date were discussed with each participant. However given the time constraints involved in interviewing busy high school students within the school setting, no follow up interviews with adolescents were conducted. One short follow up interview was conducted with a health professional to clarify a conceptual misunderstanding that arose from the first interview.

The semi structured interview guide for the adolescent interviews was initially drafted based on the qualitative and quantitative literature found on sources of adolescent sexual health information and in particular the two interview guides used by Jones and Biddlecom (2011) and Dolcini et al. (2012). The WHO toolkit for interviewing young people about their reproductive and sexual behaviours was also used as inspiration for formulating questions (Ingham & Stone, 2001). To help maintain credibility (internal validity), ensuring that the interview questions reflected accurately the actual research questions, Kvale's tabular method of turning "*thematic research questions [...] into interview questions*" (1996, p. 131) was used. Following this method, the six research questions were put into a table and interview questions were categorised according to which research questions they were answering (with some obvious overlap). The initial interview guide was then piloted with two nursing students, one 21-year-old male and one 20-year-old female. Although they were older than the target population, piloting provided an opportunity to revise the interview questions, practice interview technique and receive constructive feedback.

The interview guide was highly flexible tool, continually revised and altered during the fieldwork. The initial guide was highly detailed, functioning as a type of *safety tool* for me, since I was conducting the interviews in a foreign language. Once interviews had commenced, the guide was continually revised with surplus questions deleted, hard to understand questions reworded and new emerging questions added. Wording of questions was also revised together with the research assistant to ensure optimum clarity for the participants. My assistant and I planned pre-analysis sessions to review transcripts and assess the need to alter the interview guide. As interviews progressed, the guide was used less and less.

The interview opened with a general request for the participant to introduce themselves and asked about their interests. After this, the participants were asked to define in their own words the key terms *sexual health*, *sex education* and *sexuality*. Following on, the core of the interview included a section with questions on each potential source of information: family, school, friends, internet, health professionals, television, movies, advertisements, radio and religion. A number of probes were included for those adolescents whom did not spontaneously give in depth information about their experiences or opinions. Example probes were about the type of communication, content of the information, how helpful it was and about how they felt during the communication. Finally, the interview concluded with general summarising questions about what they felt all adolescents should learn about and where this information should come from. It was neither the aim nor was it possible to ask all questions in all interviews. Some adolescents required a more 'exploratory' approach with few open questions, whilst other adolescents required more a 'descriptive' approach with many specific questions and extensive probing.

In the case of the key informants, separate interview guides were developed for each key informant group. My assistant and I reviewed all of the sections of the adolescent interviews and focus group discussions directly related to the informant group (for example school or health professionals). These guides included only a few exploratory questions as well as examples of anecdotes or themes from the semi-structured interviews that were brought up for discussion with the key informant. Due to time and financial constraints, I conducted the key informant interviews alone in Spanish without my assistant.

All interviews were conducted during school or office hours and in empty offices or interview rooms. The chairs were set up in triangular way with the participant facing the window so that they could see the researcher and assistant at all times but could also look out the window if they did not want to give eye contact. This was an attempt to make sure the participant did not feel interrogated but at ease in the interview situation. Interviews were between 45 to 75 minutes long, with one exception of an interview where the participant was pushed for time and the interview was condensed to 40 minutes. A selection of food and drink was provided.

Focus group discussions

Two focus group discussions were organised upon arrival to Chile, one with females and one with males. The aim was to find out what words are used to describe sexuality, both by adolescents and the society around them and what sources of sexual health information Chilean adolescents use. Results from this focus group helped us to revise the semi-structured interview guide. Upon completion of the interviews, two new focus group discussions were conducted with very different focus. In these final discussions, a few preliminary results from the semi-structured interviews were presented to the adolescents in order to stimulate an interesting discussion and help validate the findings.

The sample includes adolescent females and males 18-19 years old living in Santiago. Choosing adolescents over 18 years was a pragmatic choice to facilitate the informed consent process. Participants were encouraged to talk with their parents about their participation in the study. Although normally for focus group discussions there is a desire for *homogeneity* in the sample, and for participants to be stranger, for discussions around sensitive topics such as sexuality, it may be advantageous that the participants know each other and have a level of trust within the group to create a safe environment for discussion (Halkier, 2010; Hyde et al., 2005). In the first three focus group discussions all the participants knew each other, whilst the final group included both first and second year university students, some of whom had not met before. Conducting mixed gender focus group discussions was considered, however to encourage *homogeneity* and increase the level of trust between participants, all groups were separated by gender.

My research assistant was present to observe, take notes, keep time and support transcription of the discussion, while I was the focus group moderator. For the first focus group discussions the discussion opened with an 'ice breaker' activity whereby all participants were

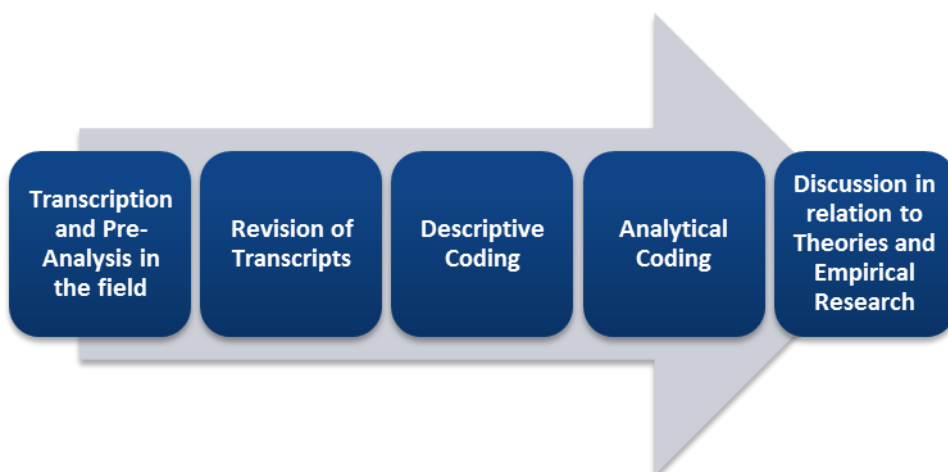
asked to write anonymously a list of all the words they knew related to sex, sexual health and sexuality, then followed on with open questions about different sources of information and how they utilized these to learn about sexual health and sexuality. There were open questions about all sources from the literature and there was also room for spontaneous probing on new emergent themes.

For the final two focus group discussions a new thematic guide was developed with an ‘ice breaker’ activity where the participants were presented with the list of words created by participants in the first focus groups and asked to comment on these. Following on, the guide included a number of themes or examples from adolescent interviews that were interesting, surprising or particularly noteworthy. Again, there was room for spontaneous probing on themes discussed by participants.

The school focus group discussions were held in an empty library and the university discussions were held in a faculty conference room. The discussions were between 50 to 80 minutes long. Food and drink were provided.

Data analysis

The data analysis for this project is fluid and incorporates an *abductive* approach (Fangen, 2004). Firstly the design of the project is informed by an extensive literature review and by different theoretical perspectives mentioned earlier. At the same time, the analysis is inductive in the sense that new themes emerged from the data that were unexpected and contrasted earlier preconceived ideas from the literature and theory were included. Data analysis started in the field and continued in a more systematic manner after returning from the field. The data analysis process can be described as follows:



Data analysis in the field

Data analysis started on the first day of data collection with observations of the interviews, journaling notes of my experiences as a researcher, and transcription of each interview. Furthermore, debriefing and pre-analysis sessions with the research assistant supported ongoing analysis of the data collected in relation to the research objectives and emerging themes. During these sessions we discussed recurring themes, similarities and differences between adolescent responses. In this way we began to observe saturation of the data.

The final data set includes audio recordings and transcripts from 27 interviews and four focus group discussions, observations of each interview or discussion, notes written by my research assistant during the interviews, mind maps created in our analysis sessions and finally a personal field journal written regularly. The writing of the journal itself worked as a tool in reflection and analysis of themes and experiences from the field. Journaling also allowed for linking fieldwork experiences with observations from everyday life in Santiago. Sexuality is a topic that interest many people, therefore the journal includes stories shared by friends and acquaintances about their own sex education in school or in the home, or their opinions on sexual health issues. I was also in Chile for the November presidential elections where sexual and reproductive health topics, particularly legalization of therapeutic abortion and same sex marriage, were hotly debated. Therefore my journal also contains reflections on what I observed and conversations I had with others during the elections.

I was lucky to live with a Chilean family during my data collection period. The family of four included two adolescent females. Living with this family gave me the opportunity to observe first-hand the highs and lows, joys and challenges of being an adolescent in contemporary Chile. The girls taught me about adolescent trends, language, fashion and behaviour. Furthermore, through conversations with their parents I gained insight into the joys as well as the challenges facing parents raising adolescents in this context.

Data analysis after fieldwork

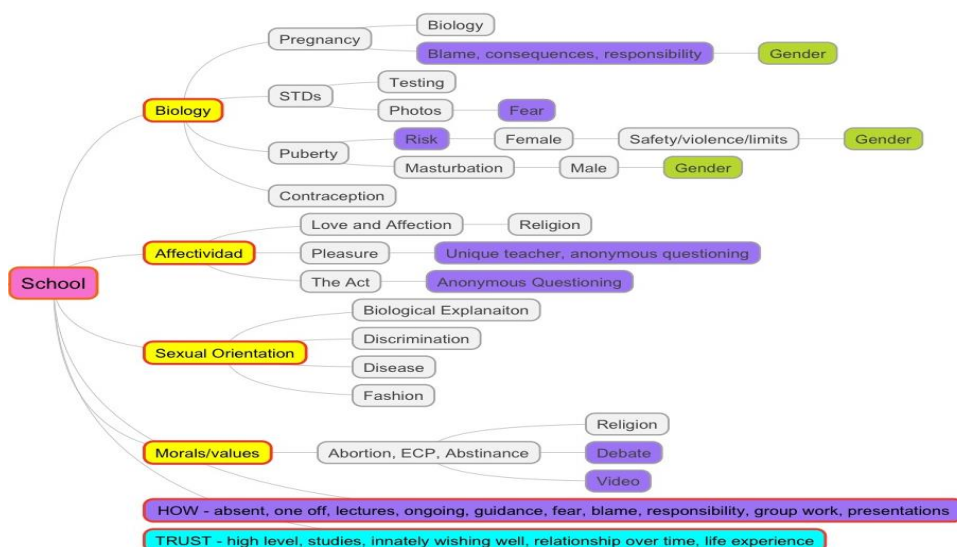
The formal data analysis performed after returning to Norway draws primarily on Fangen's (2004) three levels of analysis and Taylor-Powell and Renner's (2003) five steps of analysis. A detailed stepwise description of the analysis process is provided below, keeping in mind that creativity and flexibility in the process means that the steps were not always followed in a completely linear fashion.

Step One: Descriptive coding - The participant voice

The idea with this first step of analysis is to capture the participant voice with limited analysis. Fangen (2004) describes this as the first level of data analysis, describing the content whilst maintaining the participant voice as much as possible. Taylor-Powell and Renner (2003) describe this process in three steps: getting to know the data, focussing analysis case by case or by group, and coding either with present categories based on research objectives or using emergent categories that stem from the data. I have chosen to code case by case (interview by interview) and use codes stemming from the research questions, whilst jotting down in a notebook potential emergent codes.

It must be said that it was impossible to be completely descriptive as much analysis and thinking work was already conducted in the field through discussions with my research assistant, supervisors and peers. During this first step, the choice was made to focus on the initial two focus group discussions and 20 adolescent individual interviews. This was because the final two focus group discussions and key informant interviews all function as a form of validation of findings and deeper analysis of data collected in these adolescent interviews.

This process started by listening through all 20 interview and two focus group audio recordings and correcting all transcriptions. Afterwards, 36 initial descriptive codes were developed based on the research questions and transcriptions were coded manually with coloured markers according to the main categories of *source* of information (e.g. family, school and friends). Using colour coded mind maps, sub-codes were then added, providing more detail under the broad categories and case profiles were made for each participant utilizing these new detailed sub-codes. See an example for the category *school*:



Step Two: Analytical coding – Combining the researcher voice

In this step the aim was to code the data analytically in the stage that Taylor-Powell and Renner (2003) describe as the stage where the researcher reviews the codes to find connections and patterns both between and within categories. In order to do this, the data from key informant interviews, final two university focus group discussions, notes from analysis sessions, research assistant notes and field journal notes were now incorporated. The remaining transcriptions were reviewed, corrected and coded.

In this step, codes were combined, expanded and moved. During this process it became clear that new perspectives on adolescent sexual health information were gained when codes were grouped into new categories according to *content* of sexual health information (for example contraception, love, abortion or homosexuality), rather than *source*. These codes were entered into colour coded tables. This allowed for gaining a fuller understanding of what adolescents learn from these different sources, the similarities and differences between the information provided, and what gaps exist. See example for the category *homosexuality*:

Content	Source	Communication	Words
Discrimination	School Friends Parent Priest	Group work, presentations Joking Bullying (classmate, party) Guidance (respect) Personal Opinions	<i>Desviación sexual</i> <i>Repulsivo/ bacán</i> <i>Sería terrible, extraño</i> <i>Mi mama se muere...</i> <i>Aceptación</i>
Biological Explanation	School Healthcare	Lectures, Debates Consultations	<i>Desorden hormonal</i> <i>Decisión personal</i> <i>Se nace así</i>
Medicalization	Healthcare	Consultations	<i>Problemática</i> <i>Condición</i>
Fashion	Friends Healthcare School	Personal experience/opinion	<i>Moda, son/están homosexuales</i> <i>La moda de bisexualidad</i>
Contagion	Healthcare Friends School	Talking between friends Silence	<i>La fiebre</i> <i>Todos van a ser</i> <i>Propiciar la conducta</i>

Step Three: Discussion - Analysing with theories and empirical research

In this final step the data analysis consists of what Fangen (2004) calls the third level of analysis, where the researcher looks for hidden meanings in the data by analysing the emic (insider) perspectives of the participants with the etic (outsider) perspectives from external theories and empirical research. For Taylor-Powell and Renner (2003) this is the fifth step where the researcher brings everything together and interprets the data on a higher level. This step constitutes the discussion chapter of this thesis.

As the detailed colour coded mind map of descriptive codes shows, many themes were explored during fieldwork. Although the six research questions provided a great deal of structure to the analysis, many interesting themes still emerged during the data collection. One major emerging theme that I chose to explore in increasing detail in adolescent interviews, key informant interviews and the final focus groups was gender equality and gender socialization. Gender was a recurrent theme that sprung up throughout interviews through discourse, metaphors, descriptions of experiences and social critique. For this reason, gender plays a major role in the analysis of the data collected.

I have reflected that this choice to explore gender equality stems from my human rights approach to sexual and reproductive health. This rights approach sees gender equality as the building block for fulfilling sexual and reproductive rights, especially as it relates to women and sexual minorities. Therefore I have chosen to emphasise the discussion of issues related to discrimination, gender disempowerment and challenges to fulfilments of sexual and reproductive rights for adolescents. This focus was also influenced by my research assistant and her strong interest in gender studies, which in itself sparked interesting discussions during the fieldwork period. The following section on trustworthiness of the data will explore my researcher pre- understandings and assumptions, as well as introduce my research assistant, her role, interests and influence on data collection.

Trustworthiness of data collected

Trustworthiness is the overall term for whether readers of a research report can ‘believe’ in the results presented. The trustworthiness of the data collected in this research project will be analysed through a presentation of researcher reflexivity, assumptions, pre-understandings, the researcher role and the research assistant. Furthermore, the trustworthiness of the study results will be discussed in relation to the credibility and transferability of the results.

Credibility (or internal validity) refers to the study's ability to truthfully answer the questions it aims to answer and the transferability (or external validity) refers to the extent to which the findings can be applied beyond the study context (Dahlgren et al., 2007).

Researcher reflexivity

This research is based within a hermeneutic paradigm, not seeking a universal interpretation of adolescent learning about sexual health, rather to understand the unique cultural variation in the Chilean context. According to this view, no action or statement can be understood outside of its cultural context or worldview, and the researcher becomes an important tool in constructing knowledge together with the participants (Rossman & Rallis, 2012, p. 23). As with any research tool, it must be 'calibrated' through continuous reflexivity. This means that the researcher has to constantly critique the way in which their own assumptions and pre-understandings influence their role as a researcher and thus the data collected (Rossman & Rallis, 2012, p. 23). In the field, this ongoing reflection was conducted primarily in the form of journaling and discussions with my research assistant.

Assumptions and pre-understandings

My pre-understandings about sexual health and sexuality stem from my own personal upbringing, nursing and current masters education, and literature review. I was brought up in a relatively liberal, non-religious context in New Zealand and my unique combination of experiences and sociocultural influences will have shaped my own personal sexual scripts. Through this research I have had the opportunity to reflect on how this may have influenced assumptions and pre-understandings I had going into this project. One example is the fact that I asked participants to define *sexual health*, *sex education* and *sexuality*, however I did not explicitly ask participants how they defined the terms *sex*, *virginity* or *homosexuality*. This raises a new topic for future research.

My nursing education in New Zealand focused greatly on holism, situating sexuality within a holistic framework of health. My current studies in Norway have brought a strong human rights perspective into my definition of sexuality. Given this, the information I believe adolescents should receive about sexual health and sexuality includes biological, psychological, emotional, social and ethical aspects of sexuality, with a focus on promoting sexual and reproductive rights. Throughout the fieldwork I was challenged by scenarios where adolescents described their needs for information along narrow, biologically focussed

lines. Through reflection on my own pre-understanding I became aware of the importance of not imposing my holistic vision of what I believe they should learn onto the participants. Rather I sought to explore reasons why they defined their needs in this way and what sociocultural factors might influence the way they defined sexual health and sexuality, and therefore their information needs.

Through the literature review and discussions with professors and colleagues, I have come to realize that I have strong personal beliefs related to sexual and reproductive rights, and in particular gender equality, homosexuality and abortion. Thus during the interviews and group discussions, I had to be continuously aware of not imposing my opinions related to gender equality, homosexual and abortion rights onto the participants. Instead I sought to non-judgmentally explore the participant's opinions on these topics. This was not always easy, particularly when I was faced with openly discriminatory opinions. However, I repeatedly reminded myself that my role as a researcher was not to challenge their opinion, rather to explore their meaning for the adolescent and their social network (especially friends, school peers and family).

The researcher role

Research always involves power imbalances which need to be recognised and efforts need to be made to reduce the social distance between researcher and participant (Neuman, 2011). Neuman (2011) states that qualitative researchers "*walk a fine line' between intimacy and detachment*" (p. 168) and the researcher needs to create an empowering environment, sharing their position of power, whilst maintaining an 'optimal distance' between themselves and the research participants. Balancing power between the participants and myself was a constant challenge during the fieldwork and required a great deal of reflection on my researcher role. I aimed at achieving an *optimal distance* with the participants, balancing the *necessary closeness* needed to build trust with the adolescents to discuss such a sensitive subject within a short time frame, with the necessary *distance* to maintain professionalism and perspective (Malterud, 2001). Differences in age, gender and ethnicity may have contributed to both increasing and decreasing this distance.

I am a 28 years old, which made me approximately a decade older than the adolescents I interviewed. It became clear in the interviews that the adolescents all had high levels of trust in adults they interacted with, such as teachers and health professionals, so the age difference

may have been an advantage. Conversely, the age difference may also have inhibited our ability to *speak the same language*. For this reason, it was important for me to find a research assistant who was between 20-25 years old, and would be able to both connect with the adolescents culturally, as well as help me to understand the contemporary adolescent language. Being a woman may have created a distance between the male participants, and myself. I had initially thought of employing a male assistant, however after interviewing both males and females for the position, I decided upon the person I felt would be best for the role.

Interviews are artificially constructed scenarios where the rules of engagement are presented by the researcher and power between the researcher and participant is negotiated (Kvale, 1996). I tried to negotiate the power in the interviews in a number of ways. First of all, from the very outset I tried to convey my desire to share power in the interaction by collecting each pupil from their classroom and engaging them in "small talk" as we walked to the interview room. This often included asking about their classes or extracurricular activities, which helped "break the ice" before entering the interview room and going through the informed consent procedure. Also, each focus group discussion opened with introductions and an icebreaker activity. Active listening, paraphrasing, smiling and giving encouraging nods were all communication tools used to build trust and help make the participant feel empowered in their role as the story teller.

Secondly, at the start of every interview or discussion, I introduced my research assistant and explained her role. I would make a joke about not being Chilean and thus needing some "translation help" with Chilean slang, which often made the adolescents laugh. Through this joke I hoped to relax the participant and promote a more equal sharing of power between us, as they saw I was an outsider eager to learn from them. This may also have created a greater cultural "distance" between myself and the participants. The presence of my research assistant may have helped to reduce this "distance" as she is Chilean and thus able to relate better to the adolescents as a fellow Chilean young person.

My ability to communicate in Spanish was a strength in this study. First of all in the planning stages it was a strength to be able to review research published in Spanish, as well as gain an overview of government documents and laws pertaining to the topic. In the field it was a strength for me to be able to connect directly with the participants and the community around me, rather than through an interpreter. I did a majority of the transcriptions myself which was

an excellent way to come in contact with the data, uncover themes of interest to discuss with my assistant and to continuously critique my performance as an interviewer.

My Spanish is fluent but not perfect and I made many small mistakes with words and prepositions. I have reflected that this may have had a positive effect in balancing the power in the interaction, as participants also saw my vulnerability in communicating as an outsider. Not being Chilean also limited the extent to which I could understand metaphors and slang used by the adolescents, however it also meant I had no pre-assumptions as to what these expressions meant. Having a research assistant was very helpful in reducing the effect of my language and cultural barriers to understanding. Before starting fieldwork I had anticipated more problems in understanding the adolescents, however my experience in the field was that the adolescents did not use much slang and slowed down their speech for me. This may be because they knew I was not a native speaker, but it may also be that since interviews were conducted in schools, and Chilean schools emphasise respect of teacher authority, the pupils may have equated my role with that of a teacher. By introducing myself as a student there to learn from them I tried to negotiate my role as something different from a teacher.

Research assistant

My research assistant was Magdalena Rivera, a 25-year-old anthropology student completing her final year of studies. She had prior experience with qualitative research including focus group discussions and interviews. Magdalena had a particularly strong interest in the topics of gender, sexuality and maternity, and contributed with both personal and academic reflections on this research project. Coming from an anthropology background and having herself grown up as an adolescent in the Santiago, Magdalena was very focused on the social interpretations of what adolescents were saying, putting them into a greater sociocultural context. She also drew on her own experiences with sex education in school and observations she had made of sexual health campaigns.

Magdalena's role during the focus group discussions was note taking, timekeeping, as well as assisting with misunderstandings due to my Spanish language skills. During the individual interviews she took notes about themes that were discussed, recorded observations of body language, as well as constructive comments about improvements that could be made to my interview technique. Occasionally she also contributed directly to rephrasing of questions or probing on interesting responses that I had not picked up on. In this way she helped ensure I

had the greatest possible understanding of not only what was said, but also what this meant within the Chilean social and cultural context. Alongside general debriefing after each interview, we also conducted eight formal pre-analysis sessions where we discussed in more detail the data collected, created mind maps of themes emerging from the interviews, evaluated the recruitment techniques and adjusted the interview guide. This pre-analysis helped shape the direction the study took through the fieldwork.

Prior to starting the data collection, Magdalena and I discussed in depth the study aims, purpose and methods, as well as the ethical considerations of conducting the research. These considerations were particularly related to confidentiality of information and destruction of audio and transcript data after completion of the data collection (See appendix 2 for signed declaration of confidentiality).

Credibility

As mentioned earlier, credibility entails making sure that the data collected actually answers the research questions at hand. Furthermore, credibility relates to whether the research has been able to capture the multiple realities of the study participants and reported the results in a way that accurately reflects the participant's views, experiences and context (Dahlgren et al., 2007). Thus, being able to assess the credibility of the research also depends on the transparency through which the researcher describes the choices made in the research process, especially related to sample selection and choices made in data analysis (Malterud, 2001). Transparency is key in any research but particularly in qualitative research where the researcher as a 'tool' brings with them their own assumptions and pre-understandings that influence choices made in research design, data collection and analysis.

Strategies for ensuring credibility in this research project include varying types of triangulation which can be categorised using Denzin's (1989) four types of triangulation:

- ***Data triangulation*** - involved the inclusion of participants of varying ages, from different schools and institutions with varying backgrounds, as well as key informants working with adolescents. This helped to place the adolescent perspectives in the context of those actively working with adolescents in a professional context.
- ***Methodological triangulation*** – involved using different data collection techniques of semi structured interviews and focus group discussion. In particular the final focus

group discussion helped to validate the results from the individual interviews, placing them in a wider context through discussions with university students.

- ***Investigator triangulation*** – involved employing a research assistant who observed and participated in the adolescent interviews and focus group discussions. In this way she was able to contribute with her understandings of the data collected. There was also a form of investigator triangulation through discussions with my two supervisors whom each had different perspectives and insights in to the data collected.
- ***Theory triangulation*** - involved exploring a range of different theories including feminist theories, gender, risk and social constructivism, seeking to analyse the data from many different perspectives.

Transparency was aimed for through detailed presentation of myself as the main researcher, with my pre-understandings, assumptions and reflections on my role as a researcher, as well as a presentation of my research assistant. To ensure transparency in the methods used, detailed explanations have been provided of the study settings (especially school institutions), steps in gaining access to recruit participants, actual recruitment process, data collection and development of interview guides, transcription and data analysis.

The major analytical challenge in this research was that the scope of the study was very large. Exploring topics as broad as *sexual health* and *sexuality* with such a large number of participants resulted in a large amount of raw data. The final data set consisted of 387 pages of transcriptions alongside observational notes, journaling, notes from research assistant, audio of analysis sessions and mind maps. Thus, within constraints of this thesis it was not possible to incorporate everything and I have aimed to be as transparent as possible in the analytical choices that were made in relation to my human rights approach to sexual and reproductive rights.

The study also has limitations. A major limitation of the study is the lack of incorporation of parental perspectives in the data collected. Including parental perspectives could have provided valuable insights into how parents experience communication with their adolescents, the challenges they face in this communication, and their opinions of the changes going on in Chilean society in relation to sexual health, sexuality and gender equality.

A potential limitation in this study is the need for ethical consent from parents of participants under 18 years of age. It was anticipated that parental consent might be a barrier to participation, and in total, 18 of the 39 consent forms (46%) were returned. It is unclear why these were not returned. One reason may be that due to social pressure, adolescents may have felt pressured to volunteer to participate because their friends volunteered, when in reality they did not wish to participate. The effect of this could be that the sample has an overrepresentation of adolescents with particular interest in the topic of sexual health. Other reasons may be that they forgot to ask their parents, lost the consent forms, did not believe their parents would consent or did not receive consent. This final option raises a concern that the need for parental consent would bias the sample to only include adolescents with open communication with their parents on sexual health issues, however, three participants whom reported no communication with their parents still received consent to participate.

Finally, a limitation of the study is that given the age of the adolescents, participants were often asked about experiences they had had many years earlier. Thus recall bias may have influenced what information the participants remembered and shared. In order to improve recall, adolescents were often probed as to how they felt in specific situations. Although they might not initially remember the content of conversations with their parents during puberty, adolescents often remembered how they felt in these situations, which then triggered their memory. Follow up interviews and participant validation of the data may have reduced this recall bias, but this was not feasible within the constraints of interviewing in schools.

Transferability

Transferability relates to the extent to which results can conceptually (not statistically) be applied to other contexts and is strongly linked to sampling (Malterud, 2001). To increase the possibility of the results being transferable to other settings, I aimed to describe the Chilean context, study setting and population in detail. Furthermore, the different sampling procedures utilized aimed to ensure maximum variation and have been explained in detail.

It is likely that the general results are transferable to other Chilean adolescents all over the country, as the adolescents are exposed to many of the same core socializing agents. These agents include schools (and thus teachers and same-age peers) and religion, as well as internet and media. Specific aspects of the results may be less transferable in rural areas due to differences in access to healthcare professionals, as well as the existence of more traditional

gender roles in rural contexts. Also, the extent to which the results are transferable to specific indigenous groups, immigrant groups or sexual minority youth is also hard to determine.

In the wider Latin American and global contexts, the results may be transferrable to other urban adolescent populations where primary socializing agents are family, schools and healthcare professionals, where traditional religious gender roles still greatly influence discourse on sexual health and sexuality, and where generational change is challenging these traditional roles.

Ethical considerations

The primary ethical considerations of this study relate to obtaining voluntary informed consent as well as evaluations of potential benefits and harm. Verbal and written consent or assent was collected from all participants after discussing together the intentions of the study, structure of the discussion or interview and ethical considerations, with a particular focus on confidentiality. Many participants read the consent form carefully, however some seemed to skim the information before signing. Therefore, the key ethical considerations of participation were summarised verbally in easier language and checking for comprehension. This was an attempt to ensure the participants truly comprehended the aims of the study, confidential nature of data collected and how data would be stored, and used. This is important because *“informed consent is more than a legality; it is a moral responsibility”* (Kutner, 2003, p. 344).

Consent is an ongoing process and should always be open to negotiation and re-evaluation by the participant (Bhutta, 2004). Therefore, even though participants had earlier consented to participation, on the actual interview day I collected each participant from their classroom and gave them the opportunity again to consent or refuse to participate. It was also stressed in the introduction to the consent form that the participants were at liberty to withdraw their consent and end the interview at any time.

For those participants under 18 years of age, I had initially hoped to perform the study with passive parental consent for three reasons. One reason was to avoid the sample only including those adolescents with parents open to discuss sexuality with their child, but rather an array of adolescents with varying relationships with their parents. The second reason was to avoid adolescents self-censuring themselves in the fear that their parents could access information

from the interview. Finally, passive consent was desirable in order to make sure that refusal to participate was on the grounds of actual refusal rather than being unmotivated to respond.

Through conversations with researchers in Chile it became clear that active parental consent would be required for participants less than 18 years of age recruited from school settings. Therefore, written parental consent and written and verbal participant assent was collected for participants under 18 years of age. Participants over 18 years of age did not require parental consent, but they were all encouraged to discuss their participation with their parents. All participants were given a copy of their personal consent or assent forms, and copies of parental consent forms were sent home with the participants after the interviews.

Another ethical consideration was that given time constraints, five participants who returned parental consent forms could not be interviewed. In these cases I explained why it was not possible to interview them, and thanked them and their parents for consenting to participate.

There was no direct benefit to participants for participation and the potential harm was assessed to be low. Although the aim is to study adolescent *sources of information* and *learning* about sexual health and sexuality, and not sexual *experiences*, it was anticipated that during the interviews, participant(s) might reveal prior traumatic sexual experiences (for example sexual abuse). Upon arrival to Chile I liaised with a specialized adolescent sexual health clinic where I could refer participants for counselling services in the event that they experienced any psychological trauma through participation in the research. I carried small information cards with me to all interviews, however no need for referral arose.

Chile has no independent national or regional ethical review board, thus in accordance with current practice, this study was reviewed by a university ethical review board. This study was approved by the Ethics Review Board at the Faculty of Medicine, University of Chile, Santiago. The Norwegian Regional Ethics Board (REK) made a preliminary assessment of the study and did not deem it necessary to review the study in full. The study was approved by the Norwegian Social Science Data Services (NSD) (See appendix 3 for copies of all three documents).

Chapter 4: Findings

This chapter provides an overview of the key findings from the data collected in the field. The findings are divided into five sections: Definition of key terms; summary of sources of information; trust; content wording and communication of information; and gender.

Definition of key terms

As described in the methodology chapter, the first step was first to explore how the participants themselves defined the three key terms *sexual health*, *sex education* and *sexuality*. This was important for ensuring intersubjectivity but it also helped shed light on wording used in the adolescent and adult discourse around sexual health in Chile.

In summary, *sexual health* was seen from an adolescent perspective as a biological concept including STDs and prevention of unwanted pregnancies. One participant expanded her definition to include the concept of loving oneself, another included the concept of family and one participant who is herself an adolescent parent, included the concept of sexual abstinence. The key informants went further to include broader definitions of wellness and incorporating a holistic perspective including psychological and sociocultural aspects and sexual health as an integral part of a human being that makes them complete.

Sex education was seen by adolescents as both a passive and active process of learning to prevent STDs and unwanted pregnancies, including teaching of contraception as well as the broader concept of the significance of health and disease. Two adolescents referred to sex education as synonymous to sexual health. One male participant described sex education as a “*culturalization*” of individuals. Key informants presented varying definitions focused around sex education as a mode of achieving responsible decision making to guarantee optimal sexual health. Two participants included the aspect of understanding the meaning behind biological and emotional reactions in the sexual context and one defined it as a domestication of an individual in society to avoid erratic, erroneous behaviour.

Finally *sexuality* was the hardest concept to define. For adolescents it included the partner relationship as well as friendships, sexual orientation (homosexuality, heterosexuality, bisexuality), the sexual act and reproductive organs, biological formation of the body with hormones, physical and psychological sexual identity as a male or female, and what one

thinks about sex. For the key informants the term incorporated broader sexual identity and gender aspects, seeing sexuality as an integral part of a human being and a way of communicating with a partner and the outside world. One defined it also as the meeting between the emotional and physical responses to sexual exploration individually and in a couple. The catholic priest provided a holistic definition including a religious definition of sexuality as a couple and their union with God.

This variety in definitions has implications in this study for how the participants related to the open questions about *sexual health and sexuality* and the degree to which they needed to be probed on topics not included within their own definitions of these terms. On a broader level it has implications for viewing the incongruence between the broad adult definitions and the narrower definitions given by the adolescents they are providing information for.

Sources of information

The primary sources of information utilized by Chilean adolescents in this sample are family, school and friends. Although there were gender differences in the utilization of family as a source of information, these differences were small with both females and males primarily quoting parents and school as their main sources of information. Many adolescents talked with friends or partners about topics related to sexual health and sexuality, and although these conversations were often seen as important, there was often resistance to the idea of friends and partners being sources of information in the formal sense.

There were visible gender difference in the use of secondary sources, with females using health care services as a source of information whilst males were more likely to utilize internet as a source of information. Although the adolescents themselves contested the idea of pornography being a source of sexual health information, it was a commonly used medium for males to learn about sexuality, specifically pleasure and the sexual act. Alternative media sources such as television, films, radio and advertisements were sporadically mentioned but not named as key sources of information. A television documentary *Contacto* framed around a school sex education program, which was screened on television on the 16th July 2013 and later available online, was discussed by three adolescents. All these adolescents had a positive attitude towards the program and said they had learnt from it.

Although males and females received information from similar primary sources, there are considerable gender differences in the content of the information they received and the way in which this information was communicated. These differences will be presented throughout the sections on content and communication of information and the broader implications of this will be presented in the section on gender.

Trust

The most highly trusted sources of information were school, family and health care professionals. Reasons for this trust included the innate belief that these adults wished them well, the life experience that these adults had, role modelling healthy sexuality and the length of time the professionals and teachers had spent studying for their careers. Triangulation of information at a later time also increased trust in these sources, exemplified by this male participant who described what made him trust his teacher:

I trust [her] because she is supposedly be teaching me, my school teacher, and anyway, with time afterwards I have found out that it was really the way she explained. It was true. (Male, 16 years, I⁷:36)

Similarly a female participant described why she trusts information from her mother:

P⁸: I can't trust anyone but my mother. Because I have lived all my life with her, we have been through many things together, and I know that my mother would never want something bad for me. [...] I trust my mother [...] And also, with time I have realized that they are true.

R⁹: How have you realized this?

P: At school for example, or through conversations that I have sometimes with my cousins or another family member. (Female, 16 years, I:13)

These examples show how even with key sources that illicit high levels of trust, adolescents still seek opportunities to corroborate information to reaffirm this trust.

⁷ I = Interview number

⁸ P = Participant

⁹ R = Researcher

Friends and partners encouraged varied levels of trust, some participants describing increased trust if the friendship had evolved over a long time, however there was also scepticism about where these friends had learnt this information and their lack of life experience.

Internet was regarded sceptically by participants that actively used internet as a source of information. These participants described three different techniques for assessing critically the trustworthiness of information. The first technique described by five participants was to read a number of web pages to check for corroboration of information. The second technique mentioned by another five participants was to choose specific websites that elicited more confidence such as those written by doctors, universities or the ministry of health. The final technique mentioned was cross checking or triangulating data with a trusted adult or books from school biology classes. One male participant who used internet as a primary source described the websites he trusted and his process of information triangulation:

P: Firstly I look to see if the information is complete or incomplete, and if it is from a good source. [...] From universities, investigations, or the ministry of health, things like that.

R: Ok, but if you read something on a web page and you think that this is not correct, what do you do?

P: I have to ask, I would ask a professor. A professor, since they are well informed. [...] An adult, more than anything. (Male, 17 years, I:38)

When probed about where they had learnt that they needed to be critical towards information on the internet, one participant mentioned an older family friend explaining about credible websites and another female participant describing how a teacher had warned her about the need to be wary of information from Wikipedia:

Last year my language professor told me that Wikipedia was not very trustworthy because anyone can write information there. I used to believe a lot in Wikipedia, and took information from there every day, but after what my teacher told me, I started to doubt it. (Female, 16 years, I:20).

This quote exemplifies the potential positive influence schoolteachers and other trusted adults can have on teaching adolescents critical use of the internet.

Television in general was seen as subjective, not reflecting reality and purely for commercial gain, however the exceptions were scientific documentaries fronted by scientists and health staff whom gained trust in the participants that mentioned this source. An example of this was the documentary *Contacto* which was described as trustworthy.

Content, wording and communication of information

Biology: STDs and pregnancy

All the 20 adolescents interviewed had learnt about sexual health from a biological perspective. This included the topics of puberty, pregnancy, STDs and contraception. This information had come primarily from teachers, with all 20 participants learning to a greater or lesser degree in school. This information was included either as an academic subject within biology or natural sciences, or from the school psychologist or teacher during orientation classes. In the school setting this information was communicated in the form of one way lecturing, often including power point presentations and photos covering the theoretical aspects of sexual health and aimed towards a final examination in the subject. In one school the teaching was more interactive with participants giving class presentations on STDs and in another the teacher had shared a personal experience with an illness to encourage the adolescents to use contraception. Given that this information was often covered in biology and approached from an academic perspective, eight out of the 20 participants did not spontaneously name school as a source of information for their personal learning about sexual health and sexuality.

Sexual activity was often presented as a high-risk activity alongside teaching about drugs and alcohol. Fear was a common tool used in school teaching around STDs through showing photos or videos of infected genitals or chronically ill people. One psychologist justified the use of photos and videos in teaching of STDs as follows:

I think they have to see the syphilis ulcers, [...] in order to not terrorize them, but in reality this is what happens, and for example see how people with AIDS end up, and feel that the human liberty is something extremely important (Psychologist, I:3)

This same psychologist stated that due to the school being catholic it was complicated to teach about contraception and condom use. Therefore adolescents learned about the risks of

sexual behaviour, however were not simultaneously taught the tools to ensure safe sex practices. Fear education was seldom accompanied by practical education on how to access and use condoms, or how to negotiate condom use. Only one participant had the experience of seeing a practical demonstration of how to put a condom on a broom and one male had been given a condom in class. One participant, whom mimicked the action of putting a condom on, said she had learnt this from the television documentary *Contacto*. One participant shared his opinion of the absence of practical teachings of how use a condom:

This is what is also missing in school [...] they can teach you all the theory, but they don't teach you any of the practice. In school they don't teach you how to put a condom on. So obviously, you could arrive to the act and it doesn't help you to know all the theory if you don't know the practice (laughter). (Male, 16 years, I:34)

This lack of focus on depth in sex education including the practical teaching was reiterated by a female participant:

It's like they don't want us to learn much. And afterwards they blame us [...] that we didn't protect ourselves when in the end it is they that did not focus enough on the topic. (Female, 17 years, I:1)

Pregnancy was taught from a biological perspective explaining human reproduction, as well as presenting adolescent pregnancy as a consequence of irresponsible sexual conduct. Thus fear, blame and future orientation were all tools utilized when discussing adolescent pregnancy and parenthood. Another school psychologist described her use of future orientation in her conversations with adolescent males about condom use, encouraging them to think about how their lives would change if they were adolescent parents. This future orientation message was repeated in focus group discussions with males in this same school who reflected collectively on what life would be like as an adolescent father.

Aside from school, 17 of the 20 adolescents in individual interviews had talks with their parents about some or all of the topics of puberty, pregnancy, STDs and contraception. For eight of these adolescents in individual interviews and three participants in the focus groups a specific life event triggered a communication with their parents, with only one participant describing communication with her mother as lifelong and continuous. Triggered events

included entering puberty, starting their first relationship, upon request from school, prior to school camp and for one female, unplanned pregnancy. This final participant described how she had not communicated with her mother about sexual health prior to her pregnancy:

In the beginning no, that's why I fell pregnant, but afterwards yes, [we talked] all the time. Because I fell pregnant at 15, in the middle of puberty. But after this we always talked, my mother, my sister and my father too. But beforehand no, like I hid it just for myself. [...] we would talk and we would say "we'll talk about it tomorrow", and "we'll talk about it tomorrow", it's like the nerves make you say "we'll talk about it tomorrow". (Female, 18 years, I:32)

This quote raises a number of themes including the "hidden" nature of female sexuality and timing of communication. Late communication about sexual health topics was also described by other participants. These participants described examples of how their parents or teachers tried to provide sexual health information long after the participants had already learnt about the topic. A female university focus group participant described her parent's reaction to starting her first relationship:

Before I started dating, I had learnt everything from books, because I like to read a lot [...] But then I started dating and then came the massive attack from my parents (laughter) about adolescent pregnancy and things like that. [...] just when I started dating it was like they assumed that I was no longer a little girl, I was now big and they needed to start informing me and this surprised me as to why they did not inform me before? Instead I learnt on my own. (Female, 19 years, FGD¹⁰ 3, P:2)

This issue of the optimal timing of parental conversations with their children was discussed by all health professionals and by the priest. When asked what their advice would be for parents educating their children about sexual health, they described the need for life long, communication about sexuality, starting in infancy with self-care of the body and building trust over time precisely to avoid a situation as mentioned by the previous quote where the participant was left wondering why she had not been educated earlier. One health

¹⁰ FGD = Focus Group Discussion

professional described the challenge for parents approaching the topic of sexual health once their child had already entered adolescence:

I tell them, if you have never talked about the topic with your children in the period when the [...] parent is the super hero, it is difficult to approach it in adolescence [...] they no longer see our superhero cape, now they see our mistakes, and think that maybe we are not telling them the truth [...] my advice is always, always, always tell the child the truth [...] from when they are very young” (Health professional, I:1)

This advice brings up the issue of the importance of supporting and teaching parents on how to talk about sexual health and sexuality with their children from an early age. It is also an example of the potential for positive parenting guidance that can come from health professionals. To further support parents in their role as primary educator for their children, the catholic priest discussed the church's main role in sex education as educating and providing support for parents. He described the need to support parents to create and maintain trusting relationships with their children, to be able to communicate openly and honestly about sexual health and sexuality topics.

For the adolescents interviewed, triggered conversations were either one off experiences of *the talk*, or the start ongoing conversations with their parents. For female adolescents, the transition into adolescence marked by their menstruation was often linked to the concept of risk, either risk of sexual violence and kidnapping, or more generally risk of pregnancy. These triggered conversations were most often experienced as embarrassing for the adolescents, however those with subsequent ongoing communication described the building of trust and thus diminishing embarrassment over time.

Two interview participants and two focus group participants shared that they were children of adolescent parents. For them, communication was also triggered by a fear that they would repeat the same scenario as their parent. This is exemplified in a comment made by a female in the university focus group:

My mother had me at 18, so she always had a fear, the whole family had this fear that I would repeat my mother's experience. (Female, 19 years, FGD 3, P:5)

Thus, similar to the school setting, fear was also a tool used by mothers in communicating to daughters about sexual health and specifically adolescent pregnancy. An example is how a female described how her mother had used fear as a deterrent from adolescent pregnancy:

Ever since I was very young she made me scared about birth, about the pain and all these things so that I would not fall pregnant. (Female, 19 years, FGD 3, P:1)

The informal sources of friends and older siblings also provided information on biological aspects of sexual health, often providing advice or guidance based on personal experience or filling a "gap" in the knowledge of their friends who did not talk with their parents. The two adolescent mothers both described their special position as mothers in providing credible advice to female friends, stemming from their own experiences. One of these mothers described conversations she had with her friends:

I always tell them, "please protect yourselves. It is wonderful to have a baby but, at our age, because it is so early, you are still in school, entering university..." so I am always like the mother of the group because I say to them, "protect yourselves", "don't be stupid". (Female, 18 years, I:32)

This focus on promoting protection in sexual relations between friends was common. Another topic that was discussed between friends was the actual sexual act. One female recalled hearing her sexually experienced female classmates talk about non-vaginal sex as follows:

"They say there are different forms [of sex], for example there is anal, the mou... through, through the mouth [...]and others arghhh (sound of disgust)" (Female, 17 years, I:1)

Although this participant displayed curiosity in describing these conversations, her body language also portrayed disgust at the topics.

This raises the theme of non-vaginal sex, which was also present in the focus group discussions. In the initial two high school focus group discussions, the participants were first asked to write a list of words or expressions to describe sex between friends. The male list included at least six terms related to oral sex, two of which was discussed in the group,

resulting in great deals of laughter. The much shorter list of words provided by the female group did not include any words describing oral sex. In the two university focus group discussions the participants discussed the trend that oral and anal sex amongst youth is seen as not risky because cannot lead to pregnancy and could maintain *virginity*. This trend will be discussed more in the section on abstinence.

All participants described the necessity of discussing sexual health and especially contraception with a partner (boyfriend or girlfriend). Ten participants described conversations they had had with a partner. One female described how important it was for both males and females to talk about contraception and also testing for STDs if they had been in a sexual relationship previously. She described how she did not feel embarrassed talking to a partner about sexual health, mimicking a conversation:

It's like "hey, chubby, why don't we talk to your dad and we can tell him to buy other things [condoms] because these are annoying me", or "I'll say to my mum that she should change my pills because these are expensive", or "you pay half the cost of the pills so that it is a bit more even", things like that (Female, 16 years, I: 3)

In this example the participant also talked with her partner about the shared responsibility for contraception. One male described how he felt talking to his partner about sexual health:

I felt... that I was doing the right thing. [...] I felt responsible talking about this. (Male, 16 years, I:27)

It was evident that the participant felt mature in this situation and confident in sharing responsibility for sexual health choices with his girlfriend. Both of these two participants were pupils in the private catholic school. Even when participants were not sexually experienced, two females described conversations with a partner about possible sexual relations in the future. One catholic participant described what she talked about with her boyfriend whom she had been together with for two years:

That if we want to do something one day, that we need to protect ourselves... that we need to have affection... the things that go on during the sexual relation, and... the normal things that are talked about. (Female, 17 years, I:13)

These examples of shared responsibility and open communication stand in stark contrast to one adolescent mother from one of the partially subsidised, secular schools. This participant described communication with her partner:

P: After I had my daughter he told me I had to protect myself, I mean, obviously one has to protect oneself, but more because of this [the pregnancy].

R: And before your pregnancy did you talk at all about the topic of sexual health or sexuality?

P: That I had to protect myself, he told me that I should go to protect myself, and just when I went [to a healthcare clinic] to protect myself, I got pregnant [...]

R: And did you ever talk about the topic of condoms?

P: No, never. (Female, 19 years, I:24)

This quote illustrates that this partner communication incorporated a gendered responsibility for contraception. In this case, the participant had not talked to her mother about sexual health or sexuality and the only message from her father had been to use condoms.

Internet was utilized by adolescents who were especially curious about a sexual health topic. Apart from curiosity, two male participants also used internet to seek information on a personal sexual health condition prior to visiting an urologist. Internet was commonly used for searching for information for school projects.

Finally, only females utilized health professionals as a source of information. Gynaecologists and midwives were described as having an educational and guidance role, explaining contraceptive choices and providing a space for confidential questioning. Accompanied by their mothers, they sought professional advice or guidance either as a general control following menarche, seeking contraceptives upon starting their sexual debut or in relation to a medical condition. Not all participants had parents willing to talk about sexual health or take their daughter to a health professional for advice on sexual health. One female participant described how she had repeatedly tried to talk to her parents about sexual health however , they had not wanted to talk to her about the topic. She described a dialogue in detail:

I have told my parents, "you need to educate us sexually because, we don't know anything", "ah, but there is the internet", they answer me. "But the information is not always correct, there is always false information that is not correct", "ah, but it is in the internet", "but Dad, Mum, you need to help me, I have to know some things". (Female, 16 years, I:17)

Stating that internet was not a credible source of information she "*begged*" her mother to take her to the gynaecologist where she could ask questions and receive information on STDs and contraception. Although this may be an unusual case where an adolescent driving communication with her parents, one health professional acknowledged that there are parents who will not talk to their children about sexual health. In these cases she said parents should be encouraged to seek support from health professionals or teachers to ensure their child is well informed.

Four males had contact with health professionals, however two were for specific sexual health conditions and two were in the role of accompanying their female partners. It was reiterated by two males that health professionals were only consulted if there was pathology, not for information. This lack of focus on male sexual health information was discussed by all health professionals and one described this as a great "*debt*" to adolescents in general, since all adolescent health programs stem from the area of gynaecology (*Health professional, I:2*).

Considering the high levels of trust both males and females have in health professionals, there seem to be an untapped potential regarding orientation of males on sexual health issues by health professionals. One health professional who teaches sex education in schools described her approach of separating classes by gender and thus focussing her teaching with males specifically on what they wanted to know regarding sexual health and sexuality. In this way she ensured the teaching was not solely focused on female sexual health and risk, rather giving adolescent males an opportunity to actively define what they wished to learn about in their sex education classes.

At the end of each interview the participants were asked which topics they thought all adolescents should learn about sexual health and sexuality. Although a large breadth of topics were probed on through the interviews, almost universally the participants responded with the biological topics pregnancy, STDs and contraception. Only five participants, notably the three

adolescent parents, mentioned broader topics falling under the topics “*afectividad*”, communication, morals, safety or legal teachings. Two males who were curious about female sexuality described the importance of learning to communicate with a girlfriend about sex.

Afectividad: Love, "the sexual act" and pleasure

In contrast to the universality of sex education on biological sexual health topics, there was great variation in adolescent experiences of learning about the social and emotional aspects of sexuality. In Spanish, these social and emotional teachings are clustered under the umbrella term *afectividad*, which has no direct translation in English.¹¹ It is taken to include the topics of emotional, personal, intimate and partner relations as well as themes of communication, love, romance, attraction, desire, pleasure, affection, caring, self-care and self-esteem.¹² The focus here will be on love, “the sexual act” and sexual pleasure.

Love or affection was not spontaneously mentioned by any participant, however when probed, six participants had talked about these topics at home. From home these messages were either that love and sex were two separate concepts or that it was necessary to have love before engaging in sexual relations. One participant specifically shared his belief that parents were those responsible for teaching about values and love to their children, letting schools and health professionals take responsibility for teaching biological sexual health. The message he had received from home was as follows:

That sex is related to love, that is what they teach you in the family [...] when I was young they talked a lot to me about sex being the most beautiful thing that exists in life and that it is a form of sharing love. (Male, 17 years, I:27)

This positive message of love and sex contrasts to the earlier mentioned direct association of sex to risky behaviours such as consuming drugs and alcohol.

In the school setting, love was mentioned by four interview participants and two female focus group discussion participants. These focus group participants recounted how love was talked

¹¹ *Afectividad* is defined by the Royal Academy of Spanish Language (RAE) as “development of the propensity to love; combination of feelings, emotions and passions in a person; a tendency towards emotional and sentimental reactions” (RAE, 2014).

¹² Given that the term is so broad and has no appropriate direct translation to English, the Spanish term will be used throughout the remainder of this thesis.

about in religion classes. One of these participants went on to describe how the focus on teaching about love changed as she got older:

In religion they taught us about afectividad and all of that, [...] but when we reached third and fourth grade high school, they started saying, I don't know, "that love is not anything magical, instead it is just biological reactions" [...] like they tried to remove all of the magic. (Female, 19 years, FGD 3, P:2)

Thus a form of *biological reductionism* reduced the "magic" love to a purely biological process of biological reactions. This undermined the teaching of *afectividad* the participant had had in religion classes all through her schooling. When probed about *afectividad*, two male participants related this topic specifically and exclusively to religion. Unsurprisingly therefore, the catholic priest interviewed discussed at length the importance of sexual relations being within the context of a committed, loving relationship.

It was observed that many of the topics falling under the umbrella term *afectividad* were discussed in the catholic school included in this study or described by participants whom had attended catholic schools previously. One male from one of the secular schools described the previous school he had attended, which was run by catholic priests. At that school he had received comprehensive sex education including topics of biological sexual health and contraception, alongside many topics of *afectiviad*. This participant stated that the education was comprehensive precisely "because" the school was catholic (*Male, 16 years, I:36*). The catholic priest interviewed also discussed the importance of parents and teachers teaching adolescents about contraception, alongside teachings that encourage reflection on themes of love, morals, feelings and affection.

The link between religion, *afectividad* and comprehensive sex education is interesting. Therefore, this theme was introduced for discussion in the final two focus group discussions at the university. In the female group, one participant described how religious schools automatically assuming it to be their "role" to teach adolescents about topics of *afectividad* and "the family" (*Female, 18 years, FGD 3, P:3*). Conversely, participants in the male group cautioned the assumption that this openness to teach comprehensively about sexual health and *afectividad* was necessarily true for other catholic schools. These males collectively discussed a type of continuum of "fanaticism" and religious order which defined how open the school

was to teaching on sexual health and sexuality, giving examples of more conservative schools where sex education was completely absent.

All three-school psychologists gave differing explanations for this biological-*afectividad* divide in both secular and religious school teaching. The one psychologist described her opinion that teachers forget that adolescents have emotions and feelings, something she felt was reflected in government programs that focus on the biology of sexuality. This psychologist described her opinion of this, stating that:

Emotions are far more important to me than the biology, because it is the emotions that move us to do the other things, they are the ones that make us react in the face of different situations (Psychologist, I:1)

One health professional, whom also works giving sex education classes in high schools, criticized those educators that approached sexuality from a purely biological perspective teaching only about contraception and demonstrating how to use condoms. Instead she discussed the importance she placed on psychosocial elements of sexuality including love:

Often I also tell them [the pupils] that one of the risks of sexuality at such a young age, is not just pregnancy and sexually transmitted diseases, is it that you fall so deeply in love, that you fall into a depression [...] In a class there may be few pregnancies or few who have diseases, but there might be many whom have suffered heartbreak...it affects their self-esteem. (Health Professional, I:1)

Another psychologist accounted for the biology-*afectividad* divide stating that teaching biological aspects of sexual health was easier than broaching the emotional aspects of sexuality. This was evident in the descriptions given by adolescents and psychologists on the communication styles used in learning about biology compared to classes on *afectividad*. Biological sexual health classes were commonly one way, non-participatory lectures where teachers used powerpoint presentations to cover the material. This contrasted to classes covering broader topics of sexuality and *afectividad* that commonly utilized more participatory, interactive teaching such as school debates, student presentations and group work. One psychologist described how she tried to create an atmosphere completely different from the normal academic classes when teaching on *afectividad*:

In my class the idea is that the children are the protagonists [...] For example, I made a competition, "the competition of afectividad" [...] they made two teams and they had to answer questions [...] the dynamic was different from other classes. (Psychologist, I:1)

This description shows how using alternative teaching techniques for making the classes more interactive demand more time and planning from the teachers or psychologists, as well as a different power relationship between teacher and student.

"The sexual act" was also included in some of the the adolescent definition of sexuality. Within the school environment, this topic was not incorporated into the formal education, rather it emerged during anonymous questioning sessions. In these sessions students could anonymously write questions on a piece of paper for the psychologist to answer. Two females recounted their experiences of the same question and answer session, both describing their discomfort and disbelief about questions their classmates posed about the sexual act. One participant described the situation:

The psychologist arrived, with the orientator, and told us, "I want to inform you a bit about sexuality. I am going to give you each a piece of paper and I want you to write me a question, I will read them all anonymously so that I can answer you all without making you embarrassed". But we were so young that the questions were like... "what does semen taste like", and it was like hmmmmm... like I am not interested in knowing that, but she still responded to them. (Female, 16 years, I:3)

A number of participants expressed a desire to have the option of anonymous questioning, so it seems like this could be a valuable tool in sexual health education when discussing particularly taboo subjects. However, according to the two females mentioned above, anonymous questioning may also encourage laughter or feelings of disgust or aversion.

One psychologist described the challenges in long-term implementation of sex education classes both due to time constraints but also her experience that a number of teachers became uncomfortable in teaching about sexual health and sexuality. She shared her belief that if a teacher was uncomfortable with the topics covered in sex education, no amount of capacity building would improve the situation. She also discussed in particular the challenge of

answering the anonymous questions, having herself been challenged by a student asking her if sexual intercourse "hurt" (*Psychologist, interview 2*). Another psychologist shared her experience being asked about "sex with animals" during anonymous questioning sessions (*Psychologist, I:3*).

Thus, information on sensuality, sexual acts and eroticism were primarily learnt about from friends and partners with prior sexual experience and pornography. Firstly, friends were a source of information on sexual acts both for males and for females. Although three participants from the catholic school stated that talking explicitly about a sexual experience was taboo between friends, two females from another school described their curiosity in asking sexually experienced friends about the sexual act. One participant described a lunchtime conversation with a sexually experienced classmate:

We asked her everything, how did she do it, why did she do it, how did it start, [...] we had so many questions, since we have not done it yet, we are virgins, so we wanted to know everything and we asked her [...] everything, everything, everything, whatever we thought of, we asked. (Female, 17 years, I:1).

This participant expressed a curiosity around the topic of sexuality and compared herself to other religious female classmates whom self-censored themselves to these conversations, not wanting to listen. One female interviewed from the same class stated she did not wish to listen to stories about other's sexual experiences and she was not interested in talking to boyfriends about sex, other than stating that she was a virgin and only interested in being with a partner who was also a virgin. She also described how she disliked it in when they learnt about menstruation in school, stating that:

I think that only women need to know [about menstruation], because it's not like it is something... pretty. It is like a stage, no more. I mean, it is part of us (females), they (males) don't need to know." (Female, 16 years, I:29)

Thus even within the same classroom, there were contrasting perspectives on how comfortable and curious the participants felt communicating with both female and male friends about sexual health, sexuality and the female body.

Communication between males and females about sex was not as common as between same-sex peers, and only one male participant who seemed particularly curious about female sexuality said he had learnt a great deal from his female classmates. Learning about the sexual act from same sex peers in some cases seemed to include social pressure to engage in sexual acts. One male participant described jokes made about a fellow classmate:

I have a classmate that has been with his girlfriend for two years and he has still not had sexual relations with her, and he has no problem in saying that. [...] we aren't going to criticize him, I mean, it's a personal decision. But [...] between the closest friends all the same it is like, "hey, and when are you going to cut the cake with your girlfriend? When are you going to become a man?" (Male, 18 years, I:43)

This example shows how social pressure could take the form of jokes between friends and also highlighted a gender stereotype that engaging in sexual relations defined "being a man". One psychologist described building self-esteem as fundamental for adolescents not to submit to this social pressure, instead making decisions based on reflection of what they want and what is best for them:

For me it all starts with the development of self-esteem. [...] because the way I see it, until fourth grade it is the protective layer that will protect you from all types of risky behaviour. (Psychologist, I:2)

Alongside friends, internet and specifically pornography, were described as the main sources of information on "the act". Although a number of participants and especially females expressed negative attitudes towards pornography, it was also seen as the only medium for learning explicitly about the sexual act. The older participants in the two university focus groups expressed a more positive and accepting attitude towards pornography as filling a gap in formal sex education. One female participant explained:

I think that pornography talks about precisely the topics that are not touched upon in sex education, which is like the coitus, like the act, like, how to be sensual, how to be desirable, like, the whole part about pleasure [...] like in school they talk to you about sex as something so scientific, like "ok, so there is penetration, ejaculation and a baby is formed bla bla bla bla". But what is the actual act like, like how to do it, like what is

good, like what is bad, and I feel that pornography becomes the reference for this. (Female, 19 years, FGD 3, P:4)

This more reflective evaluation of the function of pornography in teaching the explicit sexual act was a stark contrast to the dismissive attitude of many younger, particularly female adolescents. One female described those who viewed pornography as having "*strange problems in the head*" (Female, 17 years, I:1), whilst another female refused to answer the general question of why she thought some Chilean adolescents watched pornography. Other participants, primarily male, discussed the sole purpose of pornography as meeting sexual needs. When asked about whether he believed youth in Chile watched pornography to learn about sexual health and sexuality, one participant responded by naming pornography as a direct causal factor in adolescent pregnancy:

I think that yes [adolescents watch pornography]. [...] There is a misinformation. Because of this I think that sometimes youth, younger than me, have babies and things like that. [...] Because basically in a pornographic video you see people having sexual relations, right? They don't show you how to put a condom on. (Male, 16 years, I:36)

When asking about the acceptability of pornography, there was a universal gender difference in the responses across all the individual interviews. Male participants described the act of viewing pornography as normal, although potentially only acceptable up to a certain age, whilst for females it was universally regarded as taboo. One male described a female watching pornography as "*strange*" (Male, 16 years, I:34), whilst another female described her "*fear*" of one day encountering pornography in the internet by accident (Female, 17 years, I:13). When asked if pornography was accepted between females, one male explained that he thought it was a hidden practice:

I would say that it is far less accepted, there could be some [females that watch] but they would stay silent. They wouldn't talk about it. [...] You expect that a female will be a lady. You expect a male to be more like a cave man (Male, 17 years, I:38)

This taboo can be explored in the words this participant uses, contrasting the female "*lady*" to the male "*cave man*". This comparative double standard was discussed spontaneously in all

four focus group discussions. The hidden nature of female sexuality and pleasure was an emergent theme in this research.

Considering the ease of access to pornography, the differing attitudes towards the role of pornography and the gender differences in acceptance of pornography, there seem to be a gap in the teaching of critical use of pornography as a frame of reference for the sexual act.

This discussion of pornography links into the topic of pleasure, which was perceived to be a taboo across both formal and most informal sources. Pleasure was a topic that was not included in the formal sex education for any of the participants, however, one participant described learning about the word “orgasm” in a novel she read for school:

I only recently heard about pleasure and orgasm this year. In fact I read it in a book. It mentioned the word [orgasm] and I did not know what it meant [...] I had heard the word many times but I didn't know what it was. (Female, 17 years, I:1)

Reasons why pleasure was not discussed in the school context were explored by all three school psychologists as well as the midwife teaching sexual health in these schools. The main reason was the belief that talking of pleasure counteracts the aim of sex education to delay sexual debut and reduce adolescent pregnancies. One psychologist described the teaching on the topic of pleasure as challenging but not impossible, if approached from the angle of adolescent emotions. In the university female focus group the participants discussed the gap in education on sexual pleasure, but noted that it was vital that pleasure was discussed alongside responsibility. One participant described this as follows:

I think that if they cover the topic of pleasure, they have to cover it together with the diseases, always subtly, but each one in their place. Because, they also have to say that it is all done with responsibility and conscience, because one can't just cover the diseases just to make them scared. (Female, 19 years, FGD3, P:1)

The only element of sexual pleasure which was incorporated into formal sex education was the topic of male masturbation. When probed, four males explained how school psychologists had talked of masturbation as a natural part of male sexual development. For example one male recounted his experience:

The professors tell you that "for you guys it is normal". (Male, 16 years, I:34)

Even when the topic of male masturbation was broached in the school setting, none of these participants recalled any messages related to female masturbation. Between male friends, masturbation was seen as normal, however female masturbation was discussed as either non-existent or a hidden practice. In the female university focus group the subject of female masturbation was spontaneously brought up and discussed at length between the participants. One participant describing her experience of the taboo of female masturbation in school:

I remember very strongly in school the taboo topic of knowing oneself, [...] like masturbation for example, that for females it is a very strong taboo, very very strong [...], for the males it was like [...] they were joking all the time, having competitions for who could spend most time without masturbating (laughter) [...] It has always surprised me, like, "why can't women touch themselves?" (Female, 19 years, FGD 3, P:4)

As more females joined the discussion, they came to critique the verbal discourse linked to female masturbation:

P5: ... for males it is like super common, everyone talks about it like they assume that the males are doing it constantly, but the woman who does it is like breaking the norm, "the revolutionary".

P4: I also feel that there is like a stigma with this, like the woman that does it is like "the desperate one". [...] like "oh no, how can you stoop so low". (Females, 19 years, FGD 3, P:4 & P:5)

Thus from this theme of pleasure came the broader theme of the hidden nature of female sexuality and pleasure, as well as the taboo of the female body.

When probing adolescents on topics that should be discussed with a partner, 16 participants described the importance of discussing contraception and protection from STDs, however only four males and no females spontaneously included pleasure as a topic for discussion. One male said pleasure was something older, more mature couples talked about.

Sexual Orientation: Many ways to talk about the “others”

The topic of sexual orientation was discussed in all interviews and focus groups particularly related to the primary sources of information of school, family and friends. Sexual orientation was often absent in the formal education and one reason for this was explained by one health professional who teaches sex education in high schools:

*One approaches what one sees, approaches sexuality from the point of view of prevention of adolescent pregnancy, which in its essence is what scares us adults.
(Health professional, I:1)*

She also said that sexual orientation was not discussed in schools since it is still viewed as a question of core social values by many people in Chile. This was reiterated by the psychologist at the catholic school whom said she could not be seen to be supporting homosexuality, as this was not in line with the catholic philosophy of the school. Thus the focus on heterosexual sexuality in formal education aiming to prevent unplanned pregnancy, reveals a gap in the sex education of sexual minority youth.

However, even given this overarching focus on heterosexual sexual health, homosexuality was a topic sporadically present in both formal education in schools and within the healthcare setting, as well as in informal communication at home and between friends. Homosexuality was discussed by study participants from five different perspectives: discrimination; as a biological phenomenon; as a medical condition; as something contagious and as a fashion.

In the school setting sexual orientation was broached from two contrasting perspectives. Firstly, three students were taught about respect and not discriminating someone on the basis of their sexual orientation and in one school there was a student debate about social and legal rights of homosexual people in Chile. The second perspective was a biological explanation of homosexuality. Four participants in individual interviews described learning about homosexuality in biology classes as a result of hormonal imbalance. To contrast this biological explanation, just one participant described learning about homosexuality as a personal choice and that sexual identity was partly shaped by family socialization.

Two participants that had no school teaching around sexual orientation, stated that they thought this was because the school focus is on family planning in a heterosexual context or because it was a sensitive topic. One male describes why homosexuality was not discussed:

They didn't teach us about this [homosexuality], for example, the sexual deviations. They didn't teach us about this. I don't know why, supposedly because maybe they didn't teach us because it is like a very sensitive topic. (Male, 16 years, I:36)

The concept of sexual orientation being a sensitive topic reiterates the earlier point by a health professional that in Chile, homosexuality is stills considered by many as a question of core values. The wording used by this participant is noteworthy, referring to homosexuality as a "*sexual deviation*". This leads on to the concept of medicalization of homosexuality.

Two of the health professionals and one psychologist described homosexuality on medical terms as a "*problem*" or "*condition*" with a focus on accompanying the adolescent in addressing this problem or "*assuming*" their condition. One adolescent participant also discussed a formal class debate on whether homosexuality was a disease or not. The remaining health professional referred to homosexuality as normal.

This medicalization of homosexuality by health professionals was coupled with a desire to support the adolescent in their sexual development and decision-making process. The health professionals described working in a team with psychologists or psychiatrists to support the adolescents in declaring themselves to their families and the greater society. One health professional described her role as follows:

Explaining to him that this could be something natural, it could be something transitory or something definite, but he has to work on it. [...] when he has decided on his sexual orientation, he will face a society that is still not prepared for him. (Health professional, I:3)

Thus by *medicalizing* homosexuality, an opportunity was opened for health professionals to support adolescents to build confidence and self-esteem. This medicalization links into the discourse on homosexuality being something contagious, which was mentioned by one health professional and one school psychologist. The health professional described a situation when

a schoolteacher called her stating she had a problem that all her 8th grade pupils wanted to be homosexual. The health professionals described her surprise:

It had never happened to me that all of them caught the fever. (Health professional, I:1)

The metaphor of homosexuality being a "fever" and the teacher's worry about her class seems to reflect the idea that homosexuality is something contagious. The health professional described going on to do a "diagnosis" of the class and found only two males with homosexual tendencies. It was unclear in this interview what the health care professional's attitude was towards this situation, what she meant by "diagnosis" and how she conducted her sex education classes. Therefore a follow up interview was organized to elaborate and clear up a potential misunderstanding. It became clear that the "diagnosis" was not a medical diagnosis of homosexuality, rather an initial survey used when planning sex education classes with a new group. In the short anonymous survey, pupils filled in what they wanted to learn about and where they were in their sexual development (including whether they were attracted to females, males or both). She went on to conduct sex education classes answering to the questions that the class had and referring the two males on for follow up with a psychologist.

One female adolescent described the socially "contagious" nature of homosexuality. Initially she described her tolerance of homosexuality, however when asked about her friend's attitudes to homosexuality she responded saying:

Everyone says that it is ok but still... it isn't good that they show it to children, for example. [...] Because afterwards they [the children] will think that it is ok and then they will all want to be homosexual. (Female, 16 years, I:29)

Although not asked explicitly about their opinion of homosexuality, this double discourse of respect on the one hand, but a desire for distance or restriction of public displays of affection between homosexual couples on the other, was described by five adolescents in interviews and focus group discussions. Interestingly there was also a gendered double discourse with one male participant describing homosexual males as "repulsive" but lesbians as "cool" (Male, 17 years, I:27). Conversely a female said that there was no problem talking about male homosexuality but that talking about lesbianism would be "strange" and having a lesbian

friend “*would be terrible*” (Female, 19 years, I:32). Only one participant said explicitly that she disliked homosexuality, whilst two participants described accepting homosexuality fully.

As for informal sources of information, eight participants also talked about the topic of homosexuality in the home, either with parents encouraging them to be respectful and not discriminate, or in the form of sharing differing points of view. One participants that shared her support for homosexuality, talked about discussions she had in her family:

Oh yes, I am very in favour of this, of homosexuality, gay marriage, and everything that comes along with this. However, my mother and brother are very against the topic, but in general we talk about the topic more like on a social level. (Female, 18 years, I:50)

This contrasts to the experience shared by another female participant who described her mother's opinion of homosexuality:

My mother does not like homosexuals, she doesn't believe in it, because she is religious, my mother is evangelical. [...] If I were a lesbian my mother would die. She wouldn't accept it. (Female, 17 years, I:1)

As the first example shows, even with differing opinions on the acceptability of homosexuality, it is still possible to convey an underlying respect, whilst the second example shows how one mother's opinion is projected as a fear onto her daughter.

Between friends the topic of homosexuality was debated as a social issue according to personal conviction and it was also a cause for discrimination and bullying. The participant mentioned above described how she and other classmates refused to sit next to another male classmate they thought was “gay”, whilst a male participant from another school described being in parties where friends pointed out "gay" people causing everyone to stare. Similarly when homosexuality was discussed in the initial female focus group, the participants described a general negative attitude in the school towards homosexuality and adolescents pointing out who was gay and lesbian in the school. Interestingly, when probed, none of the school psychologists mentioned sexual orientation as a cause of bullying.

From a religious perspective, the catholic priest explained the main teaching of the church as a respect for all peoples as children of God, a condemning of all acts of violence and discrimination based on sexual orientation. He went on to state that the only acceptable attitude towards homosexuality was one of complete acceptance. He opposed the concept of homosexuality as a biological phenomenon, providing an interesting contrast to the health professionals and the biological explanation of homosexuality.

Moral and legal issues: Abortion, emergency contraception and abstinence

Abortion was a topic that was not initially incorporated in the probes around sex education. However, abortion was spontaneously brought up by two participants who gave presentations on abortion, and later five participants from the same class in the private catholic school described a school debate on the decriminalization of abortion. The five students described what the debate was like for them. One described his experience as follows:

Once we had the topic of abortion and it was super interesting this debate because there was a clash between the opinions of the males with the females. [...] Because there are those that say "yes" to abortion, to therapeutic abortion and all of this, that the woman has the right over her own body and those that say "no" to abortion, that one doesn't have the right to kill anyone. (Male, 16 years, I:34)

To contrast this debate where students were encouraged to reflect on different points of view on the issue of abortion, this same male described an experience when he was younger and had been shown a video by a schoolteacher of what an aborted foetus looked like. The participant described being shocked and said that experience that shaped his opinion against abortion. Thus, even within the same institution, two differing approaches to an issue can encourage very different thought processes in an adolescent.

The moral aspect of abortion was broached in only two family settings with female participants who had open, continuous and trusting communication with their mothers. In both cases the mothers shared their opinions that abortion was wrong, however encouraged their daughters to reflect and form their own opinion on the issue.

From a religious perspective the catholic priest interviewed shared his opinion against abortion, however when probed specifically on the teaching around abortion as a social issue in schools, he focused on the importance of teaching responsible sexuality to adolescents.

The emergency contraceptive pill was rarely discussed in the school setting and from a biological perspective no participant received information as to the functioning of the pill. One adolescent and one psychologist explained that teaching about emergency contraception would encourage unprotected sex. The subject was discussed from a moral standpoint focusing on responsibility and blame for unsafe sexual practices. One male participant described the message he received in religion classes:

That we need to care for our bodies and avoid having a sexual relation where the female could fall pregnant, instead of just coming and taking the pill, like taking the easy way out. We have to be responsible beforehand. (Male, 16 years, I:38)

Similarly in the home setting, one female participant described the only circumstance under which her mother would support her to take the emergency contraceptive:

My mother says that, if one day someone rapes us, it would be the only time when she would accompany me to take it [emergency contraception]. (Female, 16 years, I:10)

Thus, the moral aspect of taking emergency contraception was discussed in both the school and home settings with a strong discourse of blame and responsibility for having unprotected sex and a need to face the consequences of this behaviour. It was not clear whether these participants or their parents regarded the emergency contraceptive as a form of abortion.

One health professional directly attributed recent reductions in adolescent pregnancies to the increased access to emergency contraceptive and both professionals whom provide emergency contraceptive services described the process as unproblematic from a provider perspective. One health professional described the women that came to her clinic in need of the emergency contraceptive:

Most of the people that come in need of emergency contraception, not just adolescents, I am talking about adult women too, come with a lot of shame. (Health Professional, I:2)

Although the process of accessing the emergency contraceptive may have improved, this example shows that the process may not be problem free for women of any age as they face shame and personal moral questions.

Finally, the topic of abstinence was only spontaneously mentioned by one adolescent participant who herself is an adolescent mother. This same participant described how abstinence was briefly incorporated in the biological teachings of contraception in 8th grade:

In biology, well, they touch on it [abstinence] in the unit on sexuality [...] Like they say "you have to be abstinent, that is the contraception", but it is not a topic that they teach for example, like for one or two months. (Female, 18 years, I:32)

Aside from this participant, none of the other adolescents received any messages about abstinence from school even though 12 participants attended catholic schools at some point in their education and three participants linked abstinence directly with religion. One female stated that she believed that abstinence was no longer "relevant" for Chilean society today (*Female, 18 years, I:50*), whilst a number of participants, particularly the males in the two focus group discussions, laughed at the concept of abstinence. One male in the university focus group described abstinence as a form of "repression", with others stating that abstinence is not effective as a form of contraception. Two participants described a double standard of youth abstaining from vaginal sex but instead having unprotected oral or anal sex:

P1: For example, they say "let's abstain and do it orally", and in the end they still catch AIDS or some other thing.

P5: You still catch other things, [...] like abstinence "no I can't", "ok, from behind then". But that still won't do. (Males, 19 years, FGD 4, P:1 & P:5)

In the female university focus group discussion the topic of "pre-penetrative" sexual conduct was discussed in relation to generational change regarding abstinence. One participant described how youth nowadays were increasingly eroticized under the influence of reggaeton (Latin American hip hop) music, alcohol, and erotic displays of sexual acts in public place and parties. She stated her belief that this led to young people dismissing the importance of pre-penetrative sexual conduct of touching and kissing:

Maybe this thing like the “pre-penetration”, like everything that happens that is not penetration, like it’s ok... like it doesn’t have serious consequences [...] all these things are still eroticism, still sensuality, still body. (Female, 19 years, FGD 3, P4)

One evangelical participant, whom was emphatic about her desire to stay virgin until matrimony, talked of discussing abstinence with her friends and at home. However, for her and three other participants who described their parents as religious, abstinence was only referred to as an ideal, rather than a strict rule. One non-religious participant described having made a promise to her mother to stay abstinent until she was 18 years old, and that her sole motivation was to prove to her mother that she could be trusted. One adolescent was active in a male religious group where sexual health topics were discussed, shared his belief that abstinence was not necessary for him to follow his catholic faith. In this group their mentor had discussed contraception and the importance of being tested for STDs such as HIV. The catholic priest discussed abstinence before marriage as an ideal, however discussed a "scale" of acceptable sexual behaviour. He expressed surprise at the reported lack of abstinence teaching in the catholic schools participants in this study had attended.

Safety: Teaching on personal limits, partner violence and rape

No adolescents described being taught about setting personal limits, partner violence and rape in school, with the exception of one participant who shared his experience of learning about these topics whilst living in the United States. Although the classes were helpful, he criticized the teaching as solely focused on females. One school psychologist shared her opinion on the lack of teaching on sexual violence and personal limits:

I think that it is serious that it [violence in relationships] is not talked about. It is considered part of our culture. “Who loves you, kicks you”. Abuse, well, in reality in our population, it is a lot. (Psychologist, I:2)

The psychologist went on to describe how the school approaches the teaching on abuse and limits primarily from the perspective of teaching parents to pick up on danger signs if their child is being exposed to sexual abuse or violence. One example they talked about was “grooming”, a type of sexual abuse over the internet where an abuser obligates a victim to perform sexual acts in front of a camera whilst they take pictures.

Linked to the idea of personal limits is also the necessary guidance of knowing when one is ready for sex, which was also not spontaneously mentioned by any of the participants. This message may traditionally have been taught alongside "abstinence" however as mentioned in the previous section, there was a lack of information on abstinence in the school sex education. Similarly, skills for negotiating condom use were not taught in any of the schools. As described earlier in the case of one adolescent mother, informing about the importance of using condoms is not helpful when faced with a partner who does not wish to use condoms and sees contraception as a woman's responsibility.

Initially the topics of personal limits, violence in relationships and rape were probed on in the family context, however considering a majority of sexual violence happens in the home setting, my co-supervisor advised against asking about this as it could be traumatic for a participant whom has experienced abuse in the home. In the interviews where the topic of safety was discussed within the family setting, three female participants described examples of spontaneous communication with their mothers about safety and setting personal limits. One described her conversations with her mother:

When I started dating, she told me that I did not need to permit anything more than kisses and hugs. And that I did not need to permit someone to shout at me, to insult me, to push me, nothing. (Female, 16 years, I:29)

Potentially if it had been possible to probe more around safety in the home setting, other participants may have had similar or different experiences.

Gender

Gender plays a key role in understanding how, what and from where Chilean adolescents learn about sexual health and sexuality. During focus group discussions and individual interviews, adolescents discussed how females seek information from the family and medical professionals, whilst males have a tendency to rely more on informal sources of friends and internet. One adolescent described gendered family socialization whereby males are "*expected*" to be curious and utilize other sources while females are seen as reserved and in need of protection from risk by the family. Another male adolescent explained the gender difference as a result of the differing biological transitions into adolescence:

Females go through a drastic change when they have their first menstruation, therefore this obligates the mother to explain to her daughter what is going on [...] for males you don't notice the change as much, it is slower. So I find that in a certain way, they teach more to females than to males. (Male, 18 years, I:43)

When analysing the difference in sexual health content overall, from all sources, it becomes clear that in this study sample females receive more information on risk, pregnancy and contraception than males, however males show more curiosity in seeking information through alternative sources. The aim for schools and health professionals to prevent adolescent pregnancies places focus on female *sexual health* as a type of risk, as described by a female participant:

I feel that, with females the topic of sex is always talked about as something serious, because it is viewed as a type of risk [...] because they can become pregnant at a young age. I feel that it is very stigmatized because of this. In contrast, for males it is more like an exploration [...] more relaxed. (Female, 18 years, FGD 3, P:4)

The theme of female sexuality being hidden or stigmatized arose both explicitly and implicitly during adolescent interviews and focus groups. In an interview, another male participant shared his opinion of the gender double standard in verbal discourse:

I think that it is good that it [sex] is a topic talked about less by women. [...] regarding males, this is just a thing that will never change (laughter). (Male, 17 years, I:27)

Thus this male supported a continuing gender disparity in the sexual health discourse. This contrasts to a female participant, who was an adolescent mother, who shared her strong opinion of the gender double standards in behaviour and verbal discourse. When asked to explain about the double standards she replied:

P: That females need to be more reserved, and... to say it in a vulgar way, not go to bed with everyone, with any person that crosses her path, but if the male comes and does the same thing as the female, the female will be seen as ugly and the male will be seen as macho. So this is also part of life.

R: And what is your opinion of this?

P: That they should both be reserved. (Female, 18 years, I:32)

An interesting emerging theme was that this gender double standard was not only imposed through the school curriculum or family socialization, but that females self-censor themselves around sexual health topics. This was first mentioned in the initial male focus group where one male stated that females "*denigrate*" themselves, choosing to close themselves off from discussing sex issues with males. This self-censorship was most evident in discussions around pleasure, masturbation and pornography where female individual interview participants were more dismissive of discussing these topics than males. To illustrate this difference, words used to describe females during sex education lessons included: *quiet, reserved, withdrawn, timid, nervous, introverted, looking inwards, prudish, not wanting to see, self-conscious or contracted*; whilst males were described as *impulsive* and *curious*, often joking and laughing during the classes.

Chapter 5: Discussion

After presenting the empirical findings from the fieldwork, this chapter aims to bring the analysis to what Fangen (2004) calls the third level. On this level one aims to uncover hidden meanings in the findings, critically analysing the empirical results by bringing them into a broader perspective. Here the researcher tries to balance the etic perspective of the outsider, imposing external theoretical frameworks on the empirical data, whilst staying true to the emic insider perspective of the participants (Fangen, 2004).

In order to analyse the data on this higher level, three key themes emerging from the data will be discussed in relation to theories and previous empirical research. These were chosen as the overarching themes that influence what information adolescents learn about sexual health and highlight the core challenges to achieving optimal sexual health for adolescents. To what extent these themes are specific to Chile or can be seen in a more universal light will be explored by drawing parallels and comparisons with other empirical research.

The first two themes discuss the sources of information, content and communication of information on a primarily *micro* level. The themes are:

- The limits of biological reductionism
- Theory vs practice

In the discussion of these *micro* level themes, it is easier to maintain the emic perspective as it draws directly on what the adolescents and key informants said. Theories related to self-efficacy and risk will be explored in relation to the study findings on sexual health information content and communication. Given the limitations of the thesis, the overriding focus in this discussion will be on the information adolescents receive from teachers, parents, friends and health professionals, since these were discussed by both male and female adolescents as most common and/or trusted sources of information.

The third theme, social construction of gender and sexuality, moves the discussion to a *macro* level looking at greater social realities in Chile, reflected in the data collected. This discussion will be framed around feminist and gender theories looking at how sociocultural gender norms are incorporated into adolescent sexual scripts through various socializing agents, most notably religion. Stigmatization of female sexuality and gender double standards of discourse and behaviour will be discussed, alongside implications of strict gender roles on partner

violence, reproductive decision-making and sexual minorities. This topic was chosen because gender socialization was a dominant emerging theme that arose from the data collected. This section will aim to bring the discussion a higher level, from the etic perspective seeking to understand the hidden meanings behind what is said, and in this way analysing the influence of sociocultural norms on adolescent learning about sexual health and sexuality in Chile.

As a general overview of the sources of information used by adolescents in this study, parents (most often mothers), schools and friends were the primary sources of information used, with parents, schools and health professionals eliciting most trust. This coincides with previous quantitative research from Chile (González et al., 2007; Pérez et al., 2004). Internet was used only to a limited degree and with scepticism. Those adolescents whom actively used internet all described different mechanisms used to determine the validity of the information on the internet, primarily through double checking with teachers, parents or other adults. This mirrors the results from similar studies showing that internet does not seem to replace the primary sources of family, schools and friends when it comes to sexual health information (Dolcini et al., 2012; Jones & Biddlecom, 2011). As described in other settings, the role of health professionals was gendered with females describing visits to midwives and gynaecologists to learn about contraception and sexual health (Jones et al., 2011). This reflects results from both local and global settings discussing the barriers of including males in adolescent health services (MINSAL, 2010a; Whitfield et al., 2013). Earlier research has shown that sexual minority adolescents rely primarily on information from health professionals (Rose & Friedman, 2012), which was reiterated by two of the health professionals interviewed in this study. Internet and friends will be discussed only briefly. Unlike previous studies, TV, films, documentaries and advertisements were not seen as important sources of information, therefore they will not be discussed further (Dolcini et al., 2012; Jones et al., 2011).

Theme One: The limits of biological reductionism

In this study, all the adolescents learnt about the biological aspects of sexual health as it relates to puberty, pregnancy, STDs and to a lesser degree, contraception. This information was primarily from school but for many it was also discussed by parents and some health professionals as the participants entered puberty. These sources coincide with the sources that illicit most trust in the adolescents interviewed. Internet was used to a limited degree to find

information on biological themes of sexual health and most commonly this was in relation to school projects.

When asked about what topics all adolescents should learn about sexual health and sexuality, all participants described the biological aspects of sexual health with only a few mentioning wider emotional, relational, social and/or moral aspects of sexuality. Where sexuality is taught within the school sex education program (for example in biology or religion classes) greatly sets the agenda for how sexuality will be approached. Therefore, one reason why adolescents viewed sexual health and biology along such biological lines may be because they themselves learnt about sexual health primarily in biology classes, and in this way even topics of *afectividad* may be taught along biological lines. Borges et al. (2006) call this "*biological reductionism*" whereby teaching on *afectividad* and what one participant called "*the magic*" of sexuality is omitted or reduced to a biological explanation. This also leads to the primary information focusing on pregnancy, STDs and female *risk*. Before discussing the place of *afectividad* in adolescent learning about sexual health and sexuality, the limitations of biological reductionist teaching and focus on female *risk* will be discussed.

Content of biological teaching

Firstly, when appraising the content of the biologically focussed teaching, it becomes clear that focussing on the biological processes of pregnancy and STDs without also discussing the emotional aspects of sexuality, effectively supports a split between mind and body (Harré, 2001). In this mind-body dualism, adolescents are expected to take rational decisions based on being cognitively aware of negative biological outcomes of risky unprotected sexual behaviour, without taking into account the emotional and physical impulses that drive the development of sexual attraction. As one psychologist in this study pointed out, in reality it is the emotions that drive us to act in a certain way in the face of physical impulses, thus to encourage safe sex behaviours is impossible if teaching does not approach these emotional impulses. Similarly, a healthcare worker described the need to talk to adolescents about love, relationships and heartbreak, considering these elements of sexuality may have consequences for an adolescent's emotional state and in particular their mental health.

Another limitation of this biological-*afectividad* separation in teaching content is the effect it has on teaching on the topic of homosexuality. With a biological focus on reproduction and prevention of pregnancy, the topic of homosexuality was either omitted or often explained in

biological terms as a hormonal disorder. This biological explanation is further underpinned by the apparent *medicalization* of homosexuality as a “*condition*” by two medical professionals in this study. Both *biologicalization* and *medicalization* support the idea that sexual orientation can be divided into defined categories of homosexual and heterosexual rather than a multidimensional continuum (Beh, 2006). Furthermore, by not discussing homosexuality from the point of view of *afectividad*, sexual minority youth are not encouraged to explore the elements of emotional or romantic attraction alongside the biological “erotic” same-sex attraction (Saewyc, 2011). This means that the predominant biological *heteronormative* focus on pregnancy, may alienate sexual minority adolescents.¹³ This in a time when they may be in particular need for teaching about *afectividad*, rather than being told that they have a hormonal disorder or condition that makes them abnormal in relation to their peers (Rose & Friedman, 2012).

Many sexual minority adolescents experience bullying, enacted stigma and discrimination and are at greater risk for mental health problems and suicide (McCarty-Caplan, 2013; Saewyc, 2011). Two examples of discrimination of *suspected* sexual minority adolescents were given by adolescents in this study, whilst a double discourse of comments describing a tolerance for sexual minorities alongside a need for them to keep their distance was also common. Therefore, providing emotional support for these adolescents in the form of discussing same-sex attraction from a normality perspective focusing on feelings and attractions rather than biological differences may be important in preventing negative social and health outcomes (McCarty-Caplan, 2013; Saewyc, 2011). This support could come from formal sources such as schools or from health professionals, as evidenced in this study. Interestingly, in practice, through the *biologicalization* and *medicalization* of homosexuality, health professionals in this study are given a point of entry to provide this emotional support for sexual minority youth.

A focus on the acceptable biological teachings across formal and informal sources is not unique to the Chilean context. Both quantitative and qualitative studies from Brazil (Borges et al., 2006), Canada (DiCenso et al., 2001, p. 37), Norway (Møllhausen, 2005), New Zealand (Allen, 2007) and the UK and Australia (Walker & Milton, 2006) all attest to the primary focus on biological aspects of sexuality in sex education in schools and in communication

¹³ The term heteronormative means that the underlying presumption is that heterosexuality defines normal sexual orientation.

from parents. This suggests that this biological reductionism by teachers and parents is also a tendency in a diversity of global contexts outside of Chile.

Communication of information on biological sexuality

In schools, communication on biological aspects of sexual health was primarily one-way and non-participatory. This was particularly evident in the school setting where sexual health was covered in biology or natural science classes with a highly academic focus, where adolescents becoming passive learners. This may not be surprising since biological sciences are often focused on categorising and defining biological phenomena, with less focus on developing critical thought such as in social sciences, literature and philosophy. As a result of this one way teaching, a number of adolescents did not spontaneously associate these classes with learning about sexual health and it was not until they were probed that they discussed learning about sexual health in biology classes in school. Some participants also viewed biological teachings in light of acquiring knowledge to pass school examinations, rather than knowledge with practical importance in their lives.

From parents, many adolescents also told of triggered conversations where they received non-specific messages to "protect themselves" from pregnancy and STDs, rather than a dialogue about what the adolescent wished to learn about sexual health and sexuality. Thus, like in the school setting, a number of adolescents whom receiving these short, decontextualized messages did not automatically refer to their parents as a source of information. It was notable that both adolescent mothers interviewed described having received some short, decontextualized messages on "protection" before becoming pregnant. However, the lack of depth or specificity of information meant that both females expressing a wish that they could have had a proper dialogue with their mothers before becoming pregnant.

Although the parents of the adolescents were not interviewed in this present study, previous research with parents describes a common trend in many global settings that parents see themselves as the most important and trustworthy educator for their child, but that the role is challenging (Lagus, Bernat, Bearinger, Resnick, & Eisenberg, 2011; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998; Nambambi & Mufune, 2011). A Namibian study which included interviews with both adolescents and parents found that both groups felt it was important to talk of sexual health in the family, especially considering the risks of HIV infection (Nambambi & Mufune, 2011). However, as with the present study, communication was

primarily passive, one-way and the topic of sex was still described as taboo for some parents. This can be understood as a form of inner battle fought by parents on the one hand not wishing to open the door for their children into the adult world, whilst at the same time acknowledging the need to communicate with their children in the face of contemporary challenges such as HIV and adolescent pregnancy (Nambambi & Mufune, 2011). In the Chilean context, the prevalence of HIV is comparatively low, however as described by adolescent and key informants in this study, increases in adolescent pregnancies in early adolescence and eroticization of adolescents in popular media are real contemporary changes parents are facing. Examples of this eroticization were given by Chilean adolescents in this current study, describing the influence of reggaeton music, pornography and the exposition of sexual acts in public spaces.

Fear and female risk

Fear was a tool utilized by both teachers and parents to highlight to adolescents the biological consequences of unprotected sex. In a number of school settings, photos were used to show infected genitals with the intention of convincing adolescents of the negative effects of unprotected sex. One participant also described her mother talking to her of the pain of childbirth. The use of fear as a technique in health promotion is widespread, however a recent literature review of 60 years of *fear appeal research* describes how the *fear arousal* from threatening health messages may lead to *risk denial*, whereby the target audience disassociate themselves from the *risk* group, thus counteracting the intention of the messages (Ruiter, Kessels, Peters, & Kok, 2014). Fear arousal techniques are rarely coupled with instructions on specific health promoting action (Ruiter et al., 2014), which was evident in this present study. In this study adolescents described fear techniques used by teachers and parents, however this information was not always accompanied with practical explanations of how to access and use contraception, and not accompanied by skill development on how to negotiate safe sex with a partner.

Through interviews and focus group discussions, both female and male adolescents described how *risk* was portrayed by teachers, parents, friends and media as greater for females than males. It is the case that for biological, social and cultural reasons, adolescent females carry a higher health and socioeconomic burden of negative sexual health outcomes (Beh, 2006). Biologically, women are more at risk due to the greater biological susceptibility to STDs as well as considerable health risks involved in pregnancy and childbirth at a young age (Beh,

2006). Furthermore non-vaginal heterosexual sexual activity such as anal and oral sex also places females at greater risk for STDs. There are three intertwined reasons for this. Firstly these sexual practices are more often performed without condoms; secondly females have a higher risk of STD infection during receptive anal sex (McBride & Fortenberry, 2010); and thirdly there is a greater prevalence, and societal normalization, of fellatio (oral sex performed on a male) compared to cunnilingus (oral sex performed on a female) (Bay-Cheng, Robinson, & Zucker, 2009; Chambers, 2007).

From a rational perspective, public health and sex-education programs that focus primarily on female risk may be justified by the above mentioned increased health and social burdens females carry in relation to pregnancy and increased biological susceptibility to STDs (Lupton, 1999). Lupton (1999) criticizes this rational, pragmatic logic, stating that what we understand as *risk* cannot be isolated from historical, social and cultural processes. Building on the work of Mary Douglas, Ulrich Beck and Michel Foucault, Lupton (1999) explores the sociological links between risk and culture, society, gender, history and religion, especially how public health policies based on risk may be both discriminating and moralizing. Given the observed focus on female risk in this current study, it is interesting to explore the influence of culture, society, history and religion on socializing and problematizing female sexuality in light of reducing *risk*.

The overwhelming focus of the discourse on biological risk can be challenged in light of the sociocultural construction of female *risk* in society. By linking risk to females, a greater moral burden placed on females and therefore female sexuality may be portrayed as more of a risk to social order than for males. Thus expression of female pleasure may be constrained and examples of female desire, such as masturbation, viewing pornography and having multiple partners, may be stigmatized (Chant & Craske, 2003). This was seen in the current study through the discussions of the gender double standards in both sexual discourse and behaviour, as well as the observed absence of information on female pleasure. The words used in the female university focus group of a female whom masturbates as “*desperate*”, “*revolutionary*” or “*stooping so low*” underpinned the idea of female sexual pleasure contradicting traditional ideas of female chastity and passivity. This stigmatization will be further explored in the section on gender socialization, however it is suffice to say that from a feminist perspective, historical, social and particularly religious influences linking women’s sexuality greater to *risk* and sin perpetuates the oppression of women (Chant & Craske, 2003).

This oppression is further increased through the heightened social and economic burdens placed on adolescent mothers including school interruption and the trend that females and their families carry the burden of raising the child (Beh, 2006).

A very real consequence of focussing adolescent sexual health communication on *fear* and *risk* is the creation of *sex negative* networks and aversion (Dolcini et al., 2012). In these cases, adolescents may come to view sex on purely negative terms of risk, not anticipating sex to be a pleasurable experience and avert talking about contraception with friends or romantic partners (Dolcini et al., 2012). Given the prior discussions on *risk* in the Chilean context, it would be expected that females would be most likely to construct *sex negative* ideas from the information they receive. In this current study, one female participant expressed overtly and consistently sex negative attitudes, to not wishing to discuss sex with female friends or romantic partners, and even describing menstruation as something ugly that should be hidden from males. The remainder of the participants held more positive views on sex and sexuality, however the small sample size of this study and voluntary nature of participation makes it impossible to draw conclusions about the actual presence of adolescents with sex negative attitudes in the schools visited.

The use of non-participatory teaching styles, focusing on biological sexual health and female *risk*, stands in stark contrast to comments made by two psychologists interviewed whom described the importance of reflection in influencing sexual behaviours. One psychologist reiterated how reflection was a vital tool for protecting adolescents from social pressure to engage in early sexual debut or unprotected sexual intercourse. The other psychologist used *future orientation*, in the sense of orientating adolescents about opportunities in the future, as a tool to encourage reflection on the consequences of unprotected sex (adolescent parenthood and STDs). *Future orientation* was also talked about between both male and female friends as a peer mechanism to encourage safe sex practices through reflection. This was particularly important for the two adolescent mothers who talked to their female friends about the challenges of adolescent parenthood and the opportunities that lay ahead in the future.

The current place of “the magic”

Adolescents learnt about topics falling under the global theme of *afectividad* in varying degrees and from different places. Themes of *afectividad* were primarily discussed in the home, between female friends, between partners and in the context of school religious

teachings. As presented in the findings, themes of love, *afectividad* and what one participant called the "magic" of sexuality were often associated directly to religion. In this small sample of three schools, the younger participants from the catholic school reported having received the most comprehensive education on sexual health and sexuality, incorporating extensively topics of *afectividad* and even debating controversial topics such as abortion. It is in no way the intention to generalize across all religious and secular schools, and it is important to add that religiosity was not the only characteristic differing between the three schools in the sample. Socioeconomic status also differed, and as a Chilean study showed, increased socioeconomic status is a significant factor associated with increased knowledge about sexual health (Pérez et al., 2004). Furthermore, the male focus group discussions brought this finding into a broader social context describing a continuum of "order and fanaticism" in religious Chilean schools, quoting examples of conservative religious schools with no sex education at all. Nonetheless it is interesting to explore what it is about religious education that may encourage more comprehensive teaching of sexuality.

Religious affiliation is a known protective factor for delaying sexual debut both in Chile and in other global settings (Murray et al., 1998; Pérez et al., 2004; Pilgrim & Blum, 2012), however the nuances of this relationship are unclear. The attitudes of religious adolescents varied in this study, with some viewing premarital sexual experiences and religious faith as mutually exclusive, others as compatible. A majority of the participants, both religious and non-religious, seemed to dismiss the idea of religion playing a role in defining contemporary sexual scripts. If religion is tightly linked to teaching on the topic of *afectividad*, by dismissing the role of religion in defining personal sexual scripts, adolescents may also end up dismissing the value of learning about *afectividad*. This was visible during the interviews when adolescents were asked at the end of each interview what they felt adolescents should learn about sexual health and sexuality. Even though a broad range of themes were raised throughout the interviews such as love, pleasure, affection, relationships, abuse and sexual orientation, the great majority of adolescents named only biological topics such as pregnancy, STDs and contraception.

In this study, sexual abstinence is an almost absent theme in school sex education and in the home. In this sample only one adolescent, herself a mother, described having learned about abstinence and this was in the biological context of *abstinence as contraception*, rather than in the context of orientation classes talking about love, relationships and *afectividad*. In the

home, even though a number of participants had religious parents, abstinence was referred to as an ideal, rather than a requirement. Furthermore, during the focus group discussions and individual interviews the concept of sexual abstinence also met with laughter and immediately dismissed as an out-dated conservative concept in Chile.

Thus, in this setting it seems that teaching on sexual health and contraception and teaching on abstinence are seen as mutually exclusive. This contrasts to results from a similar qualitative interview study from the United States where adolescents described the compatibility between contraception and abstinence messages (Jones et al., 2011). Adolescents defined sexual abstinence in different ways, not only on religious terms, but also as a process of waiting until one is *ready* or waiting until one is in a stable relationship. These different definitions meant that learning about contraception was not seen as opposing messages of waiting until one was *ready* (Jones et al., 2011). This compatibility of messages contradicts the argument of supporters of abstinence-only education whom criticizes comprehensive sex education for confusing adolescents with mixed messages (Kirby et al., 2007).

Challenges of teaching on afectividad

Psychologists in this study gave varying reasons for why *afectividad* was not as readily incorporated into adolescent teaching as biological aspects of sexual health and sexuality. They described challenges in teaching on *afectividad* including needing to invest more time into planning lessons, the importance of classes being interactive and thus to a certain degree the power relationship between teacher and pupil being challenged. An example was given of the psychologist who designed her classes in an interactive way, dividing the class into teams and encouraging the students to be the “*protagonists*” of the class. This finding is supported by results from a study with teachers of HIV/AIDS education in South Africa where the teachers described a form of *renegotiation* of the relationship between teacher and student when teaching about sex and sexuality (Helleve, Flisher, Onya, Mūkoma, & Klepp, 2011). Teachers were required to switch between different roles of “*teacher*”, “*parent*”, “*friend*” or “*counsellor*” (Helleve et al., 2011, p. 23) when teaching about sexuality, each of which indicates a different balance of power in the interaction.

In the home, this discomfort in talking about *afectividad* was reflected in those parents who provided short, preventative messages linked to risk of pregnancy and contraception, without developing ideas of love, relationships, feelings, desires or sexual impulses. These

preventative messages were also triggered by situations where parents felt their adolescent was at risk (for example with first menstruation), which feeds into the simplistic view that sexuality is linked to biological risk. Also, as discussed earlier, risk related to unprotected sexual intercourse was universally seen as greater for females due to pregnancy, therefore responsibility for contraception also often placed on females. Teaching about love was seen by both adolescents and key informants as a responsibility of parents, and although a few adolescents had talked about love with their parents, for many this often seemed to be overshadowed by a focus on risk.

As discussed by key informants in this study, parents are most often the first and most important educators for their children. As exemplified through the example of the participant whom repeatedly tried to engage in conversations with her parents, but was referred to the internet, parents may need help in becoming more confident educators for their children. In order to do that, just like schoolteachers, parents may need guidance in confronting their own sexuality in order to communicate openly and effectively with their children, starting in infancy and continuing through childhood and adolescence (Walker & Milton, 2006). In this study, psychologists, health professionals and the religious leader all described ways they could support parents in this learning to encourage lifelong communication about sexual health, sexuality and *afectividad*.

As seen in this study, health professionals also play a role in the clinical setting moving beyond biology and broaching topics of *afectividad*. The results show that this is of particular importance for two groups. Firstly it is important for those adolescents who do not have open communication with their parents about sexual health and sexuality, and whose school sex education has a purely biological focus. Secondly, it is important for sexual minority adolescents who may not be supported in heterosexually focused school education and may not actively seek support from home. Rose and Friedman (2012) found in their systematic review on sexual minority health youth health seeking behaviour that health professionals were their main source of information, even when practitioners were unaware of the youth's sexual orientation. This further highlights the importance of healthcare workers to move beyond a medicalization of homosexuality to focus on encouraging safe sex behaviours and also to broaching the subjects of *afectividad* so that these adolescents also get a chance to explore topics related to what one participant called the “*magic*” of sexuality.

It must be noted that those adolescents and key informants that discussed the lack of focus on *afectividad* in adolescent sexual health information, did not present this as an alternative nor replacement for biological teachings. Learning about biological functioning is important and in reality as the findings showed, for many adolescents interviewed it was seen as the most important information. Discussing a merging of *afectividad* and biology is instead an acknowledgement of the limitations of heteronormative biological reductionism in informing and educating adolescents around the complexity of understanding, being in charge of and enjoying their sexuality.

Theme Two: Theory vs practice

A second primary observation from the findings is the lack of focus on the practical aspects of ensuring optimal sexual health and sexuality. The adolescents criticized information from schools and parents for not adequately preparing them with tools to prevent the negative outcomes of unprotected sexual activity. Bandura (1992) states that “*unfortunately information alone does not necessarily exert much influence on refractory health-impairing habits*” (p. 89), and goes on to advocate for information on safe sex behaviours being accompanied by tools that increase a person's belief that they have the capacity to fulfil the health promoting behaviour. This is known as *self-efficacy* (Bandura, 1992).

This is backed up by an extensive systematic review of 83 school sex education programs that claims that the most effective programs in delaying sexual debut and encouraging protected sex are comprehensive sex education programs teaching skills related to partner communication and contraceptive use, as well as the self-efficacy to be able to use these skills (Kirby et al., 2007). Thus, perhaps unsurprisingly, adolescents in this current study stated that practical as well as theoretical information on sexual health and sexuality was necessary. As with the focus on biology, a prioritization of theoretical before practical information on sexual health and sexuality is also not unique to Chile. In studies from New Zealand (Allen, 2007) and Norway (Møllhausen, 2005), high school students described how theoretical aspects of sexuality were prioritized over learning about practical tools to achieve safe and pleasurable sexual experiences.

The practical skill based learning about sexual health and sexuality emerging from this research can be divided into four sections. Those related to accessing and using contraception,

communicating with a partner about sex, setting personal limits in relationships, and the mechanisms of the sexual act.

The "how?" and the "where?" of contraception

Information about contraception and condoms was primarily provided in schools, from parents and from health professionals. Condoms were the primary contraception discussed, however the actual mechanism on how to put a condom on was only shown to one adolescent in school and one adolescent at home. This gap in practical information was exemplified in the quote by one participant about theoretical instruction on how to put on condom did not help in the moment realizing a sexual act. Furthermore, as one adolescent said, when pornography becomes the frame of reference for the sexual act there may be a misinformation in relation to how to use condoms.

Practical teaching about condom use in the school environment touches on a sensitive nerve in the Chilean context, where there still exists a myth that teaching about contraception, and in particular showing practically how condoms work, will encourage early sexual activity (Casas & Ahumada, 2009). An example of this is the large countrywide sex education program called "Conversations on Relationships and Sexuality" (JOCAS) which was rolled out on a national scale in 1996 with the supported by the United Nations Family Planning Association (UNFPA) and Chilean government (Casas & Ahumada, 2009). Although the program was well received by adolescents, it came under extensive scrutiny from conservative forces in Chile stating it was overly focused on health rather than values. There was particularly strong public criticism of a school that taught pupils how to put a condom on a banana and the program was abandoned in 2001 (Casas & Ahumada, 2009). As one health professional underlined, it is important that that teaching on practical uses of contraception such as condoms must be complimented by comprehensive teaching on *afectividad*. This seems particularly important in a country with conservative forces with considerable power to obstruct the implementation sex education programs (Casas & Ahumada, 2009).

Regarding hormonal contraception, most participants had learnt about hormonal contraceptives at school. This sample also included a high proportion of female participants whom had talked to their mothers about contraception and a number had been taken to see a gynaecologist or midwife by their mother. This may be a reflection of the sample in this study including adolescents with a greater interest in sexual health and sexuality, as well as parents

whom were more open to approach the topic of sexuality with their daughters. The main issue raised in this current study was regarding information about the biological functioning of the emergency contraceptive pill. Adolescents had either not received information about the emergency contraceptive, or received vague information as to its efficacy, overshadowed by questions of moral acceptability and potential *abortive* role.

Thus by defining emergency contraception as potentially abortive, the discourse effectively enters the same territory as debates on abortion. Even though rigorous studies have shown that the emergency contraceptive does not work if ovulation has occurred, ambiguity and lack of acceptance of these scientific results play in the favour of those *pro-life* activists against use of the emergency contraceptive (Hevia, 2012). Thus a struggle emerges between who has the most power to define the function of emergency contraception: the religious leaders whom define the emergency contraceptive as abortive or the opposing medical researchers and reproductive rights activists whom define it as non-abortive. As observed in this current study from Chile, in the midst of this debate adolescents may receive conflicting and ambiguous information about the emergency contraceptive which may impede their ability to make informed and empowered decisions about its use.

Communicating with a partner

A core practical skill for promoting pleasurable and safe sex practices and preventing situations of coercion and miscommunication, is learning how to communicate effectively with a partner about sex (UNESCO, 2009). In this study the adolescents overwhelmingly discussed the importance of communication with a partner on topics of sexual health and sexuality, however actual experiences of this were varied. The greatest contrasts in communication were between an adolescent mother who was told by her partner to "*get protection*", and an adolescent male who described having mature conversations with his partner about their sexual life as a couple. This first example highlights vividly limitations put on communication when contraception is regarded as a female responsibility and where a female may be in a disempowered position where she cannot negotiate condom use. The second example contrasts this, exemplifying how mutual responsibility and open communication may make adolescents feel mature.

Both adolescents and key informants discussed the importance of anticipatory partner communication considering the *impulsiveness* of adolescent behaviour. However taboos and

gender stereotypes may hamper this communication. In their global systematic review, Marston and King (2006) describe these social expectations and stereotypes as widely universal, where females fear that talking about sexual health would make them seem *easy*. In this present study this was not always the case, with multiple examples of non-sexually experienced female participants whom described open conversations with partners about potential sexual experiences in the future. This indicates that the strength of gender stereotyping and the taboo around talking about sex may be diminishing, however the experiences of the three adolescent parents interviewed in this study provide examples of limited or absent partner communication prior to sexual activity.

This difference in experience can be explored in relation to differing levels of self-efficacy felt by adolescents in relations with their partners. Breakwell (1997) describes the link between the theory of self-efficacy and power, stating that effective communication between partners help set these *rules of engagement* on when and where sex takes place, promoting assertive communication and a balance of power between both parts. The adolescent mother interviewed in this current study, who was told by her partner to get protection but had never discussed condom use with her partner, is an example of a power imbalance between partners. This may have negative consequences not only physical sexual and reproductive health, but also for self-esteem and mental health. Thus, sharing of power is intrinsically linked to self-efficacy and feeling in control (Breakwell, 1997).

Another key element of partner communication is the importance of building trust and respect, especially in relation to use of condoms and encouraging STD testing of partners with prior sexual experience. A major barrier to condom use is the perception that condoms are stigmatizing and a sign of lack of trust (Marston & King, 2006), and furthermore ingrained sociocultural norms may disempower females in the face of negotiating safe sex and condom use (Beh, 2006). In this current study with adolescents in the urban Chilean context, gender norms linked to acceptable male and female language and behaviour were strongly expressed by some adolescents. Therefore, it is possible that in this Chilean setting, sociocultural gender norms contribute to the disempowerment of those adolescents unable to talk to their partners about contraception, condom use and STD testing.

When it comes to talking to a partner about pleasure, the results showed that four male adolescents described the importance of talking to a partner about pleasure, while one said it

was a topic to be talked about when he got older. Learning to talk to a partner about what is good and pleasurable in sexual relations is important for building trust and gender equality in sexual relations. This is especially important given both biology and more importantly cultural norms around heterosexual vaginal sex favouring male sexual pleasure above female pleasure (Bay-Cheng et al., 2009; Reiss, 1989; Svendsen, 2012). The stigma related to talking about pleasure may be linked to the concept that pleasure is a private matter (Allen, 2007). From a feminist perspective, the lack of focus on communication about female pleasure reflects a specific stigmatization of females where “*a silence about female pleasure may also fail to convey a sense of personal empowerment and pleasurable entitlement to young women*” (Allen, 2007, p. 252). On a more sociocultural level, the taboo linked to talking about pleasure with a partner may link back to the earlier mentioned religious focus on reproduction rather than pleasure, which is linked to the sin of lust, masturbation, casual sex, infidelity or hedonistic relations (Chant & Craske, 2003). Thus pleasure may be seen as the antithesis of love and relationships, rather than being incorporated as a part of a sexual relationship that can to be talked about with a partner.

Learning to set limits and preventing violence

A key reproductive right for all is to have a sexual life free from coercion or abuse (Obaid, 2009). Adolescence is a time of increased vulnerability to sexual coercion due to lack of experience, social pressure, the mismatch of information from different sources (most commonly between parents and peers) and the progressive development of self-identity and self-esteem (Breakwell, 1997). In this study, adolescent females were often warned by their parents about risks inherent in entering puberty and they were told that they could now be a target for sexual violence. Thus for some, entering puberty became synonymous with risk, which has been described as common throughout Latin America (Goicolea, 2010; Schutt-Aine & Maddaleno, 2003).

Female adolescents in this study reported receiving information primarily from their mothers about risks of random acts of sexual violence and kidnapping. Although random sexual attacks do happen, a majority of violence against women is perpetrated by someone known to the victim and often this is a partner (Bott, Guedes, Goodwin, & Mendoza, 2012; Dartnall & Jewkes, 2013). Thus the overemphasis on the risk of random violence and how women can reduce the risk of this violence (for example through modest clothing), overshadows the far greater risks involved in partner relations (Bott et al., 2012). The lack of focus on skills to

empower females in being in charge of their sexuality, communicating with a partner and setting limits, reaffirms gender stereotypes of females as vulnerable and powerless compared to their powerful *macho* partners (Chant & Craske, 2003). This raises concerns in relation to learned gender roles that perpetuate violence against women all over Latin America, often starting with the stereotypical jealous *macho* male emotionally controlling and isolating of their female partner, which may lead to physical violence (Bott et al., 2012).

This study found a lack of focus on males when it comes to the topic of partner and sexual violence, which is a reflection of the social reality that a majority of domestic and sexual violence in Chile, throughout Latin America and worldwide, is perpetrated by men against women (Bott et al., 2012; Dartnall & Jewkes, 2013). This is unsurprising from a feminist perspective as male dominated gender hierarchies all over the world rely on patriarchal structures both in the public and private realms that oppress women (Bryson, 2003). This reliance on patriarchy leads to a reluctance from authorities to interfere with private domestic affairs, even when it constitutes domestic violence and patriarchal oppression (Bryson, 2003). However, even given this established gender oppression, from a gender perspective to achieve lasting change it is important to include males in movements to reduce gender inequality and prevent violence against women (Bott et al., 2012; Connell, 2005).

As discussed by the male participant whom had learnt about sexual violence at school in the United States, inclusion of males in education on preventing sexual violence is also important. A recent study into experiences of sexual coercion of male and female university students in Chile highlights the existence of sexual coercion of males by partners, a trend that goes against the common understanding of one rape myth that a man cannot be a victim of rape (Lehrer, Lehrer, & Koss, 2013). These myths may stigmatize male victims, especially considering the *macho* culture that prescribes masculine characteristics of strength and assertiveness in sexual encounters (Lehrer et al., 2013). Thus, both males and females need support in learning to set personal limits and seeking help in case of abuse. Furthermore, education around prevention of violence may include challenging harmful gender expectations, such the example in this study of pressuring a male to "*become a man*" through vaginal sexual intercourse.

As one psychologist discussed, in order for both males and female adolescent to protect them from vulnerability of social and partner pressure, it is important to establish self-esteem, self-

efficacy and power balance in relationships. Part of this self-efficacy relates to adolescents' abilities to first avoid and then manage situations that may lead to unwanted or unprotected sex (UNESCO, 2009). Alcohol and drugs are common factors involved in much coercive sex situations (Lehrer et al., 2013; Lehrer, Lehrer, & Zhao, 2009), and a number of adolescents described sex education classes that were taught alongside classes about drugs and alcohol. Although the influence of alcohol and drugs should not be overlooked, focussing information only on what potential victims can do to reduce risk of violence may perpetuate victim blaming rape myths (Bott et al., 2012; Lehrer et al., 2009).

The sexual act

Learning about the actual sexual act was a central topic that came up throughout the adolescent interviews in different ways. Sexual pleasure was never brought up in formal sex education classes in school, however both adolescents and school psychologists described anonymous question sessions where pupils asked questions about explicit sexual acts, ranging from oral sex to bestiality. Anonymous questioning can meet many needs such as dispelling myths, feeding curiosity, as a joke and sexualising the teacher (Charmaraman, Lee, & Erkut, 2012). The need for anonymity in asking these questions may also reflect the secrecy, embarrassment and taboo attached to these topics, as well as fear of social ridicule for not being knowledgeable on a certain topic.

Through anonymous questioning, many adolescents sought information on the explicit mechanisms of the sexual act and particularly that which was not related to heterosexual vaginal sex. This finding is supported by a study from the United States that analysed the content of anonymous questions written by 795 pupils 11-12 years old (Charmaraman et al., 2012). These authors found that 42% of the questions were related to sexual activity and behaviours, and of these questions, 13% were related to non-penile-vaginal sex compared to 4% whom asked about vaginal sex (Charmaraman et al., 2012). This focus on pleasure and specifically non-vaginal sex may be another indication that narrow *heteronormative* focus of much adolescent sexual health information (particularly from schools) may not meet adolescent information needs (McCarty-Caplan, 2013; Svendsen, 2012). The interest in non-vaginal sexual practices was also evident in the list of words the initial male high school focus group wrote, where a considerable number of words were related to oral sex. In discussing these terms there was considerable laughter between the males, which contrast to the expression of disgust presented by the only female participant whom mentioned oral and

anal sex. Although there was a gender difference in these reactions, it was interesting that this female participant still openly described her curiosity around sex and pleasure. This reflects results from a quantitative study with 1,180 adolescents in New Zealand which found that the topic both male and female adolescents most wanted included in their school sex education curricular were related to making sex pleasurable for both partners (Allen, 2007).

A discussion of non-vaginal sex arose in the male university focus group where participants critiqued their observation that adolescents today view oral and anal sex as safe, compared to vaginal sex, where they run the risk of pregnancy. The female university focus group had a similar discussion of what defines *sex* when discussing their observations of the current acceptance of pre-penetrative sex including genital touching and intimate kissing. This raises concerns related to STDs (with oral and anal sex), as well as the emotional impact of downplaying the intimacy and emotional aspects of pre-penetrative sexual acts. Furthermore, it links in directly to the larger question regarding what is defined as *sex*. In the previously mentioned anonymous question study, the 11-12 year olds asked about the definition of sex, with questions such as: “*Is anal sex still considered sex?*” (Charmaraman et al., 2012, p. 528). Thus even very young adolescents may have queries about how to define sex. Those answering these questions, whether they be school teachers, parents, friends, partners or internet forums may hold considerable power in shaping how adolescents define sex.

Thus, as with the definition of the function of the emergency contraception, there is a lot of power linked to defining terms like *sex*. Firstly, how sex is defined will influence what topics will be covered in school *sex* education programs. Secondly it helps define which sexual acts will be seen as morally punishable according to definitions of *sexual sin* set by religious moral powers. Thirdly, it is influential in determining an individual’s own sexual moral in relation to relationships and fidelity (for example what sexual act defines losing one’s virginity and what act defines infidelity). Finally, the way sex is defined in the judicial system has important implications in relation to what is understood as sexual coercion and rape.

According to a legal definition, under the section on “*rape and other sexual abuses*” in the Chilean penal code, sexual abuse of minors includes vaginal, anal and oral penetration, including when the perpetrator and victim have not touched (for example through penetration with objects) (Ministerio de Justicia, 2013). Furthermore, sexual abuse includes the incitation of sexual arousal in a victim by realizing a sexual act (for example masturbation) in front of a

victim or coercing a victim into performing a sexual act, or by forcing a victim to view pornographic material. This form of abuse without physical contact was described by a psychologist in this study with the example of “*grooming*” over the internet. This broad definition of what constitutes sex in relation to abuse may not coincide with the definitions adolescents themselves have. This may be a product of the *heteronormative* focus of school and parental education on penile-vaginal sex (Svendsen, 2012), potentially influenced by conservative religious values (Peterson, 2007). The implications of this may include low perception of risk related to negative sexual outcomes such as STDs, which could therefore be related to reduced condom use during anal and oral sex (Peterson, 2007), as well as underreporting of sexual abuse not regarded as *sex* or *abuse* (Lehrer et al., 2009).

Another perspective linked to the focus group discussion about non-vaginal sex, relates to reasons why a person might or might not define a certain act as *sex*. In a recent study exploring motivations behind individual definitions of sex, reasons for defining a scenario as “*not quite sex*” included ideas on behaving consistently with religious beliefs such as maintaining virginity, as well as other social influences such as being perceived negatively by others or having their “*heterosexual self-concept*” challenged by defining, for example, anal intercourse as *sex* (Peterson, 2007). The idea that adolescents still classify themselves as “*virgins*” even though they engage in oral sex has been extensively studied (Chambers, 2007). The point related to the “*heterosexual self-concept*” highlights a myth regarding *normal* heterosexual sexuality, that in anal sex is only engaged in by same sex couples. Research from a number of global settings highlights the prevalence of anal sex amongst heterosexual couples, although societal and cultural taboos in reporting lead many researchers to claim the results to be conservative estimates (Carter, Henry-Moss, Hock-Long, Bergdall, & Andes, 2010; Duby & Colvin, 2014; Heywood & Smith, 2012; McBride & Fortenberry, 2010).

Sexually experienced friends and partners may become a frame of reference for the sexual act, although adolescents described varying trust in what their friends said about sexual health and sexuality. Somewhat unwritten rules of sexual engagement were apparent, particularly in the catholic school, whereby the nature and timing of sexual relations were scripted in the peer network. Peers were judged on their knowledge and behaviour, and pressure was exerted on those not fulfilling these unwritten rules, whether it be abstaining from sex with an established partner or losing one’s virginity without being in a formal relationship. Therefore, findings from this current study confirm Delamater’s (1989) theory that peers are also strong

socializing agents teaching about practical aspects of dating and the sexual act.

Pornography was described as the most common source of explicit information on the sexual act. For male high school students it was highly accepted to watch pornography whilst for females the idea of watching pornography was universally dismissed as unacceptable. Here the theme of gender stereotyping emerged, with the idea of female "*ladies*" watching pornography contradicting the expected characteristics of conservatism, whilst impulsive males "*cave men*" were expected to watch pornography. This gender disparity was reinforced by both males and females and can be linked to the broader theme of stigmatization of female sexuality and pleasure.

The internet pornography industry is large and online pornographic material is characterised as being anonymous, affordable and accessible (Döring, 2009). This meant that both wanted and unwanted exposure to internet pornography was a common experience for many adolescents, which coincides with recent research into adolescent prevalence of exposure to pornography in the United States (Wolak, Mitchell, & Finkelhor, 2007). In the individual interviews, participants, particularly females, viewed pornography as something negative and some feared exposure. Conversely, in the university focus groups in a more positive light, both male and female describing pornography as a frame of reference for themes like pleasure, sensuality, acceptable and unacceptable sexual behaviour, whilst still acknowledging the wide spectrum of pornography available.

Döring (2009) conducted a study critically reviewing research over the past 15 years on the impact of internet on sexuality. Given the large amount of both quality and inaccurate information on the internet, the author advocates for the need to raise "*media literacy*" in the general public in order to "*critique, diagnose and manage [...] harmful online sexuality related activities*" (Döring, 2009, p. 1099). For adolescents this could be achieved through open dialogue with trusted adults about critical use of the internet, such as the example given with a pupil whom discussed the Wikipedia with a teacher. As described in the findings, adolescents are already critical consumers of information on the internet and seek to triangulate and verify information with trusted adults.

Challenges of teaching on the sexual act

Teaching beyond the biology of vaginal sex may be more uncomfortable for a teacher or

parent and there may be many reasons for this. For teachers these reasons include the potential effect on classroom discipline, ongoing cultural taboos linked to sex for pleasure (as opposed to sex for procreation) and the teacher's own personal beliefs regarding *normal* sexuality (Helleve et al., 2011). As for teaching about sexual pleasure, the predominant public health and educational agendas related to adolescent sexuality also focus on the reduction of *risk* and avoidance of *danger*, therefore education on pleasure may often be absent (Allen, 2007). What the adolescents show through this anonymous questioning is that it is very often the topics of pleasure that spark curiosity.

The importance of pleasure is highlighted in the World Health Organization definition of sexuality including “*eroticism*”, “*pleasure*” and “*intimacy*” and the way they place pleasure and safety side by side in their definition of sexuality (WHO, 2006, p. 6). Fine and McClelland (2006) criticize the separation of risk and pleasure in school sex education by stating that “*risk cannot be severed from pleasure [...] An exclusive focus on risk not only alienates, but also distorts the complexity of human relations and sexual desire*” (p. 326). This perspective was reflected by the female participant who said that topics of pleasure and responsibility needed to be discussed side by side.

Before moving on to the final theme of social construction of gender and sexuality, it must be noted that the findings of this study related to content, language and communication of information related to sexual health and sexuality in Chile may not be different from other Latin American or global settings. For example, a Brazilian study exploring primary school teacher's practice and attitudes towards sex education found that sex education was most commonly taught in science classes, focused on biomedical discourse, had an exclusively heterosexual approach and focused on theory rather than practice for achieving safe sex (da Silva, Guerra, & Sperling, 2013). Although most teachers saw the classes as important for both males and females, 17,8% stated sex education focussed more on females due to the risks of pregnancy (da Silva et al., 2013), supporting the similar risk and gendered responsibility for contraception found in this current Chilean study. Another example is a Norwegian study exploring adolescent female experiences of sex education in middle schools, which also has parallels to this current study (Møllhausen, 2005). The Norwegian setting may be seen as more “liberal” in relation to sexuality compared to Latin America (Svendsen, 2012), however the results include similar themes of biological reductionism and a heteronormative focus, problem and risk driven education rather than practical skills training

and perception of sexuality as "hidden" in school education (Møllhausen, 2005).

Theme Three: Social construction of gender and sexuality

This section will explore how gender and sexuality are constructed through discourse on gender socialization. Regarding construction of gender, Prieur (1996) observes that “*in all societies genders are constructed through a symbol system inscribed in minds, which most of the time functions automatically and makes us take the social world, with its sexual divisions, as a given*” (p. 104). In Chile, gender will be constructed in a unique way, based on Chile’s social, political and economic history, feminist movements, strength of social and religious institutions and unique power these institutions have on defining gender roles.

Regarding construction of sexuality, Foucault (1990) describes this construction as a way of disciplining and controlling human sexuality through defining discourse and therefore also knowledge and attitudes towards sexuality. This discourse may for example, be focused on sexuality as risk, as a biological process, as a romantic experience or discourse may focus on sexuality as a moral issue. In this study the term *sexuality* was particularly difficult to define for many participants, with definitions of sexuality varying by age, gender, relationship to parents and friends. There was also considerable variation between how adolescents defined sexuality compared to the key informants. Furthermore between the different professions, differences were present with the priest describing a more spiritual connection between mind and body, whilst the psychologists linked into the emotional elements, and medical professionals focused to a greater degree on the holistic health aspect of *sexuality*. All of these elements contribute to the social construction sexuality.

Gender socialization starts early in life, as children are taught what gender is assigned to them and subsequent appropriate behaviour (Chant & Craske, 2003; DeLamater, 1989). This social learning comes through observing their parents, the prescribed patriarchal structures and gender differentiated roles in the home (Bryson, 2003). Thus by observing the role modelling of parents in the family household environments, children learn the social expectations linked to their gender. These roles are later reinforced by peer groups, schools and media (Bryson, 2003). Schools are also potent socializing agents in defining gender role expectations and in perpetuating heteronormativity, particularly through sex education (Chant & Craske, 2003; McCarty-Caplan, 2013). As feminist writer Valarie Bryson (2003) writes, lessons children

learn about at a young age related to sex appropriate "*roles, temperament and status*" (p. 178) become deeply ingrained and particularly resistant to change at a later time.

One such lesson which was apparent in this study was the *hidden* and *stigmatized* nature of female sexuality. Adolescents both explicitly and implicitly described a stigmatization of female sexuality, which was manifested through what was said about women, as well as what was not said. It was observed that stigmatization may also be propagated through silence and female *self-censorship*. There were multiple examples of this, including the adolescent mother whom described keeping her sexuality hidden for herself, as well as the commonly described absence of information on female masturbation and pleasure in formal sex education. Stigmatization of female sexuality may also reflect a more general stigmatization of the female body, exemplified in this study by the participant whom regarded menstruation as something ugly that should be hidden from males.

Gender difference in appropriate speech and behaviour for women were both described and observed most vividly through the initial two focus group discussions in the high school. On one hand, the males provided many examples of words used to describe sex and sexuality, and then went on to elaborate on their meaning and utility with much enthusiasm and laughter. Females on the other hand, provided few examples and the discussion was shrouded by silence, discomfort and recognition that boys would naturally be more open to talk about sex and sexuality. To a more limited degree in the individual interviews, participants described these gender differences in appropriate behaviour, with a few sharing more critical and reflective opinions on this gender double standard.

Analysing this in a global perspective, it may be that this socialization of gender roles in the family may be largely universal. However, in the Latin American context, gender roles are often linked to the concepts of *machismo* and *marianismo* (Melhuus & Stølen, 1996). *Machismo* comes from the Spanish word *macho* and describes exaggeration of male masculinity and valorisation of virility (Chant, 2003; Melhuus & Stølen, 1996). What is described as the compensatory female alternative, the term *marianismo* comes from the name *Maria* and describes the characteristics of the virgin Mary as pure, chaste and virginal, as well as being a model nurturing mother (Chant, 2003). In this way women are presented with an unattainable model of both virgin and mother (Chant, 2003). Although these terms are in no way binding or exhaustive for all communities in Latin America, particularly indigenous

communities, that may have very different gender structures, the terms provide interesting starting points for discussion of gender socialization of adolescents.

In her study with female adolescents in Ecuador, Goicolea (2010) incorporated these terms *machismo* and *marianismo*, exploring how female's sexual and reproductive freedom was constrained by conceptions of females as passive in the face of male dominance. Goicolea (2010) also discussed how this gender subordination was not only covertly perpetuated through symbolic constructions of female passivity, but also overtly enacted through sexual violence. Thus traditional *macho* models of domination also help maintain the gender norm acceptability of male violence against women (Bott et al., 2012). Discrimination and inequalities between genders form the root of sexual violence (Dartnall & Jewkes, 2013) and gender discriminatory attitudes related to male dominance may be learned from a young age.

Although one male in this present study explicitly shared his opinion that female discourse should be more restricted than males, more commonly the adolescent described a generational change whereby increased participation of women in the workforce and increased political participation (exemplified by the fact that the two top candidates for the presidency in the November 2013 elections were women) meant that traditional gender roles were no longer applicable in the newer generations. This may provide room for optimism that through socialization focussing on gender equality, changes can be made to harmful gender norms that perpetuate discrimination and gender-based violence.

Gender socialization and conceptualization of the powerful, sexually aggressive *macho* male also encourage stigmatizing attitudes towards sexual minorities. This stigma may be enacted through violence and discrimination, or it may be perpetuated through discriminatory attitudes, verbal discourse and jokes (Prieur, 1996). Particularly homosexual males may be stigmatized due to the gender construction linking femininity to passivity (also explicitly in the sexual act), and thus male passivity in sexual practice to femininity (Prieur, 1996). Following this argument, the logic is that “*to be homosexual is to be like a woman*” (Melhuus & Stølen, 1996, p. 19), since a homosexual man is not a *true man*, defined as being the active part in penetrative vaginal sex (Prieur, 1996). In this Chilean study, this definition of what it meant to be a man was expressed through the example of a male being questioned about when he would “*become a man*” through having sex with his girlfriend. A directly stigmatizing attitude was expressed in the participant who described male homosexuals as

“repulsive”. This raises an important issue about the vulnerability of sexual minorities in settings with strict gender socialization, which emphasises the power and sexual aggressiveness of males and disempowerment and passivity of females.

Lesbian youth may also be vulnerable within this strict gender socialization, but as Chant and Craske (2003) point out, for a number of reasons lesbians in Latin America have received little attention. These reasons include assumptions around female sexual passivity, the non-threatening nature of lesbianism (compared to the homosexuality which was often linked to criminality) and societal focus on meaningful sexuality centring around penile penetration (Chant & Craske, 2003). This is also perpetuated through the expression that a female is *“made into a woman”* (Prieur, 1996, p. 94) through penile penetration and later motherhood. This further dismisses the meaningful nature of lesbian sexual relations by denying them any rite of passage into womanhood and stigmatizing their sexuality through silence.

Understanding why sexual minorities in Chile face such challenges to acceptance can be directly linked to the rigidity of the binary gender roles prescribed in Chilean society. Kamano (1990) claims that acceptability of homosexuality in different communities may be linked to the level of gender equality in these communities. The author makes a case explaining that homosexuality will be seen as less of a threat to the gender system in a society where categories of male and female are fluid and gender roles are more fluid. In these more gender equal societies, less assumptions will be made about innate *male* and *female* characteristics, compared to societies with more rigid gender systems that may be threatened by homosexuality (Kamano, 1990). Following this gender equality argument, the growth in sexual minority rights groups and recent changes in legislation may be a reflection of changing gender roles in Chile. Many adolescents in this study describe a generational change with the increased visibility of same sex couples in society and the concept of a current *“fashion of bisexuality”* was described to a certain degree as an example of an increased acceptability of homosexuality. However, as exemplified in the array of opinions shared about homosexuality, stating that increased visibility equals increased acceptance is likely to be premature.

Even given this potential generational change going on in Chile in relation to gender roles, any study on sexuality in Latin America would be incomplete without a discussion of the historical and contemporary role of the Catholic Church on defining appropriate gender roles

and sexuality.¹⁴ It must also be noted that it is not the intention to disregard the large spectrum of conservative and liberal opinions within the Catholic Church by presenting just one line of thought. As discussed earlier, the priest interviewed in this study may represent a more liberal and pragmatic perspective on some issues, whilst maintain a closer link to the dogma of the church on other issues, such as abortion. Shepard (2000) explains this observation by stating that although the Catholic Church may have considerable power in impeding sexual and reproductive rights, on an individual level many priests are actually more liberal and pragmatic. Similarly, the catholic school in this study is in no way meant to represent the broad spectrum of Catholic schools in Chile. Instead, the intention of this discussion is to look at historical and current influences and their interpretations, through the findings in this study and through literature on the role of Catholicism on gender socialization, and sexual and reproductive rights in Latin America.

Although few adolescents in this study said they believed the church should play an active role in teaching adolescents about sexuality, nonetheless both the historical influence as well as subtle control of public discourse means that the church does in fact play an important role in socializing adolescents. Foucault describes initial religious laws as centred around matrimonial relations, however that the "*discursive explosion*" of the 18th and 19th centuries came to focus more on the remaining deviations, for example "*adultery*", "*rape*", "*incest*", "*sodomy*" and "*bestiality*" (1990, p. 38). Thus alongside civil law, Foucault describes religion as a powerful institution that *disciplines* society through construction of the cultural norm of heterosexual vaginal sex within marriage, and insistence on confession sins falling outside this accepted sexual behaviour (Foucault, 1990).

The Catholic religion is a stronghold for binary gender separation underpinned through their discourse on *family*. This *family* orientated discourse includes narrow definitions of gender roles in heterosexual relations (Reiss, 1989), with males expected to fill the role of *patriarch* and provider, and females filling the role of mother and carer (Bryson, 2003). The sheer political strength of this *family* discourse is exemplified in the fact that in 2004, Chile became the last country to have some type of legal divorce (Haas, 2010). The Catholic Church also underlines the importance of binary definitions of man and woman, in the punishment of

¹⁴ Although there is a growing influence of Evangelical churches, the focus here will be on the Catholic Church, however parallels to other Christian churches on the subject of gender role definition can be assumed to be similar (Chant & Craske, 2003).

what they see as moral transgressions. Since the Catholic church compares women to the chaste and virginal Maria, "*penalties for women's transgressions have always been greater than for men*" (Chant & Craske, 2003, p. 134). This was underpinned by the adolescent double discourse present in this study which condemned female sexual behaviour, whilst rewarding male behaviour. Furthermore, beliefs about restrictions on what women could and could not say, as well as displays of female self-censorship underlie this idea of *marianismo*: the virginal, unknowing, naive and passive woman. Here it must be noted that this gender double standard is not unique to Chile, nor is it unique to Christian or Catholic dominated contexts, but exists all over the world to greater or lesser degrees depending on levels of gender equality (Kamano, 1990; Marston & King, 2006).

On the subject of maternity, the Catholic Church idealizes the role of the mother, with motherhood seen as destiny. However, when motherhood is experienced outside of the limits of Christian marriage, the lines of punishment for premarital sex and celebration of the maternal role become blurred (Chant & Craske, 2003). This double discourse, punishing early, premarital sexual relations alongside giving status to the role of maternity may create confusion for pregnant adolescents. On the one hand, female adolescents may be blamed or judged for getting pregnant, whilst on the other hand they may be venerated as they enter into the highly prized maternal role. In an Ecuadorian study, pregnant or parenting females described pregnancy and motherhood as producing contradictory feelings of sadness and fear in pregnancy, compared to motherhood which raised emotions of optimism (Goicolea, 2010).

If the issue is then brought into context of contemporary debates around emergency contraception and abortion, women may face a double punishment. Firstly they are punished for becoming pregnant through *irresponsible* premarital sexual activity. Secondly, if they chose to abort the foetus or adopt out their child, they are also punished by not assuming the highly valued maternal role. Because of this, anti-abortion campaigns are supported by the socially engrained high value placed on maternity in the Chilean and broader Latin American context, where a woman does not become a *true* woman before she becomes a mother (Chant & Craske, 2003; Pieper-Mooney, 2009). Seen from a feminist perspective, this veneration of the role of the mother in Latin America, both limits freedom of decision-making as well as adding a strong element of self-moralizing to choices around using the emergency contraceptive (Chant & Craske, 2003). This creates a strong barrier to accessing the emergency contraceptive and potentially abortion services in the future, even when these

options are legally permitted. As seen in this study, adolescents are socialized into facing this moral barrier through unspecific, ambiguous information as to the functioning of the emergency contraceptive alongside moral messages of "*not taking the easy way out*". This moralizing discourse was reiterated by messages to take responsibility for one's irresponsible actions and rape being the only justification for using the emergency contraceptive. And as a health professional had observed in this study, even adult women whom seek the emergency contraceptive do so with feelings of shame. Therefore it is notable, although maybe not surprising, that even when access to the emergency contraceptive (and potentially abortion services in the future) is guaranteed by law, moral questions may still overshadow the both public and private discourse.

Chile may very well be in a transition period where increased gender equality is opening up space for changes in discourses surrounding traditionally taboo topics like homosexuality, sexual violence and abortion, and changes in rights related to reproductive services such as emergency contraception. However, the extent to which views on gender roles and core values are changing in Chile is unclear. The diversity of information adolescents in this study received about issues such as homosexuality, emergency contraception, abortion and abstinence from teachers, parents, healthcare professionals and friends, reflects the ongoing plurality of opinions and values in Chile.

Chapter 6: Conclusion

The objective of this research was to explore sources of information and adolescent learning about sexual health and sexuality in Chile. Through interviews and focus group discussions, a total of 44 adolescents shared their experiences, stories and opinions. Their eagerness to participate; their curiosity, laughter, discomfort and embarrassment; their questioning and social criticism; their confidence and insecurity; their joy and their sadness; all attest to the opening paragraph of this thesis claiming that *there are few aspects of human health and behaviour that trigger more fascination and embarrassment, joy and pain, vulnerability and pride, than sex.*

On a philosophical level this study aimed to provide insights into both personal and social discourses on adolescent sexuality, and specifically how social discourses shaped the way adolescents *learn the language* of sexual health and sexuality. To achieve this, the discussion approached two key *micro* themes related to the first research questions on sources of information, content, communication and trust, as well as discussing the influence of the key *macro* theme of social construction of gender and sexuality. Further exploration specifically looking at this *macro* theme sought to answer more thoroughly the final questions about words used in sexual health discourse and the influence of gender. It also aimed to position the adolescent discourse in a more global light in relation to theories on social constructivism, feminism, gender and risk. Bringing in the concepts of *marianismo* and *machismo* sought to situate this discussion within a wider Latin American context, greatly influenced by religious binary gender roles and *family* discourse. The far reaching implications of these strict gender roles on partner violence, reproductive decision making and sexual minorities were also discussed in relation to the concepts of what makes up a *true man* and a *true woman*.

The result of this research have shown that even in the face of media and internet globalization, parents, teachers and healthcare professionals are still the most trusted and important sources of sexual health information for the adolescents in this study. Seeking to better understand the sociocultural norms that influence the sexual health information provided for adolescents, makes it easier to understand why parents, teachers or health professionals might find it hard to approach certain topics with adolescents. This may lead to a focus on the biological *risk* elements of sexuality, omitting many of the topics adolescents are interested in such as pleasure and the sexual act. Furthermore, Chile is a country in

continuous change, therefore through exploring contemporary generational changes it is possible to shed light on challenges facing teachers, parents and health professionals in communicating with adolescents. This helps to explain potential reasons for the discordance between adolescent information needs and adult provision of information.

The exploration of sociocultural norms also highlighted discourses on traditional binary gender norms, as well as *heteronormative* discourses in religion, public health services and school sex education. The social institutions with most influence in Chilean society, whether it be religion, education or medicine, wield a great deal of power in defining the way individuals conceptualize and categorize sexuality. Binary categorizations of man/woman; feminine/masculine; homosexual/heterosexual; all form rigid discourse. In these rigid discourses, the diverse spectrum of human sexuality, with a plurality of sexual identities, desires and practices, is artificially moulded into binary systems. These discourses directly or indirectly shape adolescent learning about sexual health and sexuality, particularly related to topics such as sexual practices, sexual orientation, virginity, contraception, abortion and violence. Furthermore, this learning will likely shape adolescent attitudes and behaviours in relation to their own sexuality. Whether this behaviour reflects empowered, reflective decision-making, constructive and honest partner communication and mutual respect; or not; depends greatly on how and what adolescents learn from their social ecosystem. Ultimately, this is what shapes their unique and individual *language of sexual health and sexuality*.

Recommendations for practice

The discussion of this research has raised many challenges in relation to the topic of adolescent sexual health and sexuality. Potential strategies to face these challenges will be many. It is important that these strategies focus on opening up the discourse on these traditionally taboo topics, seeking wide public and private debate (including adolescents) to challenge the traditional double discourse on sexual and reproductive rights in Chile. Although many recommendations could be suggested from the findings of this research, I have focused on six core recommendations:

- Approach sex education from an inductive approach, focussing on what adolescents wish to learn about sexuality. From there, educators can challenge and debate sexual health and sexuality issues, to encourage reflection on the many ways that sexuality can be expressed and defined;
- Challenge *heteronormativity* and *biologicalization* of information from both formal and informal sources. This includes the incorporation of topics of *afectividad*, a range of sexual practices and sexual orientations into information shared with adolescents;
- Provide scientifically sound, morally neutral, practical sexual health information to increase adolescent self-efficacy in relation to partner communication. This is important to ensure both safe and pleasurable sexual experience;
- Build teacher, healthcare professional and parenting capabilities to communicate with adolescents, not only about biological sexual health, but also about topics such as love, pleasure, emotions, attraction, sexual orientation, partner communication and abuse;
- Engage in critical debate with adolescents about information on the internet, and in particular pornography. This is order to increase media literacy and engage in debate with both male and female adolescents about sexual practices, sexual pleasure and gender stigmatization;
- Challenge harmful gender stereotypes on societal and personal levels. This is of critical importance, since increasing gender equality is the main building block for promotion of sexual and reproductive rights in Chile.

Suggestions for future research

Sexuality is a complex and multifaceted topic, making it such a fascinating field of research. There are many questions that were raised during this research project that fell outside of the scope of the study. I am choosing to just focus on a few topics that are of particular interest:

- How do Chilean youth with different backgrounds, socioeconomic situations, sexual orientations, geographical locations, ethnicities, nationalities and ages learn about sexual health?
- Of particular interest, how do sexual minority youth learn about sexual health and sexuality living in such as *heteronormative* society? Are their information needs being met?
- What is it like for parents communicating with their children and adolescents about sexual health and sexuality in Chile?
- Considering the contemporary political climate in Chile, what are adolescent attitudes towards pregnancy, emergency contraception, abortion and adoption?
- How do Chilean adolescents define the term *sex* (including *good* and *bad*, *healthy* and *unhealthy*, *safe* and *unsafe sex*). How do they define the terms *abstinence*, *virginity* and *homosexuality*? What socialising institutions or agents shape these definitions?

References

- Allen, L. (2007). 'Pleasurable pedagogy': Young people's ideas about teaching 'pleasure' in sexuality education. *Twenty-First Century Society*, 2(3), 249-264. doi: 10.1080/17450140701631437
- Atkinson, L. (1989). Social policy aspects of human sexuality. In K. McKinney & S. Sprecher (Eds.), *Human sexuality: The societal and personal context* (pp. 463-486). Norwood, N.J.: Ablex Publ.
- Bandura, A. (1992). A social cognitive approach to the exercise of control over AIDS infection. In R. J. DiClemente (Ed.), *Adolescents and AIDS: A generation in jeopardy* (pp. 89-116). Newbury Park, C.A. : Sage.
- Bay-Cheng, L., Robinson, A., & Zucker, A. (2009). Behavioral and relational contexts of adolescent desire, wanting, and pleasure: Undergraduate women's retrospective accounts. *The Journal of Sex Research*, 46(6), 511-524. doi: 10.1080/00224490902867871
- Bearinger, L., Sieving, R., Ferguson, J., & Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention, and potential. *The Lancet*, 369, 1220-1231. doi: 10.1016/S0140-6736(07)60367-5
- Beh, H. (2006). Recognizing the sexual rights of minors in the abstinence-only sex education debate. *Children's Legal Rights Journal*, 26(2), 1-20.
- Bhutta, Z. (2004). Beyond informed consent. *Bulletin of the World Health Organization*, 82(10), 771-777.
- Borges, A., Izumi, L., & Schor, N. (2006). Conversando sobre sexo: A rede sociofamiliar como base de promoção da saúde sexual e reprodutiva de adolescentes [Talking about sex: The social and familial net as a base for sexual health promotion and reproductive among adolescents]. *Revista Latino-Americana de Enfermagem*, 14(3), 422-427. doi: <http://dx.doi.org/10.1590/S0104-11692006000300017>
- Boswell, J. (1989). Revolutions, universals, and sexual categories. In M. Duberman, M. Vicinus & J. George Chauncey (Eds.), *Hidden from history: Reclaiming the gay and lesbian past* (pp. 17-36). NY: New American Library.
- Bott, S., Guedes, A., Goodwin, M., & Mendoza, J. (2012). *Violence against women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries*. Washington, D.C.: Pan American Health Organization
- Breakwell, G. (1997). Adolescents and emerging sexuality. In L. Sherr (Ed.), *AIDS and adolescents* (pp. 133-143). Amsterdam: Harwood Academic Publishers.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, M.A.: Harvard University Press.

- Bryson, V. (2003). *Feminist political theory: An introduction* (2 ed.). NY: Palgrave MacMillan.
- Cabezón, C., Vigil, P., Rojas, I., Leiva, M., Riquelme, R., Aranda, W., & García, C. (2005). Adolescent pregnancy prevention: An abstinence-centered randomized controlled intervention in a Chilean public high school. *Journal of Adolescent Health, 36*(1), 64-69. doi: <http://dx.doi.org/10.1016/j.jadohealth.2003.10.011>
- Carter, M., Henry-Moss, D., Hock-Long, L., Bergdall, A., & Andes, K. (2010). Heterosexual anal sex experiences among Puerto Rican and black young adults. *Perspect Sex Reprod Health, 42*(4), 267-274. doi: 10.1363/4226710
- Casas, L., & Ahumada, C. (2009). Teenage sexuality and rights in Chile: From denial to punishment. *Reprod Health Matters, 17*(34), 88-98. doi: 10.1016/s0968-8080(09)34471-7
- Castañeda, X., Brindis, C., & Castaneda, I. (2001). Nebulous margins: Sexuality and social constructions of risks in rural areas of central Mexico. *Culture, Health & Sexuality, 3*(2), 203-219.
- CEDAW. (2006). *Concluding comments of the committee on the elimination of discrimination against women: Chile*. NY: United Nations.
- Center for Reproductive Rights. (2013). The world's abortion laws map 2013 update. Retrieved 02.05.14, from http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf
- Committee on Economic, Social and Cultural Rights. (2000). *General comment 14: Right to highest attainable standard of health*. Geneva: United Nations.
- Chambers, W. (2007). Oral sex: Varied behaviors and perceptions in a college population. *The Journal of Sex Research, 44*(1), 28-42.
- Chant, S. (2003). Introduction: Gender in a changing continent. In S. Chant & N. Craske (Eds.), *Gender in Latin America* (pp. 1-18). London: Latin America Bureau.
- Chant, S., & Craske, N. (2003). Gender and sexuality. In S. Chant & N. Craske (Eds.), *Gender in Latin America* (pp. 128-160). London: Latin America Bureau.
- Charmaraman, L., Lee, A., & Erkut, S. (2012). What if you already know everything about sex? Content analysis of questions from early adolescents in a middle school sex education program. *Journal of Adolescent Health, 50*(5), 527-530. doi: 10.1016/j.jadohealth.2011.10.004
- Collins, R. (2004). Watching sex on television predicts adolescent initiation of sexual behavior. *Pediatrics, 114*(3), e280-e289.
- Connell, R. (2005). Change among the gatekeepers: Men, masculinities, and gender equality in the global arena. *Signs, 30*(3), 1801-1825. doi: 10.1086/427525

- da Silva, D., Guerra, O., & Sperling, C. (2013). Sex education in the eyes of primary school teachers in Novo Hamburgo, Rio Grande do Sul, Brazil. *Reprod Health Matters*, 21(41), 114-123. doi: [http://dx.doi.org/10.1016/S0968-8080\(13\)41692-0](http://dx.doi.org/10.1016/S0968-8080(13)41692-0)
- Dahlgren, L., Emmelin, M., & Winkvist, A. (2007). *Qualitative methodology for international public health*. Umeå, Sweden: Umeå International School of Public Health.
- Dartnall, E., & Jewkes, R. (2013). Sexual violence against women: The scope of the problem. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 27(1), 3-13. doi: 10.1016/j.bpobgyn.2012.08.002
- DeLamater, J. (1989). The social control of human sexuality. In K. McKinney & S. Sprecher (Eds.), *Human sexuality: The societal and personal context* (pp. 30-62). Norwood, N.J.: Ablex Publ.
- Denzin, N. (1989). *The research act: A theoretical introduction to sociological methods*. Englewood Cliffs, N.J.: Prentice Hall.
- DiCenso, A., Borthwick, V., Busca, C., Creatura, C., Holmes, J., Kalagian, W., & Partington, B. (2001). Completing the picture: Adolescents talk about what's missing in sexual health services. *Canadian Journal of Public Health*, 92(1), 35-38.
- Dides, C., Benavente, C., & Morán, J. (2009). *Estado de la vinculación de la salud sexual y reproductiva, VIH y SIDA e ITS en Chile [Status of linking sexual and reproductive health, HIV and AIDS in Chile]*. Santiago, Chile: Pan American Health Organization, Facultad Latinoamericana de Ciencias Sociales - Chile & UNFPA.
- Dides, C., Benavente, C., Sáez, I., & Nicholls, L. (2011). *Educación sexual en Chile: Implementación de la Ley 20.418 [Sex education in Chile: Implementation of the law 20.418]*. Santiago, Chile: Universidad Central de Chile.
- Dides, C., & Benavente, M. (2009). *Chile: Derechos y salud sexual y reproductiva actualización 2009 [Chile: Sexual and reproductive rights update 2009]*. Santiago, Chile: Facultad Latinoamericana de Ciencias Sociales & Centro Latinoamericano en Sexualidad y Derechos Humanos.
- Dides, C., Nicholls, L., Boso, N., & Fernández, C. (2013). Provisión de anticoncepción de emergencia en el sistema de salud municipal de Chile: Estado de situación 2013 [Provision of emergency contraception in municipal health services in Chile: State of the situation 2013]. Santiago, Chile.
- Dolcini, M., Catania, J., Harper, G., Boyer, C., & Richards, K. (2012). Sexual health information networks: What are urban African American youth learning? *Res Hum Dev*, 9(1), 54-77. doi: 10.1080/15427609.2012.654432
- Duby, Z., & Colvin, C. (2014). Conceptualizations of heterosexual anal sex and HIV risk in five East African communities. *The Journal of Sex Research*, 0(0), 1-11. doi: 10.1080/00224499.2013.871624

- Döring, N. (2009). The Internet's impact on sexuality: A critical review of 15 years of research. *Computers in Human Behavior*, 25(5), 1089-1101. doi: 10.1016/j.chb.2009.04.003
- Escobar-Chaves, L., Tortolero, S., Markham, C., Low, B., Eitel, P., & Thickett, P. (2005). Impact of the media on adolescent sexual attitudes and behaviors. *Pediatrics*, 116, 303-326. doi: 10.1542/peds.2005-0355D
- Fangen, K. (2004). *Deltagende observasjon [Participant observation]*. Bergen, Norway: Fagbokforl.
- Fine, M., & McClelland, S. (2006). Sexuality education and desire: Still missing after all these years. *Harvard Educational Review*, 76(3), 297-338.
- Foucault, M. (1990). *The history of sexuality: An introduction* (Vol. 1). NY: Random House Inc.
- Goicolea, I. (2010). Adolescent pregnancies in the Amazon Basin of Ecuador: A rights and gender approach to adolescents' sexual and reproductive health. *Glob Health Action*, 3. doi: 10.3402/gha.v3i0.5280
- González, E., Molina, T., Montero, A., Martínez, V., & Leyton, C. (2007). Comportamientos sexuales y diferencias de género en adolescentes usuarios de un sistema público de salud universitario [Sexual behaviour and gender differences in adolescents consulting at a university public health system]. *Rev Med Chile*, 135, 1361-1269. doi: <http://dx.doi.org/10.4067/S0034-98872007001000005>
- Grimes, D., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F., & Shah, I. (2006). Unsafe abortion: The preventable pandemic. *The Lancet*, 368(9550), 1908-1919. doi: 10.1016/S0140-6736(06)69481-6
- Guzman, V., Seibert, U., & Staab, S. (2010). Democracy in the country but not in the home? Religion, politics and women's rights in Chile. *Third World Q*, 31(6), 971-988. doi: 10.1080/01436597.2010.502730
- Haas, L. (2010). *Feminist policy making in Chile*. University Park, P.A.: The Pennsylvania State University Press.
- Halkier, B. (2010). *Fokusgrupper [Focus groups]*. Frederiksberg, Sweden: Samfundslitteratur.
- Harré, R. (2001). Mind-body dualism. *International Encyclopedia of the Social & Behavioral Sciences*, 9885-9889. doi: <http://dx.doi.org/10.1016/B0-08-043076-7/00077-2>
- Helleve, A., Flisher, A., Onya, H., Mũkoma, W., & Klepp, K. (2011). Can any teacher teach sexuality and HIV/AIDS? Perspectives of South African Life Orientation teachers. *Sex education*, 11(1), 13-26. doi: 10.1080/14681811.2011.538143
- Hevia, M. (2012). The legal status of emergency contraception in Latin America. *Int J Gynaecol Obstet*, 116(1), 87-90. doi: 10.1016/j.ijgo.2011.10.008

- Heywood, W., & Smith, A. (2012). Anal sex practices in heterosexual and male homosexual populations: a review of population-based data. *Sexual Health, 9*(6), 517-526. doi: <http://dx.doi.org/10.1071/SH12014>
- Hust, S., Brown, J., & L'Engle, K. (2008). Boys will be boys and girls better be prepared: An analysis of the rare sexual health messages in young adolescents' media. *Mass Communication and Society, 11*(1), 3-23. doi: 10.1080/15205430701668139
- Hyde, A., Howlett, E., Brady, D., & Drennan, J. (2005). The focus group method: Insights from focus group interviews on sexual health with adolescents. *Soc Sci Med, 61*(12), 2588-2599. doi: 10.1016/j.socscimed.2005.04.040
- INE. (2012). Síntesis de resultados - Censo 2012 [Synthesis of results - Census 2012]. Retrieved 02.04.14, from www.censo.cl
- Ingham, R., & Stone, N. (2001). Topics for in-depth interviews and focus group discussions: Partner selection, sexual behaviour and risk taking. In R. I. John Cleland, Nicole Stone (Ed.), *Asking young people about sexual and reproductive behaviours: Illustrative Core Instruments* (pp. 57-103).
- Jones, R., & Biddlecom, A. (2011). Is the internet filling the sexual health information gap for teens? An exploratory study. *J Health Commun, 16*(2), 112-123. doi: 10.1080/10810730.2010.535112
- Jones, R., Biddlecom, A., Hebert, L., & Mellor, R. (2011). Teens reflect on their sources of contraceptive information. *Journal of Adolescent Research, 26*(4), 423-446. doi: 10.1177/0743558411400908
- Kamano, S. (1990). Cross-national analysis of the social construction of homosexuality and gender. *National Women's Studies Association Journal, University of Minnesota, 2*(4), 696-698.
- Kirby, D. (2001). Emerging answers: Research findings on programs to reduce teen pregnancy (Summary). *American Journal of Health Education, 32*(6), 348-355. doi: 10.1080/19325037.2001.10603497
- Kirby, D. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research & Social Policy, 5*(3), 18-27. doi: 10.1525/srsp.2008.5.3.18
- Kirby, D., Laris, B., & Roller, L. (2007). Sex and HIV education programs: Their impact on sexual behaviors of young people throughout the world. *J Adolesc Health, 40*(3), 206-217. doi: 10.1016/j.jadohealth.2006.11.143
- Kuther, T. (2003). Medical decision-making and minors: Issues of consent and assent. *Adolescence, 38*(150), 343-358.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, C.A.: Sage.

- Lagus, K., Bernat, D., Bearinger, L., Resnick, M., & Eisenberg, M. (2011). Parental perspectives on sources of sex information for young people. *Journal of Adolescent Health, 49*(1), 87-89. doi: 10.1016/j.jadohealth.2010.10.007
- Lehrer, J., Lehrer, E., & Koss, M. (2013). Unwanted sexual experiences in young men: Evidence from a survey of university students in Chile. *Archives of Sexual Behavior, 42*(2), 213-223. doi: 10.1007/s10508-012-0004-x
- Lehrer, J., Lehrer, E., & Zhao, Z. (2009). Physical and psychological dating violence in young men and women in Chile: Results from a 2005 survey of university students. *International Journal of Injury Control and Safety Promotion, 16*(4), 205-214. doi: 10.1080/17457300903307003
- Lessa, I. (2005). Discursive struggles within social welfare: Restaging teen motherhood. *British Journal of Social Work, 36*(2), 283-298. doi: 10.1093/bjsw/bch256
- Lupton, D. (1999). *Risk and sociocultural theory: New directions and perspectives*. Cambridge: Cambridge University Press.
- Malterud, K. (2001). Qualitative research: Standards, challenges, and guidelines. *The Lancet, 358*(9280), 483-488. doi: [http://dx.doi.org/10.1016/S0140-6736\(01\)05627-6](http://dx.doi.org/10.1016/S0140-6736(01)05627-6)
- Marston, C., & King, E. (2006). Factors that shape young people's sexual behaviour: A systematic review. *The Lancet, 368*(9547), 1581-1586. doi: 10.1016/s0140-6736(06)69662-1
- McBride, K., & Fortenberry, D. (2010). Heterosexual anal sexuality and anal sex behaviors: A review. *The Journal of sex research, 47*(2), 123-136. doi: 10.1080/00224490903402538
- McCarty-Caplan, D. (2013). Schools, sex education, and support for sexual minorities: Exploring historic marginalization and future potential. *American Journal of Sexuality Education, 8*(4), 246-273. doi: 10.1080/15546128.2013.849563
- Melhuus, M., & Stølen, K. (1996). Introduction. In M. Melhuus & K. A. Stølen (Eds.), *Machos, mistresses, madonnas: Contesting the power of Latin American gender imagery* (pp. 1-33). London: Verso.
- Mesa-Lago, C. (2008). Social protection in Chile: Reforms to improve equity. *International Labour Review, 147*(4), 377-402. doi: 10.1111/j.1564-913X.2008.00041.x
- Miller, K., Kotchick, B., Dorsey, S., Forehand, R., & Ham, A. (1998). Family communication about sex: What are parents saying and are their adolescents listening? *Fam Plann Perspect, 30*(5), 218-222, 235. doi: 10.2307/2991607
- Ministerio de Justicia. (2013). *Código Penal [Penal Code]*. Santiago, Chile: Author.
- MINSAL. (2010a). *Estudio de las barreras de los servicios de salud para adolescentes en Chile [Study into the barriers to health services of adolescents in Chile]*. Santiago, Chile: Author.

- MINSAL. (2010b). *Fija normas sobre información, orientación y prestaciones en materia de regulación de la fertilidad [Set standards for information, guidance and benefits pertaining to fertility regulation]*. Santiago: Subsecretaría de Salud Pública & MINSAL.
- MINSAL. (2012). *Programa nacional de salud integral de adolescentes y jóvenes: Plan de acción 2012-2020 [National program for integrated health of adolescents and youth: Plan of action 2012-2020]*. Santiago, Chile: Author.
- MINSAL. (2013a). *Informe nacional "Evolucion VIH/SIDA, Chile 1984-2012" [National report "Evolution of HIV/AIDS, Chile 1984-2012"]*. Santiago: Author.
- MINSAL. (2013b). *Situación actual del embarazo adolescente en Chile 2013 [Current status of adolescent pregnancy in Chile 2013]*. Santiago: Author.
- Montero, A. (2011). Educación sexual: Un pilar fundamental en la sexualidad de la adolescencia [Sex education: A cornerstone for a healthy teenage sexuality]. *Rev Med Chile*, 139(10), 1249-1252. doi: /S0034-98872011001000001
- Montero, A., González, E., & Molina, T. (2008). Salud sexual y reproductiva de los y las adolescentes en Chile [Sexual and reproductive health of Chilean adolescents]. *Rev Chil Salud Pública*, 12(1), 42-47.
- Morán, J. (2013). La anticoncepción de emergencia en Chile: Estructuración de su demanda en función de variables socioeconómicas [Emergency contraception in Chile: Structure of demand as a function of socioeconomic variables]. *Rev Bras Estud Popul*, 30(1). doi: 10.1590/S0102-30982013000100007
- Movilh. (2013). Achievements. Retrieved 05.05.14, from <http://www.movilh.cl/achievements/>
- Movilh. (2014). *Informe anual de derechos humanos de la diversidad sexual en Chile: Historia anual de las minorías sexuales Chilenas [Annual report on human rights of sexual diversity in Chile: Annual history of Chilean sexual minorities]*. Santiago, Chile: Author.
- Murray, N., Toledo, V., Luengo, X., Molina, R., & Zabin, L. (2000). *An evaluation of an integrated adolescent development program for urban teenagers in Santiago, Chile*. Washington, D.C.: Futures Group.
- Murray, N., Zabin, L., Toledo-Dreves, V., & Luengo-Charath, X. (1998). Gender differences in factors influencing first intercourse among urban students in Chile. *International Family Planning Perspectives*, 24(3), 139-152. doi: 10.2307/3038212
- Møllhausen, H. (2005). *Seksualitet på ungdomskolen. En kvalitative studie av unge jenters opplevelse av undervisning som omhandler seksualitet. [Sexuality in middle school. A qualitative study of young girls' experiences of teaching about sexuality]*. (Master Thesis), University of Oslo, Oslo, Norway. Retrieved from <http://urn.nb.no/URN:NBN:no-12256>

- Nambambi, N., & Mufune, P. (2011). What is talked about when parents discuss sex with children: Family based sex education in Windhoek, Namibia. *Afr J Reprod Health*, 15(4), 120-129.
- Neuman, W. (2011). *Social research methods: Qualitative and quantitative approaches*. Boston, M.A.: Pearson.
- Obaid, T. (2009). Fifteen years after the International Conference on Population and Development: What have we achieved and how do we move forward? *Int J Gynaecol Obstet*, 106(2), 102-105. doi: 10.1016/j.ijgo.2009.03.017
- Onyeonoro, U., Oshi, D., Ndimele, E., Chuku, N., Onyemuchara, I., Ezekwere, S., . . . Emelumadu, O. (2011). Sources of sex information and its effects on sexual practices among in-school female adolescents in Osisioma Ngwa LGA, south east Nigeria. *J Pediatr Adolesc Gynecol*, 24(5), 294-299. doi: 10.1016/j.jpag.2011.05.002
- Passalacqua, A. (2006). ¿Cuántos somos? ¿Cómo lo hacemos?: Estadísticas Educación Católica Chilena [How many are we? How do we do it? Statistics on Chilean Catholic Education]. Retrieved 01.04.14, from http://www.opech.cl/bibliografico/Doc_Financiamiento/cuantos_somos_como_lo_hacemos.pdf
- Patton, M. (2002). *Qualitative research and evaluation methods* (3 ed.). Thousand Oaks, C.A.: Sage.
- Pérez, R., Barrales, I., Jara, J., Palma, V., & Ceballos, A. (2008). Knowledge of HIV/AIDS among adolescents in Chillan, Chile. *Midwifery*, 24(4), 503-508. doi: 10.1016/j.midw.2007.01.003
- Pérez, R., Cid, M., Lepe, Y., & Carrasco, C. (2004). Conocimientos, actitudes y comportamiento sexual en un grupo de adolescentes Chilenos [Knowledge, attitudes and sexual behaviours of a group of Chilean adolescents]. *Perinatol Reprod Hum*, 18(4), 225-230.
- Peterson, Z. (2007). What is sex and why does it matter? A motivational approach to exploring individuals' definitions of sex. *The Journal of Sex Research*, 44(3), 256-268. doi: 10.1080/00224490701443932
- Pieper-Mooney, J. (2009). *The politics of motherhood: Maternity and women's rights in twentieth-century Chile*. Pittsburgh, P.A.: University of Pittsburgh Press.
- Pilgrim, N., & Blum, R. (2012). Protective and risk factors associated with adolescent sexual and reproductive health in the English-speaking Caribbean: A literature review. *J Adolesc Health*, 50(1), 5-23. doi: 10.1016/j.jadohealth.2011.03.004
- Priour, A. (1996). Domination and desire: Male homosexuality and the construction of masculinity in Mexico. In M. Melhuus & K. A. Stølen (Eds.), *Machos, mistresses, madonnas: Contesting the power of Latin American gender imagery* (pp. 83-107). London: Verso.

- RAE. (2014). Diccionario de la lengua española: Afectividad [Dictionary of the Spanish language: Afectividad]. Retrieved 20.04.14, from <http://lema.rae.es/drae/?val=afectividad>
- Rector, J. (2005). *The history of Chile*. NY: Palgrave Macmillan.
- Reiss, I. (1989). Society and sexuality: A sociological explanation. In K. McKinney & S. Sprecher (Eds.), *Human sexuality: The societal and personal context*. (pp. 3-28). Norwood, N.J.: Ablex Publ.
- Rose, I., & Friedman, D. (2012). We need health information too: A systematic review of studies examining the health information seeking and communication practices of sexual minority youth. *Health Education Journal*, 72(4), 417-430. doi: 10.1177/0017896912446739
- Rossmann, G., & Rallis, S. (2012). *Learning in the field: An introduction to qualitative research*. Los Angeles, C.A.: Sage.
- Ruiter, R., Kessels, L., Peters, G., & Kok, G. (2014). Sixty years of fear appeal research: Current state of the evidence. *International Journal of Psychology*, 49(2), 63-70. doi: 10.1002/ijop.12042
- Ruiz-Canela, M., López-del Burgo, C., Carlos, S., Catatrava, M., Osorio, A., & de Irala, J. (2012). Familia, amigos y otras fuentes de información asociadas al inicio de las relaciones sexuales en adolescentes de El Salvador [Family, friends, and other sources of information associated with the initiation of sexual relations by adolescents in El Salvador]. *Rev Panam Salud Publica*, 31(1), 54-61. doi: 10.1590/S1020-49892012000100008
- Saewyc, E. (2011). Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *Journal of Research on Adolescence*, 21(1), 256-272. doi: 10.1111/j.1532-7795.2010.00727.x
- Sanchez, N., Grogan-Kaylor, A., Castillo, M., Caballero, G., & Delva, J. (2010). Sexual intercourse among adolescents in Santiago, Chile: A study of individual and parenting factors. *Rev Panam Salud Publica*, 28(4), 267-274.
- Schutt-Aine, J., & Maddaleno, M. (2003). *Sexual health and development of adolescents and youth in the Americas: Program and policy implications*. Washington, D.C.: Pan American Health Organization.
- Selikow, T., Ahmed, N., Flisher, A., Mathews, C., & Mukoma, W. (2009). I am not "umqwayito": A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. *Scand J Public Health*, 37(107). doi: 10.1177/1403494809103903
- Shepard, B. (2000). The "double discourse" on sexual and reproductive rights in Latin America: The chasm between public policy and private actions. *Health Hum Rights*, 4(2), 110-143.

- Silverman, D. (2010). *Doing qualitative research: A practical handbook*. Los Angeles, C.A.: Sage.
- Simon, W., & Gagnon, J. (1984). Sexual scripts. *Society*, 22(1), 53-60.
- South-America-Travel. (2014). Santiago de Chile. Retrieved 24.02.14, from <http://www.south-america-travel.info/chile/maps.html>
- Svendsen, S. (2012). Elusive sex acts: Pleasure and politics in Norwegian sex education. *Sex education*, 12(4), 1-14. doi: 10.1080/14681811.2012.677209
- Taylor-Powell, E., & Renner, M. (2003). *'Analysing qualitative data', program development and evaluation*. Madison, W.I.: University of Wisconsin.
- UNAIDS. (2012). HIV and AIDS estimates: Chile. Retrieved 02.04.14, from <http://www.unaids.org/en/regionscountries/countries/chile/>
- UNESCO. (2009). *International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators*. Paris: Author.
- UNFPA. (2013). *Motherhood in Childhood: Facing the challenge of adolescent pregnancy*. NY: Author.
- UNICEF. (2013). Chile: Statistics. Retrieved 02.04.14, from http://www.unicef.org/infobycountry/chile_statistics.html
- Walker, J., & Milton, J. (2006). Teachers' and parents' roles in the sexuality education of primary school children: A comparison of experiences in Leeds, UK and in Sydney, Australia. *Sex education*, 6(4), 415-428. doi: 10.1080/14681810600982267
- Whitfield, C., Jomeen, J., Hayter, M., & Gardiner, E. (2013). Sexual health information seeking: A survey of adolescent practices. *J Clin Nurs*, 22(23-24), 3259-3269. doi: 10.1111/jocn.12192
- WHO. (2006). *Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva*. Geneva: Author.
- WHO. (2012). Emergency contraception: Fact sheet N°244. Retrieved 10.05.14, from <http://www.who.int/mediacentre/factsheets/fs244/en/>
- Williams, C., Poblete, F., & Baldrich, F. (2012). Evaluación multidimensional de los servicios de salud para adolescentes en centros de atención primaria en una comuna de Santiago [Multidimensional assessment of public health care services for adolescents in Chile]. *Rev Med Chile*, 140, 1145-1153. doi: 10.4067/S0034-98872012000900007
- Wolak, J., Mitchell, K., & Finkelhor, D. (2007). Unwanted and wanted exposure to online pornography in a national sample of youth Internet users. *Pediatrics*, 119(2), 247-257. doi: 10.1542/peds.2006-1891

Appendix 1: Map of Santiago and Institutional Profiles



Suburbs of Santiago (South-America-Travel, 2014)

Institutional Profiles¹⁵

School 1, Independencia:

This school is co-ed with approximately 500 students, many coming from families who have immigrated from Peru and Colombia. Only the final four years of high school are taught in this school. The school is partially subsidised with a socioeconomic status mid-low to low. The school offers education specific to humanities and technical careers in business administration, accounting, pre-school teaching and nutrition. The school also has night classes for adults repeating secondary school (including those who are adolescent parents). The school has optional religion classes with teaching focused on school values more than beliefs. The school values are *tolerance, liberty, honesty, industry, discipline and personal attributes that will enable them to integrate leadership skills in a globalized world*. There are no established sex education classes however starting this year the new psychologist has covered some sex education topics in orientation classes. Students are taught about reproduction in biology. The psychologist teaches "*convivencia escolar*" which covers topics of *afectividad, sexuality, drugs and choice of career*.

¹⁵ Information was obtained from school psychologists and school and university web pages

School 2, Recoleta:

This school is co-ed with approximately 1500 students spanning in age from pre-kinder to fourth grade high school. The school is also partially subsidised with a socioeconomic status mid-low to low. The school offers education specific to humanities and sciences and technical career in business administration. The school is non-religious with optional religion classes. These classes include the topics of couples, family and values. The school values are *tolerance, self-development and belonging*. The school has no specific sex education program at present, however, some elements of sex education are taught, drawing on the University of Chile course "*Adolescence, a time of decisions*" and information from the ministry of education, focusing on self-esteem and relationships. The students learn about reproduction in biology. The psychologist works in a team with other professionals with the aim to impart values and give youth the opportunity to express themselves, working with topics such as drugs, bullying and sexual health.

School 3, Las Condes:

The school is co-ed with approximately 700 students spanning in age from pre-kinder to fourth grade high school. The school is private and the socioeconomic status is mid-to mid-high with an expectation that the students will become professionals. The school offers only an academic education and not technical careers. The school has a religious foundation in Catholicism with a chapel, daily prayers, preparation for first communion and compulsory religion classes. Alongside the strong religious foundation, the school values are *universality, love for work well done, spirituality, solidarity, creativity and patriotism*. The role of the psychologist is to teach "*convivencia escolar*" which includes the section on sexuality and affection. Sex education classes are run by the psychologist who uses a mix of the two programs "*TeenSTAR*" and "*Adolescence, a time for decisions*". Topics covered include spirituality, love and co-responsibility. The psychologist works directly with pupils and parents on individual and group basis, arranging activities, careers counselling and inviting other professionals to lecture students.

University

This university is partially subsidised by the government and therefore classifies as a public university. It has a number of different campuses and this faculty is situated on a campus with a range of social sciences and admits a small number of students per year (there are 65 vacancies for 2014). Anthropology is a five-year, full time study program. Admission is granted solely on academic performance in final high school exams. Students come from a range of socioeconomic, geographic and schooling backgrounds.

Appendix 2: Declaration of Confidentiality by Research Assistant

Research Assistant Declaration of Confidentiality

Project: Adolescent Sexual Health Information in Chile
Main Researcher: Anna Macintyre
Research Assistant: Magdalena Rivera

Research Team: Anna Macintyre, Mette Sagbakken, Dr Adela Montero, Magdalena Rivera.

As research assistant for the project "Adolescent Sexual Health Information in Chile", I have had the opportunity to discuss the ethical challenges of the research project with the main researcher (Anna Macintyre).

I agree to uphold the confidentiality of all participants interviewed for this research project. I agree to not divulge the identities of the participants with anyone outside the research team nor to discuss the opinions expressed by the research participants.

When transcribing interviews, I agree to keep all audio and written records on a password locked computer inaccessible to others, to not share the information with anyone outside the research team and to delete all sound files and transcriptions once they have been passed on to the main researcher.

Name: MAGDALENA RIVERA FERNANDEZ

Signature: 

Date: MIÉRCOLES 3 DE SEPTIEMBRE 2013

Location: SANTIAGO DE CHILE

Appendix 3: Ethical Approvals



UNIVERSIDAD DE CHILE - FACULTAD DE MEDICINA
COMITÉ DE ÉTICA DE INVESTIGACIÓN EN SERES HUMANOS

1/2



ACTA DE APROBACIÓN DE PROYECTO

FECHA: 20 AGO. 2013

PROYECTO: INVESTIGACIÓN SOBRE SALUD SEXUAL EN ADOLESCENTES CHILENO: UNA INVESTIGACIÓN EXPLORATORIA Y CUALITATIVA DE LAS FUENTES DE INFORMACIÓN

INVESTIGADOR RESPONSABLE: SRTA. ANNA MACINTYRE
Co-tutora Dra. Adela Montero V.,
CEMERA, Facultad de Medicina,
Universidad de Chile

INSTITUCIÓN: PROYECTO DE TESIS PARA OBTENER EL GRADO DE MAESTRÍA EN SALUD COMUNITARIA DE LA UNIVERSIDAD DE OSLO, NORUEGA

Con fecha 13 de agosto de 2013, el proyecto ha sido analizado a la luz de los postulados de la Declaración de Helsinki, de la Guía Internacional de Ética para la Investigación Biomédica que involucra sujetos humanos CIOMS 1992, y de las Guías de Buena Práctica Clínica de ICH 1996.

Sobre la base de la información proporcionada en el texto del proyecto el Comité de Ética de la Investigación en Seres Humanos de la Facultad de Medicina de la Universidad de Chile, estima que el estudio propuesto está bien justificado y que no significa para los sujetos involucrados riesgos físicos, psíquicos o sociales mayores que mínimos.

Este comité también analizó y aprobó el correspondiente documento de Consentimiento Informado en su versión modificada con fecha 02 de agosto de 2013. Se adjunta aprobación de los siguientes documentos: Consentimiento Informado.

En virtud de las consideraciones anteriores el Comité otorga la aprobación ética para la realización del estudio propuesto, dentro de las especificaciones del protocolo.

Teléfono: 9786923 Fax: 9786189 Email: ceiha@med.uchile.cl



INTEGRANTES DEL COMITÉ DE ÉTICA DE LA INVESTIGACIÓN EN SERES HUMANOS 20 AGO. 2013

NOMBRE	CARGO	RELACIÓN CON LA INSTITUCIÓN
Dr. Manuel Oyarzún	Presidente	Sí
Prof. Gina Raineri	Secretaria Ejecutiva	Sí
Dr. Hugo Amigo	Miembro	Sí
Dr. Leandro Biagini	Miembro	Sí
Dra. Lucia Cifuentes	Miembro	Sí
Sra. Nina Horwitz	Miembro	Sí
Dra. María Eugenia Pinto	Miembro	Sí
Sra. Claudia Marshall	Miembro	No
Dra. Gricel Orellana	Miembro	Sí
Prof. M. Julieta González	Miembro	Sí

Santiago, 19 de agosto de 2013.



Prof. Gina Raineri B.
Secretaria Ejecutiva CEISH

GRB/mva.
Proy. N° 059-2013



UNIVERSITY OF OSLO
FACULTY OF MEDICINE

Regional Committee for Medical Research Ethics
Southern Norway, Section D
Post.Box 1130 Blindern
NO-0318 Oslo

Telephone: 22 84 55 23

Date: 5th of April 2013
Your ref.:
Our ref.: 2010/3261

E-mail: post@helseforskning.etikkom.no
Homepage: <http://helseforskning.etikkom.no>

Dear Mette Sagbakken and Anna Macintyre,

Re: Adolescent Sexual Health Information in Chile

I am writing in reference to your preliminary project application form received on the 9th of April 2013.

The aim of the study is to explore the nature of the information Chilean adolescents both actively seek and passively receive on sexuality, as well as how they judge the trustworthiness and usefulness of information from different sources.

REC has considered your preliminary application, and has concluded that a full application to REC is not necessary. The basis for this decision is that this project will not lead to new knowledge regarding health and disease, as understood in the Norwegian Health Research Act § 2 and § 4. The aim in this case is rather to explore information channels regarding adolescent sexual health in Chile.

The project can be done without the approval by the the Regional Committees for Medical Research Ethics of Norway.

Yours Sincerely

Stein A. Evensen
Chair of the Regional Committee for
Medical Research Ethics of Southern Norway
(P.P.)
Section D

Emil Lahlum
Higher Executive Officer



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Mette Sagbakken
Institutt for helse og samfunn
Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 17.06.2013

Vår ref:34595 / 3 / LMR

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 23.05.2013. Meldingen gjelder prosjektet:

34595	<i>Adolescent Sexual Health Information in Chile</i>
Behandlingsansvarlig	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Mette Sagbakken</i>
Student	<i>Anna Macintyre</i>

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

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

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

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

Personvernombudet vil ved prosjektets avslutning, 01.06.2014, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim


Linn-Merethe Rød

Kontaktperson: Linn-Merethe Rød tlf: 55 58 89 11
Vedlegg: Prosjektvurdering
Kopi: Anna Macintyre