Culture’s Consequences: Examining the Relevance of Hofstede’s Cultural Dimensions Theory to Youth Sexual Health

Christine M. Lehane

Master’s Thesis
Spring 2014

Supervisor: Dr. Una Tellhed
Acknowledgements

Firstly, I would like to thank my supervisor, Dr. Una Tellhed, for her guidance, mentorship, advice, and inspiration throughout the duration of this research project. I would also like to thank each of my research assistants and interpreters, Ms. Priscila Rosse, Ms. Alicia Ruiz Anderson, Mr. Carl Sjögren, Mr. David Frödin, and Ms. Rachel Lehane. Without your help this project would not have been possible.

Next I would like to thank the organisations and students involved in this study. I would like to extend my gratitude to the director, Dr. Luis Vasquez, and all the members of the Yantalo Peru Foundation for allowing the integration of my master’s project into their ongoing youth sexual health research project. I would also like to thank Cesar Vallejo University, the National University of San Martin, Peru, and Polhelmskolan, Sweden for their assistance in recruiting participants.

Finally, I would like to thank my friends and family for their patience during my master’s process, especially my sisters Lisa, Rachel and Marina who helped me in every way they could. Without the support, help and advice from the people and organisations mentioned above this master’s project would not have been possible. Thank you all very much. Muchas Gracias. Go raibh míle maith agaibh. Tack så mycket.
Abstract

Cultural norms that promote gender inequality have shown to encourage power imbalances in heterosexual relationships, increasing both young men and young women’s risk of STDs, HIV, unplanned pregnancy and intimate partner violence (WHO, 2004). Understanding how exactly these cultural norms impact youth’s gendered sexual roles and overall sexual health has been increasingly highlighted as an important area for the design of effective youth sexual health education and intervention programs (UNFPA, 2010). The current study adopts the cultural dimensions Masculinity/Femininity, Power Distance and Indulgence/Restraint as proposed by Hofstede’s cultural dimensions theory (1980, 2011) and investigates their ability to predict level of support for equitable gender norms and sexual health in youth cross-culturally. Data was collected from second and third level students between the age of 16 and 21 residing full-time in Peru, Argentina, Ireland and Sweden. Results of the studies data analysis revealed that Hofstede’s Power Distance dimension was a significant predictor of youth’s level of support for equitable gender norms and Hofstede’s dimension Indulgence/Restraint was a significant predictor of youth sexual activity. Level of support for equitable gender norms in turn predicted sexual health items such as STD contraction, unplanned pregnancy and contraceptive use. The results of this study highlight the importance of including the cultural and gender perspectives in sexual health education and healthcare intervention services.

Keywords: Sex, gender, culture, power.
Culture’s Consequences: Examining the Relevance of Hofstede’s Cultural Dimensions Theory to Youth Sexual Health

“Everything in the world is about sex except sex. Sex is about power.”

- Oscar Wilde

Cross-cultural research in sexual health is essential in order to sort the universal ideas about sexual health decision making from the particulars of different cultures (Gondolf, 2004a). Especially among youths, more specific knowledge regarding the exact influence of culture on gendered sexual health attitudes and behaviours could greatly aid the design of effective youth sexual health education programs worldwide.

This study aims to identify some of the universal and more specific cultural factors which impact youth sexual health cross-culturally.

According to the World Health Organisation (WHO, 2006) sexual health is defined as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (p.5). Every day over 6,000 people are infected with HIV, global estimates of STI contraction reveals that there are approximately 340 million new cases of STI’s per year with youth holding a disproportionately large share of these cases (UNFPA, 2008). Additionally, almost 15 million adolescent girls globally become mothers every year. Furthermore, as many as one in every three women have been beaten, coerced into sex, or abused, most often by an intimate partner (UNFPA, 2008). Positive youth sexual health is not a luxury, it is a right, which is unfortunately not supported in all cultures.

To date research on youth sexual health has focused primarily on North America, as a result cross-cultural research on youth sexual health has been highlighted as a significant gap in our current body of research. This research opening has recently been discussed by Deardorff, et al., (2013), Powell, (2010) and the Population Association of America (PAA, 2014) who all specifically point to the need for more cross-cultural studies in order to contribute to the design of more effective sexual health interventions. This study aims to address this gap by examining youth sexual health cross-culturally in Peru, Argentina, Ireland and Sweden.
As well as the need for more cross-cultural studies in sexual health, recent studies (Bertotti, 2013; Fennell, 2011) have indicated the importance of further investigating one specific area of youth sexual health - heterosexual couple’s gendered power division and contraceptive use. Many researchers have shown that support for inequitable gender norms that is, unequal expectations for appropriate behaviors of men as compared to women in a society (Pulerwitz & Barker, 2008), impact the sexual power balance within a heterosexual relationship, thus potentially negatively influencing the sexual health of youth including aspects such as contraceptive use, condom use and intimate partner violence (Amaro, 1995; Campbell, 1995; Cohen & Burger, 2000; Pulerwitz & Barker, 2008). Considering that the most effective reversible methods of contraception are female targeted (e.g. hormonal pills, IUD’s, injections, implants), the reliance on female contraceptive methods often hinders the use of male methods (e.g. condom) or in cases where there is stark gendered power inequalities, no method at all (Fennell, 2011). This highlights the importance of cooperative female and male contraceptive decision making power in order to protect both individuals from STD contraction and unplanned pregnancy. The benefit of cross-cultural studies in this specific area of sexual health would include attempting to identify cultural factors related to gendered relationship power division, and level of youth sexual activity, in an attempt to provide more “culture-specific” tools for the design of effective youth sexual health education and interventions. One continuously unanswered question in this area is, are there distinct cultural factors that can help us identify these cultural traits?

According to the cross-cultural psychology researchers at Wageningen University, the Netherlands, such dimensions have already been identified. Over thirty years ago, Geert Hofstede (1980a) published his groundbreaking theory on cross-cultural differences extending from business and corporation cultural norms to sexual and reproductive cultural norms. Hofstede and colleagues argue that some of their cultural dimensions relate to the most persistent gender roles and relative sexual health of a country (Hofstede, 2011), however, thus far there has been no research evidence to support these suggestions. There have been many studies testing the validity of Hofstede’s theory for business and management (Daniels & Greguras, 2014; Søndergaard, 1994; Vitell, Nwachukwu, & Barnes, 1993) showing promising results, however, there are little or no studies directly testing the validity of Hofstede’s claims that the cultural dimensions identified relate to a cultures most persistent gender roles and relative sexual health. If these cultural dimensions did indeed show some level of predictability when identifying a country’s most persistent gender role
norms and relative sexual health, this would be hugely beneficial to the area of sexual health intervention and education design. However, with the current lack of research studies supporting these claims it would be unwise for sexual health educators to assume that such claims are reliable.

The current study, therefore, aims to identify the validity of Hofstede’s cultural dimensions, Masculinity/Femininity, Power Distance, and Indulgence/Restraint in predicting the gender role attitudes and sexual activity of youth in Peru, Argentina, Ireland and Sweden. The present study also aims to identify the influence of relationship power division, and gender role attitudes on contraceptive use and sexual behaviour with the end goal of creating gender and culturally sensitive, sexual health education suggestions for youth in Peru, Argentina, Ireland and Sweden.

This paper’s literature review will first describe the impact of culture on gender norms followed by an introduction to Hofstede’s (1980) cultural dimensions theory. Next, the influence of gender norms on youth sexual health will be examined using cross-cultural research findings. Finally, the literature surrounding sexual health in Peru, Argentina, Ireland and Sweden will be discussed highlighting some interesting findings and research gaps in this literature base.

**Influence of Culture on Gender Roles**

Research in cultural psychology has highlighted the idea that many psychological constructs are not universal and that culture plays a large role in influencing the way that people think about, and see themselves in relation to a construct such as gender. However, attempting to interpret cultural differences in psychological research is no easy task. Cross-cultural psychologists explain that psychological constructs including gender and gender roles are shaped by culture and thus differ across cultures (Markus & Kitayama, 1991b). In an attempt to understand these cultural variations in gender roles Geert Hofstede (1980, 1986, 1991, 1998, 2011) conducted an extensive, multi-national study of cultural values. The dimensions which were identified by Hofstede (1980) as relating to the most persistent gender roles in a culture included Power Distance and Masculinity/Femininity. As a result of his data collection Hofstede came to a number of assumptions about the relevance of these dimensions to societal gender roles.
Cultural Dimensions Theory. Hofstede (1980) defines culture as “the collective programming of the mind which distinguishes the members of one group or category of people from another” (p.260). He explains that the cultural meaning of masculinity and femininity are adopted by a young child growing up in his/her family and are further developed and confirmed in school, their community, employment, and religion. According to Hofstede’s Masculinity/Femininity dimension, the social roles existent in a culture are associated with the existence of two main sexes, the biological male and female (Hofstede, 1998).

More specifically, Masculine cultures (e.g. Argentina and Ireland) are those in which men are expected to be assertive, tough, competitive, and focused on success, whereas women are supposed to be modest, caring and concerned with overall quality of life (Hofstede, 1998). Conversely, Feminine cultures (e.g. Peru and Sweden) are those in which both sexes are expected to be equally modest, caring and concerned with quality of life when compared to the stark division of Masculine cultures (Hofstede, 1998). Through these assertions, Hofstede shows a link between culture and gender roles, whereby the prevailing role distribution between partners in a heterosexual relationship reflects that cultures position in the Mas/Fem dimension and thus the values concerning appropriate behaviour for boys and girls are passed on through generations, upholding this cultural trait (Hofstede, 1998). The idea that men should be strong, assertive and success driven and women should be caring, affectionate and emotional is not a concept that Hofstede came up with himself. Gender stereotyping occurs whereby males and females are arbitrarily assigned characteristics and roles determined and limited by their sex (CDEG, 2011). Nevertheless, Hofstede has added to the literature on gender stereotyping by suggesting that these stereotypes may differ significantly cross-culturally.

However, the Mas/Fem dimension is not the only dimension which Hofstede (2011) relates to cultural gender role attitudes. Introducing another dimension which Hofstede states relates to gender role attitudes is Power Distance. According to Hofstede (1998) the sharing of power in society in general, including that of women versus men, largely depends on the countries placement on the Power Distance dimension. Essentially, the Power Distance dimension refers to the extent to which the society accepts that power is distributed unequally (Hofstede, 1998). It ranges in value from zero, for cultures with small power-distance (e.g. Ireland and Sweden), to 100, for cultures with larger power distances (e.g. Peru and Argentina) (see Appendix 5, Figure 1). Hofstede (1998) cites the European Media and
Marketing Survey carried out by de Mooij (1998) in which the cultural dimension Power Distance was highly correlated with attitudes related to women’s liberation, more so than the Mas/Fem dimension. Therefore, Hofstede suggests that gender roles within relationships and cultural ideas of appropriate male and female behaviours can be influenced by the Mas/Fem dimension, whereas, he suggests that overall gender role power division attitudes in a society can be influenced by the countries location on the Power Distance dimension.

It is known from previous cross-cultural psychological studies that culture impacts gender trait stereotyping in youth (Williams & Best, 1982), however, to date, there is only one study which tests the validity of Hofstede’s dimensions in youth gender role attitudes cross-culturally. This study was conducted by Gibbons, Stiles, and Shkodriani (1991) using a sample of 265 international students attending schooling in the Netherlands. The adolescents were aged 11 to 17 and spanned 46 countries. The students were divided into two groups according to Hofstede’s (1983) cultural clusters. Therefore, group 1 consisted of students whose countries leant more towards individualism and had lower average levels of power distance: United States, Canada, Australia, Israel, South Africa, Great Britain, Ireland, Germany, Denmark, Sweden, Norway, and The Netherlands, and group 2 consisted of students whose countries leant more towards collectivism and had a higher power distance average: Venezuela, Argentina, Chile, Peru, Brazil, Turkey, Greece, Yugoslavia, Belgium, France, Spain, Libya, Egypt, Kuwait, Iran, Pakistan, India, Sri Lanka, Indonesia, Thailand, Philippines, Malaysia, Burma, Singapore, Korea, Japan, Ethiopia, Sierra Leone, and Ghana. The researchers hypothesized that the students in group 1 would respond less traditionally than the students in group 2 because the cultural values reflected in these groupings would predict socialization toward more traditional gender roles in group 2 countries than group 1 countries. The results showed that group 2 did in fact show significantly more traditional gender role attitudes than group 1 as measured by the Attitudes towards Women Scale for Adolescents (Galambos, Richards & Gitelson, 1985). Interestingly, analysis of variance showed a significant main effect for gender, further investigation into this effect revealed that there were no significant gender differences in attitudes for the students in group 1, however, there was a significant difference in male and female student attitudes in group 2 with boys responding in a more traditional manner than girls. It is worth noting that in this study the Mas/Fem dimension showed no effect.

The findings of Gibbons, Stiles, and Shkodriani (1991) were later supported in 2003 by Hanson-Frieze and colleagues when comparing sex differences in the gender role attitudes
of university students in the US (cluster 1), Slovenia and Croatia (cluster 2). The researchers
found that overall, men held less egalitarian or more sexist attitudes about the appropriate
roles for women and men with the smallest difference identified among the US sample,
followed by Slovenia with Croatia holding the largest sex differences in gender role attitudes.
The researchers reported that strength of religious belief was a significant factor in the
prediction of gender role attitudes in youths and future studies should investigate the
influence of religion.

This gender difference found in cluster 2 countries has since been explained by
Petersen and Hyde (2010). Having studied attitudinal and behavioural data of men and
women from 87 countries and 6 continents between 1993 and 2007, the researchers
discovered that in nations and cultural groups where a greater level of gender equality
existed, people displayed smaller gender differences in attitudes and behaviors than did people from more traditional nations and cultural groups. Moreover, the researchers stated
that overtime many of the traditional gender role differences seem to be disappearing. This
second revelation is in line with the predictions of Inglehart and Norris (2003) who state that
as countries become more developed (i.e. move up on the human development index), the
gender role differences in that country will steadily decrease. Therefore, the researchers
suggest that future studies should consider the role of human development level.

Influence of Culture on Sexual Health

Following this knowledge an interesting question would be, do culturally constructed
gender roles impact the sexual health of heterosexual couples? This question has been
addressed by Pearson (2006) who states that youth’s sexual and reproductive decision making
is shaped by their culture’s normative ideas about suitable sexual roles for women and men,
therefore, the ability for young men and women to engage in safe sexual behaviour can be
hampered or helped by these cultural norms. But how exactly does this work? Pearson (2006)
explains that when normative ideas about appropriate sexual roles for men and women dictate
the power distribution within sexual relationships unequally, young women may find it
difficult to express their concerns or desires in relation to contraception, family planning, and
general household duty division. These cultural gendered sexual norms may hinder the
discussion of sex, put women in a passive position, and relate masculinity to control and
dominance (Martin, 1996), thus placing both young men and women at risk of HIV/STD
contraction and unplanned pregnancy (Pearson, 2006).
The importance of researching the influence of cultural gendered norms on sexual health was recently stressed by Deardorff, et al., (2013) who studied the influence of Latino youth sexual norms on condom negotiation strategies. Their study included data from 571 Latino non-acculturated youths living in the San Francisco Bay area. This study revealed that within the Latino youth culture, gendered sexual values were significantly related to condom negotiation strategies. The researchers concluded by suggesting that educators designing youth sexual health programs for the Latino populations within the US should consider including program components that address culturally constructed gender sexual values.

Additionally, a later study carried out by Pulerwitz, Amaro, De Jong, Gortmaker, and Rudd (2002) demonstrated the impact of heterosexual sexual relationship power division on condom use and subsequent HIV risk in the US. The authors stated that the woman in their study’s ability to negotiate safer sexual practices, particularly condom use, was a vital component for HIV/STD prevention. Data was collected from 388, mostly Latina, women resident in Massachusetts. Their results revealed that women with higher levels of equal sexual relationship power division were five times as likely as women with lower levels to report consistent condom use. The researchers concluded that gender-based power imbalances may constrain women's condom negotiation ability and that these findings highlight the importance of including the issue of gendered sexual relationship power division in the design and implementation of programs that promote safe sexual health.

This suggestion has also been supported in a study conducted in South Africa in which the authors identified gender power imbalances in sexual relationships as a major factor impeding condom use in sexually active adolescents (Boer & Mashamba, 2007). Similarly, Paiva (1993) conducted research on gender roles and condom use in Brazil. Following her findings that sexual gender norms do indeed impact adolescent condom use, she emphasized the need for gender inclusive sexual health education to improve condom use among Brazilian adolescents.

Finally, one of the earliest and most extensive reports to address the issue of youth sexual values and attitudes cross-culturally was conducted by the World Health Organisation (WHO, 2004). Their review aimed at identifying risk and protective factors for youth sexual health in developing countries. This review included publications from Sub-Saharan Africa, Latin America, South East and South Asia. Following their analysis, the researcher identified a number of protective and risk factors. Some important findings made by this study showed
that *education* and schooling were key factors for reducing the risk of early sexual initiation, pregnancy, and early childbearing, along with increasing the likelihood that youth would use condoms and contraception during sexual intercourse. Secondly, the report highlighted that positive attitudes in relation to condom use, partner support and approval of contraceptive method were critical in ensuring the practice of safe sex (WHO, 2004).

**Mas/Fem Dimension and Sexual Health.** All of the above studies reveal the global extent of the involvement of gender in sexual health. Considering Hofstede’s identification of a cultural dimension (Mas/Fem) which according to Hofstede (1998) is indicative of the dominant gender role structure in a culture, how does this dimension relate to youth sexual health? Hofstede (1998) asserts that “sexual behaviour is culturally constructed, and some of it relates to the national culture dimension of Masculinity/Femininity” (p.153). He argues that domestic and educational chores are, on average, more equally distributed in more feminine cultures, that feminine cultures show more acceptance of women’s active role in sexual relations, that abortion, contraception, masturbation and homosexuality are more stigmatized in masculine than feminine cultures, and that there are larger gaps between the norms and values expected of men and women in relationships in Masculine cultures (Hofstede, 1998). Hofstede’s suggestion that a country’s placement on the Mas/Fem index can influence the gendered sexual values of that culture were recently supported by Joshi, Peter, and Valkenberg (2014) in a study comparing virginity loss and pregnancy in the US and The Netherlands, with the US showing more strictly dichotomous gendered sexual values, in line with the Mas dimension, and The Netherlands showing more overlapping gendered sexual values, in line with the Fem dimension.

**Indulgence/Restraint and Sexual Health.** Furthermore, Hofstede introduces the cultural dimension Indulgence/Restraint. According to Hofstede (2011) “Indulgence stands for a society that allows relatively free gratification of basic and natural human desires related to enjoying life and having fun. Restraint stands for a society that controls gratification of needs and regulates it by means of strict social norms” (p. 15). In relation to sexual behaviour, Hofstede (2011) suggests that in countries which rate highly on the Indulgence side of the dimension the sexual norms should be more lenient (e.g. Sweden), whereas for countries which map lower on this dimension, sexual norms should be stricter (e.g. Peru). This assertion was supported by Minkov (2007) who analysed the recent World Values Survey data and found an association between Indulgence/Restraint and sexual norms, with countries aligning more towards Indulgence showing more sexual activity and lenient sexual
norms than those on the Restraint side of Hofstede’s (2011) dimension. Having discussed Hofstede’s dimensions, this report now moves on to discuss the current state of affairs regarding youth sexual health in Peru, Argentina, Ireland and Sweden.

**Sexual Health Statistics**

**Argentina and Peru.** Kostrzewa (2008) reviewed case studies carried out by the World Health Organisation in order to shed some light on the current situation for youth sexual health in Argentina, Brazil, and Peru. For the purpose of this study this paper will focus solely on the Argentinian and Peruvian findings. This article identifies the factors that contribute to risky sexual behavior and negative reproductive health in youth in Argentina and Peru. The author reveals that the average age of marriage for Peruvian and Argentinian youth is 21 to 23 years of age with over 30% of Peruvian young women giving birth before the age of 20 years and 33% of Peruvian youths relying mainly on the traditional birth control method i.e. the calendar or rhythm method. Additionally, it was found that Peruvian adolescents have little knowledge of STI’s and HIV/AIDS, however, while knowing that they should use protection when engaging in sexual intercourse many youths reported not using any form of contraception. The author concluded by stating that the findings from Peru suggest that the national sex education program provided to schools has the potential to be an important source of accurate information on sexual health related topics for youth and should be developed further to ensure the adequate use of such a program in Peruvian schools. Relating to Argentina, the author concludes that there are conflicts between the gender roles that young Argentinian men learn in their families and are now expected of them in their reproductive life and that these gender role expectation differences need to be addressed in youth sexual education (Kostrzewa, 2008).

In another study carried out by Schmitt (2005) the author researched the “sociosexuality” (SOI) of 48 nations, two of which were Argentina and Peru. According to the author those who score relatively low on this dimension are said to possess a restricted sociosexual orientation, in that, they are more monogamous, entertain prolonged courtship, and place heavy emotional investment in long-term relationships. Those residing at the high end of sociosexuality are considered more unrestricted sexually, showing a more promiscuous sexual pattern, place less emphasis on courtship, and place lower levels of importance on romantic relationship closeness (Simpson & Gangestad, 1991). Schmitt used the Sociosexual Orientation Inventory to form national averages of sociosexuality cross-
culturally. His findings showed both countries as relatively central with Argentina leaning towards the mid to higher end of the SOI dimension and Peru leaning towards the mid to lower end of the dimension (Schmitt, 2005). These findings are in line with the expectation of Hofstede’s Indulgence/Restraint dimension highlighting the need to address sexual health education services and contraceptive availability in Argentina and Peru.

Recently the Population Reference Bureau (2013) released a report on health statistics of the world’s youth. In this report statistics on youth marriage, adolescent fertility rate, contraceptive use, HIV/AIDS prevalence and IPV attitudes were illustrated (see Appendix 5, Table 2). The report revealed that Argentina has the highest adolescent fertility rate of our studied countries at 54 births per 1000 women aged 15 to 19 years. Compared with Argentina, Peru has a slightly lower adolescent fertility rate at 48 births per 1000 women aged 15 to 19 years. HIV/AIDS prevalence rates for youth aged 15 to 24 years reached 0.2% for males and females in Argentina and between 0.1 and 0.2% for males and females in Peru. In addition, the report shows that 44% of women aged 15 to 19 and 57% of women aged 20 to 24 are using some form of modern contraceptive in Peru, however, this data has not been recorded for Argentina and attitudes towards IPV were not recorded for any of the countries studied in this paper. This highlights the immediate need for more information regarding youth sexual health globally.

Continuing from the acknowledgement of the high adolescent fertility rate in Argentina, Gogna, Binstock, Fernández, Ibarlucía, and Zamberlin (2008) examined this in order to make evidence based recommendations to public policy makers. In their study, the researchers identified a number of factors relating to adolescent pregnancy including lack of sexual health knowledge and education, and gender power imbalances in relation to sexual norms. The authors concluded by highlighting the need for adequate sexual health education including information on gender power relations, an increased level of contraceptive counselling facilities and efforts to encourage men’s involvement in pregnancy prevention.

It can be seen from these studies that the youth of Argentina and Peru are sexually active, do not necessarily use adequate contraceptive strategies, lack information relating to sexual health, experience sexual gender power imbalances and are therefore at risk of contracting HIV/STD’s or experiencing an unplanned pregnancy. How does this compare to Sweden and Ireland?
Ireland and Sweden. De Irala, Osorio, Carlos, Lopez-del Burgo (2011) researched the contraceptive use of women in five European countries, Germany, France, UK, Romania and Sweden. For the purpose of this report the focus will mainly be on the results related to Sweden. 306 Swedish women between the age of 18 and 49 were included in this study, results showed that 34.6% of women were using oral contraceptives, 22.5% used the male condom, 9.8% used the withdrawal method, 4.9% used the traditional calendar method, 4.6% used injectable contraceptives or the implant, 0% used the female condom, 19% used the intrauterine device and 13.7% did not use any form of contraceptive. These results highlight the importance of collaboration between partners when making contraceptive decisions. The only contraceptive methods listed which prevent HIV/STD transmission are the male and, lesser well known, female condom. While the male condom shows a 22.5% usage among Swedish women, the female condom had 0% usage. Therefore the prevention of STI contraction among this sample of women mainly lies in a couple’s joint decision to use the male condom.

A study conducted in 2007 focusing on the sexual health of 718 Swedish high school students revealed that 75% of students were sexually active, 5% had previously had an abortion and 4% had previously contracted an STI. Young men also reported more unprotected sex than young women (Larsson, Tydén, Hanson, and Häggström-Nordin, 2007). Additionally, Edgardh (2002) stated that attitudes towards sex in Sweden, in line with Hofstede’s Indulgence/Restraint placing of Sweden, are very liberal. In his literature review Edgardh continues by stressing the growing problem of STD contraction among the Swedish population with Swedish adolescents showing the steepest rises in STD contraction. However, are sexual gender norms a factor in youth sexual health in Sweden? If so, the current sex education program in Sweden needs to be updated to include education relating to the sexual gender norms which are currently impacting the sexual health decision making of youth in Sweden.

This question was addressed by Ekstrand, Tydén, Darj, and Larsson (2007) who held 40 interviews with 17 year old boys in relation to sexual health. Surprisingly, given the level of overall gender equality evident in the Swedish state (World Economic Forum, 2013), the researchers discovered that the boys perceived girls as having a greater responsibility in relation to using contraceptives and avoiding pregnancy, and as a direct result often put a blind trust in the girls’ use of hormonal contraceptives or their purchase of emergency contraception following sexual intercourse. This study reveals that even in nations with a
high level of gender equality, though context and factors may differ, gender still plays an important role in youth sexual health.

Now that youth sexual health in Sweden has been discussed, the discussion continues to the research focusing on Irish youth. In 2006 the Irish Study of Sexual Health and Relationships conducted a nationally representative study looking at people’s sexual health and attitudes. Some of the most interesting findings reported by the ISSHR include that among women, 56% of those under the age of 25 cannot correctly identify the most fertile period of a woman’s menstrual cycle. 54% of men and 73% of women have heard of Chlamydia, yet only 37% of men and 60% of women have adequate, correct knowledge of Chlamydia. Of the respondents who were under 25 years, 57% of men and 77% of women agreed with the statement that homosexual sex is never wrong. 33% of females under the age of 25 stated that they would not consider using oral contraceptives as a result of the potential medical side effects. Of those aged 18 to 24 years 84.3% of men reported having had sexual intercourse compared to 81.8% of women. Contraceptive use has generally been shown as quite high amongst Irish youth with 93% or Irish men aged 18 to 24 using contraception and 94% of women of the same age group using contraception. Interestingly in contrast to Sweden, the male condom is the most frequently used form of contraception with 82% of men and 74% of women aged 18 to 24 reporting the use of condoms (ISSHR, 2006).

Unfortunately despite the level of data available on youth sexual health outcomes such as contraceptive use, there is little or no information regarding the role of gender power division on contraceptive decision making strategies.

In summary, the importance of understanding cultural factors that contribute to the formation and maintenance of restrictive sexual gender roles and how these gender roles can impact youth sexual health have been identified. The evidence in favour of Hofstede’s cultural dimensions, Mas/Fem, Power Distance and Indulgence/Restraint in relation to predicting cultural gender roles and identifying their potential role in youth sexual health has been discussed. While examining cross-cultural studies testing these dimensions, factors highlighted by previous researchers which can impact a country’s level of gender stereotyping in sexual health such as education, religion and overall human development level were acknowledged. As a result of reviewing the literature it is apparent that to the best of this researcher’s knowledge, there has been little or no cross-cultural research between Peru, Argentina, Ireland and Sweden examining the validity of Hofstede’s cultural dimensions in relation to youth sexual health.
The purpose of the present study therefore aims to identify the validity of Hofstede’s (1980, 1991, 1998, 2011) cultural dimensions, Masculinity/Femininity, Power Distance, and Indulgence/Restraint in predicting the gender role attitudes and sexual activity of youth in Peru, Argentina, Ireland and Sweden. The current study then aims to examine the proposed link between gender role attitudes and sexual health with the overall goal of creating culturally and gender sensitive, sexual health education suggestions for youth in Peru, Argentina, Ireland and Sweden. On the basis of the above literature review this study has formed the following hypotheses:

**Hypothesis 1.** In line with the suggestions made by Hofstede (1998) this study hypothesizes that the Mas/Fem cultural dimension and Power Distance cultural dimension, across the present study’s cross-cultural comparisons, will predict a country’s level of support for equitable gender norms.

According to the cross-cultural Power Distance differences the present author expects Ireland and Sweden to show the most gender equitable norms. Argentina is expected to come next with Peru showing the most inequitable gender norms.

**Hypothesis 2.** In line with the suggestions made by Hofstede (2011) this study hypothesizes that the dimension Indulgence/Restraint will be related to the level of sexual activity of the youth in each country.

Consistent with this hypothesis it is expected that Sweden will show the highest level of youth sexual activity. Somewhat similar to each other, it is expected that Ireland and Argentina will fall in the middle. Finally, it is hypothesized that this study will find the least youth sexual activity among the Peruvian sample.

**Hypothesis 3.** In this study it is expected that level of support for gender equitable norms should predict sexual behaviours such as contraceptive use, STD contraction and unplanned pregnancy, in that, those with more equitable norms will show more contraceptive use, and less incidences of unplanned pregnancy and STD contraction.

**Hypothesis 4.** Finally, in accordance with the factors emphasized by previous researchers, it is hypothesized that there will be:

a) Sex differences in the level of support for gender equitable norms with males showing more inequitable norms than females.
b) Less support for gender equitable norms when respondents rate religion as important to them.

c) Higher support for gender equitable norms among third level students when compared to second level students.

d) Higher support for gender equitable norms and more sexual activity where the human development level is higher.

Method

This section outlines the methods that were used in the current research. Firstly, a description of the research design is outlined, followed by a description of the sample and sampling strategy, the data gathering process, the measuring instruments that were used, and lastly, the ethical considerations that had to be taken into account.

Research Design

The current study adopted a quantitative approach. It was a non-experimental, cross-sectional survey research design. The survey was conducted both in schools, universities and online in order to reach participants across the differing demographic regions, rural, urban town and urban city.

Participants

Peru. Participants were recruited through the National University of San Martin, Cesar Vallejo University, and two secondary schools in the Moyobamba district of San Martin, Peru who agreed to facilitate this study. Participants were between 16 and 21 years of age, lived permanently in Peru and were either in their last two years of obligatory schooling or university undergraduates. A total of 174 participants were recruited, 88 females, 77 males and 9 preferred not to disclose. The mean age was 17.6 years (SD = 1.39, range = 16-21).

Argentina. Participants were recruited from the National University of Quilmes, and one secondary school from the Neuquén province. Participants were between 16 and 21 years of age, lived permanently in Argentina and were either in their last two years of secondary school or university undergraduates. A total of 56 participants were recruited, 35 females and 21 males. The mean age was 18.8 years (SD = 1.7, range = 16-21).

Ireland. Participants were recruited from the University of Limerick, University College Cork, and secondary schools in the Munster region. Participants were between 17
and 21 years of age, lived permanently in Ireland and were either in their last two years of secondary school or university undergraduates. A total of 150 participants were recruited, 76 male, 72 female and 2 preferred not to disclose. The mean age was 18.4 years ($SD = 1.35$, range = 17-21).

**Sweden.** Participants were recruited from Lund University, Malmö Högskola, and two secondary schools in the Skåne region. Participants were between 16 and 21 years of age, lived permanently in Sweden and were either in their last 3 years of schooling or university undergraduates. A total of 158 participants were recruited, 80 male, 75 female, and 2 intersexed individuals. The mean age was 19 years ($SD = 1.52$, range = 16-21).

**Measures**

**Demographic Data.** The demographic questionnaire consisted of 17 items. It asked respondents questions in relation to nationality, age, sex, education level, religious affiliation, personal importance of religion, marital status, employment status, father and mother’s employment status, sexual activity level, and children. Only key variables in the above information were used in addressing the research questions of the current study (see Appendix 3).

**Sexual Health Data.** Previous sexual health issues were determined by the variables “have you ever had an unplanned pregnancy” and “have you ever contracted an STD” with 1 indicating that a participant has previously had either an STD or unplanned pregnancy and 2 indicating that a participant has not previously had an unplanned pregnancy or STD.

Similarly, contraceptive use was determined by the variables “do you use condoms when having sex” and “do you use any other form of contraceptive other than condoms when having sex”. Contraceptive use was given a code of 1, while non-use of contraceptives when having sexual intercourse was coded as 2. The condom use and other contraceptive use variables were combined to avoid overall contraceptive use estimation errors as a result of gender divided access to different types of contraceptives.

The questionnaire was administered in Spanish for Peru and Argentina, Swedish for Sweden and English for Ireland. As the language of the researcher is English, an interpreter was present in each case where English was not the language being used.

**The Gender-Equitable Men Scale (GEM Scale).** Support for equitable gender norms was assessed using the Gender-Equitable Men Scale (Pulerwitz & Barker, 2008). This
scale was chosen due to its inclusion of relationship power division attitude items, relatively short length (fit the time frame offered by schools), and focus on male dominance (consistent with the focus of Hofstede’s Mas/Fem and Power Distance dimensions). This tool is made up of 24 items; it is multifaceted measuring multiple domains within the construct of gender norms with two factors gender inequitable and equitable norms. Scale items on gender norms related to sexual and reproductive health, sexual relations, violence, domestic work, and homophobia are included. Scores form a continuous scale from 24 to 72, in that, a score of 24 to 40 indicated low support for gender equitable norms, a score of 41 to 56 indicated moderate support for gender equitable norms, and a score of 57 to 72 indicated high support for gender equitable norms. The scale was designed to be broadly applicable and culturally sensitive, so indicators can be applied and compared across different settings (see Appendix 4).

The GEM Scale has demonstrated acceptable psychometric properties. Internal consistency reliability of the two factors was tested using Cronbach’s alpha. The two factors, inequitable and equitable gender norms showed alpha values of .85 and .77 respectively. The internal consistency reliability of the overall scale is .81 and was therefore deemed reliable (Pulerwitz & Barker, 2008).

Dimensions Data. Data on the official scores of each country along Hofstede’s cultural dimensions was retrieved from Geert and Gert Jan Hofstede’s official website (Hofstede & Hofstede, 2010).

Human Development Level. The Human Development Index is a statistic put together by the United Nations Development Program (UNDP) comprising of a country’s life expectancy at birth, education level and gross national income. The statistic for each country is available via the most recent report released in 2013 (UNDP, 2013).

Procedure

General Procedure. A number of schools and universities were contacted and the principals and department heads were provided with information on the study and a copy of the study materials. The data was collected by means of two self-report paper and pencil measures (demographic questionnaire and the GEM Scale) and were filled out in the classroom. Each institution allocated 20 minutes for the questionnaire and a further 60 minutes for a presentation and discussion covering the main areas of youth sexual health.
Prior to conducting the study all the necessary permissions needed to enter into the schools and universities, test and educate the youths were acquired.

Prior to the commencement of the classroom data collection, the class teacher was asked to leave the room to ensure student privacy and all students were asked to read through the consent forms placed on their desk in front of them and sign if they were willing to participate in the study. The students were then asked to separate their desks so that it was not possible for others to read their answers and place their school bags on the desk if they felt it would help ensure further privacy. Following this each student was reminded that there was no right or wrong answer and that the statements included in this questionnaire were to be answered according to their own personal opinion. Each student was then given a demographic questionnaire and GEM Scale stapled together. Participants were reminded not to write their names on the forms and were then told to start. Data collection took approximately 15-20 minutes by time all the forms were collected and filed.

Following data collection approximately 5 minutes were allocated for questions relating to the questionnaire and scale. A brief educational sexual health talk was provided to the class which lasted approximately 45 – 50 minutes with 5 extra minutes for questions. After the presentation and discussion links to approved youth sexual health education websites were provided and the slides, videos and quizzes from the presentation were given to the schools and universities for use with future classes.

All documents and presentation slides, quizzes and materials that were not available in the sample’s native language were translated by a bilingual translator and proof-read by another bilingual translator to ensure appropriate translation. All documents were pre-approved by the schools, universities, the Yantalo Foundation, and Lund University who were supervising the project. For each data collection an interpreter from a different region was provided. The interpreter was present to aid the researcher in data collection and the sexual health presentation, therefore, due to the sensitive nature of the study it was deemed important that the interpreter was not from the same district and did not know any of the students involved in the study.

Procedure Alterations. For the Argentinian and Irish data collection the method followed the description above, however, rather than using a pen and paper method each student was given access to a computer and was given a slip of paper with the link to the
survey and follow up sexual health talk online. This was also the case for the Swedish university student data collection.

The minimum age of participation for Irish students was raised to 17 due to the legal age of sexual consent in Ireland standing currently at 17, and the potential legal obligations for reporting underage sexual activity in Ireland.

Due to the previous research findings showing low levels of condom use among Swedish youth, all students both second and third level were asked to come up with suggestions on how to improve condom use among youth, suggestions can be found in appendix 7.

**Ethical Considerations**

This research followed all ethical guidelines for data collection involving school and university aged youth. The age group of students was adherent to the legal age of sexual consent in each country. Schools, teachers and students were all provided with information about the project prior to deciding upon participation. Schools and participants were required to consent to their participation in the research in order to continue with the study. Participants were made aware that they could withdraw from the study at any time and that all of their personal details will remain private and confidential. No other identifying details other than age, sex and nationality are reported to further ensure privacy. A full debrief and information on sexual health and the role of gender was provided to every group following their participation. The researcher also provided each participant with a contact detail for further information or questions on the study. Additionally, it is important to note that there is usually more diversity within a population than there is between populations (e.g., in terms of level of acculturation, age, education, health status, and attitudes), information in the following sections should not be treated as stereotypes to be broadly applied to any individual member of a cultural group.

**Results**

**Analysis**

Prior to analysis, data was screened for missing values and violation of assumptions with no serious violations identified. Internal consistency reliability analysis for the GEM scale showed to be reliable ($\alpha = .7$). The scale was scored so that a larger score was indicative of
more support for gender-equitable norms. Descriptive statistics and sexual health frequency statistics for each country are presented in Table 1, Appendix 5.

Firstly, regression analyses were conducted to test the suggestions made by Hofstede (1980, 1998) that the Masculinity/Femininity and Power Distance dimensions can predict the level of support a country’s sample will show for gender equitable norms. Secondly, regression analyses were generated to test Hofstede’s (2011) suggestion that the Indulgence/Restraint dimension can predict the relative sexual activity of each sample. Following the above analyses regression analyses were used to test whether level of support for gender equitable norms could predict sexual health indicator items such as STD contraction, reported unplanned pregnancy, and contraceptive use. In order to make country level suggestions, the third step was repeated within each country’s sample. Lastly, the potential influential factors acknowledged by previous researchers (sex, religion, education level, HDI), were tested.

**Hypothesis 1**

To test the predictions that Hofstede’s Masculinity/Femininity and Power Distance dimensions should predict level of support for gender equitable norms cross-culturally a simple multiple regression analysis was conducted with country as the dependent variable and the dimensions Mas/Fem and Power Distance as independent variables. The results of the analysis revealed that a significant proportion of the total variation, 17.4%, in GEM scale score was predicted by the model, $R^2 = .174$, $F(1, 537) = 112.84$, $p < .001$. However, Hofstede’s Power Distance dimension was the only good predictor of a country’s level of support for gender equitable norms, $\beta = -.418$, $t(538) = -10.61$, $p < .001$, with Mas/Fem showing no significant contribution, $\beta = .016$, $t(538) = .399$, $p = .690$.

**Hypothesis 2**

In order to assess the ability of Hofstede’s Indulgence/Restraint dimension to predict the level of sexual activity of the youth in our sample a binary logistic regression analysis was conducted. The results showed that Indulgence/Restraint was statistically significant, $\chi^2 (1, N = 538) = 18.32$, $p < .001$, indicating that the model could distinguish between respondents who were and were not sexually active. Indulgence/Restraint explained between 3.3% (Cox and Snell R square) and 4.6% (Nagelkerke R squared) of the variance in sexual activity, and correctly classified 63.4% of cases.
Hypothesis 3

The next hypothesis suggested that level of support for gender equitable norms as measured by the GEM scale should predict reported sexual health issues. To test this hypothesis a binary logistic regression analysis was conducted between GEM scale score and unplanned pregnancy. The results showed that GEM scale score was statistically significant, \( \chi^2 (1, N = 538) = 13.95, p < .001 \), indicating that the model was able to distinguish between respondents who did and did not report having previously had an unplanned pregnancy. GEM scale score explained between 4\% (Cox and Snell R squared) and 11.1\% (Nagelkerke R squared) of the variance in reported unplanned pregnancies, and correctly classified 94.7\% of cases. Similarly, the results of a second binary logistic regression analysis showed that GEM scale score was again statistically significant, \( \chi^2 (1, N = 538) = 5.66, p < .05 \), indicating that the model was able to distinguish between respondents who did and did not report having previously had an STD. GEM scale score explained between 1.6\% (Cox and Snell R square) and 4.2\% (Nagelkerke R squared) of the variance in reported STDs, and correctly classified 93.3\% of cases.

The above analysis was also conducted to statistically check the hypothesis that GEM scale score should predict contraceptive use. The results showed that GEM scale score was statistically significant, \( \chi^2 (1, N = 538) = 23.63, p < .001 \), indicating that the model was able to distinguish between respondents who did and did not report using any form of contraceptive. GEM scale score explained between 5.8\% (Cox and Snell R square) and 14.2\% (Nagelkerke R squared) of the variance in reported contraceptive use, and correctly classified 92.9\% of cases.

Country Level Analysis. In order to assess the above hypotheses within each country the data file was split by nationality and the above analyses were regenerated. To test the hypothesis that level of support for equitable gender norms should predict sexual health issues in each country a binary logistic regression analysis conducted firstly between GEM scale score and unplanned pregnancy, and secondly, between GEM scale score and STDs. The results showed that GEM scale score was statistically significant, \( \chi^2 (1, N = 91) = 7.31, p < .05 \), amongst the Peruvian sample, indicating that the model was able to distinguish between respondents who did and did not report having previously had an unplanned pregnancy. GEM scale score explained between 7.7\% (Cox and Snell R square) and 16.2\% (Nagelkerke R squared) of the variance in reported unplanned pregnancies, and correctly
classified 92.3% of cases. Similarly, GEM scale score was statistically significant, $\chi^2 (1, N = 119) = 8.56, p < .05$, amongst the Swedish sample and explained between 6.9% (Cox and Snell R square) and 19.2% (Nagelkerke R squared) of the variance in reported unplanned pregnancies, while correctly classifying 92.3% of cases.

Likewise, GEM scale score was again statistically significant, $\chi^2 (1, N = 91) = 6.62, p < .05$, amongst the Peruvian sample, indicating that the model could distinguish between respondents who did and did not report having previously had an STD. GEM scale score explained between 7% (Cox and Snell R square) and 18.2% (Nagelkerke R squared) of the variance in reported STDs, and correctly classified 93.4% of cases. GEM scale score was also statistically significant, $\chi^2 (1, N = 93) = 6.75, p < .05$, amongst the Irish sample and explained between 7% (Cox and Snell R square) and 37.3% (Nagelkerke R squared) of the variance in reported STDs, while correctly classifying 98.9% of cases.

This analysis was also conducted to investigate the suggestion that GEM scale score should predict contraceptive use in each country. The results showed that GEM scale score was statistically significant, $\chi^2 (1, N = 93) = 6.31, p < .05$, in the Irish sample only, indicating that the model could distinguish between respondents who did and did not report using any form of contraceptive. GEM scale score explained between 6.6% (Cox and Snell R square) and 22.0% (Nagelkerke R squared) of the variance in reported contraceptive use, and correctly classified 96.8% of cases.

Interestingly when investigating Spearman rho correlations between the GEM scale items and sexual health while controlling for the influence of participant sex, there were a number of factors that significantly related to reported previous sexual health issues, either unplanned pregnancy or STD contraction, and contraceptive use in each of the country samples (see Appendix 6).

**Additional Factors**

**Sex.** An independent-samples t-test was conducted to compare the GEM scores for males and females. It was identified that the differences identified in male and females responses on the GEM scale were mainly coming from Peru (Males: $M = 59.53, SD = 8.16$; Females: $M = 63.10, SD = 4.83$; $t (165) = -3.47, p < .05$, eta squared = -.08) and Sweden (Males: $M = 66.08, SD = 4.30$; Females: $M = 67.29, SD = 2.67$; $t (155) = -2.10, p < .05$, eta squared = -.03).
As above, in line with previous research recommendations, Chi-Square tests were conducted for each country’s sample to compare contraceptive use and sexual health issues for sexually active males and females. Firstly, no impact from sex was identified in any country sample on level of reported sexual health issues, i.e. STD contraction or unplanned pregnancy. However, when looking at condom use amongst Peruvian males and females, males showed more condom use than females, $\chi^2(1, N = 86) = 9.41, p < .05$. The same pattern is seen in the Peruvian sample regarding male and female contraceptive use other than condoms, $\chi^2(1, N = 86) = 5.29, p < .05$.

In the Argentinian sample there were no sex differences in condom use, however, females showed more contraceptive use other than condoms than males, $\chi^2(1, N = 38) = 9.91, p < .05$.

In the Irish sample males showed better condom use than females, $\chi^2(1, N = 91) = 6.62, p < .05$, however the reverse is true for alternative contraceptive use other than condoms whereby females showed significantly more alternative contraceptive use than males, $\chi^2(1, N = 91) = 4.79, p < .05$.

Similar to Argentina, Swedish males and females did not differ on condom use, however a significant difference was identified between males and females on contraceptive use other than condoms with females reporting more alternative contraceptive use than males, $\chi^2(1, N = 117) = 6.35, p < .05$.

**Religion.** As suggested by previous research a Spearman-Rho correlation analysis was conducted between religious importance and GEM scale score, unplanned pregnancy, STD contraction, and contraceptive use in each sample. A significant relationship was identified between religious importance and GEM scale score in Ireland only, $r = -.226, N = 150, p < .05$, with higher levels of religious importance indicating lower levels of support for gender equitable norms. However, religious importance did not relate to sexual health. Therefore, religious importance was not deemed a potential mediator between GEM score and sexual health.

**Education.** In considering the recommendations by previous studies, an independent-samples t-test was conducted to compare GEM scores for second and third level students. Results determined that the differences identified in second and third level students responses on the GEM scale were solely coming from Peru (Second level: $M = 59.61, SD = 6.82$; Third level: $M = 63.23, SD = 6.12$; $t(174) = -3.68, p < .05$, eta squared = .08).
**Human Development Index.** As was suggested by Inglehart and Norris (2003) a Pearson product moment correlation coefficient revealed a high, negative correlation between HDI and Hofstede’s Power Distance dimension, $r = -.997, N = 538, p < .001$, and a strong, positive relationship between HDI and Hofstede’s Indulgent/Restraint dimension, $r = .911, N = 538, p < .001$, showing that as countries move up on the HDI they also become more indulgent.

Unsurprisingly, the results of a simple linear regression analysis revealed that 17.1% of the total variation in GEM scale score was predicted by HDI, $R^2 = .171, F(1, 537) = 110.59, p < .001$. In other words, a country’s score on the human development index is also a good predictor of a country’s level of support for gender equitable norms, $\beta = .414, t(538) = 10.52, p < .001$. Additionally, HDI was significant predictor of sexual activity, $\chi^2 (1, N = 538) = 11.87, p < .05$. HDI explained between 2.2% (Cox and Snell R square) and 3% (Nagelkerke R squared) of the variance in sexual activity, and correctly classified 63.4% of cases.

Lastly, a one-way analysis of variance was conducted comparing the GEM scores for each country. The results revealed that only the Peruvian sample ($F(3, 174) = 42.66, p < .000$) was significantly different from the other samples on average GEM score (see Table 1, Appendix 5 for GEM score means and standard deviations by country).

**Discussion**

The present study aimed to identify the validity of Hofstede’s cultural dimensions, Masculinity/Femininity, Power Distance, and Indulgence/Restraint in predicting the gender role attitudes and sexual activity of youth in Peru, Argentina, Ireland and Sweden. In turn, the current study aimed to examine the relationship between sexual health and gender role attitudes with the overall goal of creating culturally and gender sensitive, sexual health education suggestions for youth in Peru, Argentina, Ireland and Sweden.

**Culture/Gender/Sex – What is the Link?**

As mentioned previously, Pearson (2006) discussed how culturally formed normative ideas about appropriate gender roles in youth sexual health may in turn impact the ability for young men and women to discuss sex and safe sexual behaviour. She explained that these gendered sexual norms can affect the power distribution in a relationship increasing the
difficulty for young women to express their opinions in relation to contraception, family planning, and general household duty division. Thus placing both members of the relationship at risk of HIV/STD contraction, intimate partner violence and unplanned pregnancy (Pearson, 2006). Therefore, it is not only important to investigate the impact of gender norms on sexual health, but also the relationship between culture and those gender norms which impact sexual health.

Returning to Hofstede’s (1998) dimensions, Masculinity/Femininity refers to the dominant sex role pattern in a society, focusing predominantly on the role of men, in both traditional and modern cultures (Hofstede, 1998). In line with this suggestion, Hofstede (1998) stated that in a Masculine society men should dominate in all settings and women should hold a weaker, less powerful position in the family. Alternatively, on the opposite side of this dimension, feminine societies should show more equal power division between males and females (Hofstede, 1998). The results of this study support the findings of Gibbons, Stiles, and Shkodriani (1991) in that despite using a gender power related scale (GEM scale), the Masculinity/Femininity dimension was not a predictor of support for gender equitable norms. In fact, Peru which is ranked as a Feminine society by Hofstede (1980) showed to be the least supportive of gender equitable norms, whereas Ireland which is ranked as the most Masculine society in our study demonstrated the most support for gender equitable norms. Considering this outcome, it is worth considering the criticisms of the Mas/Fem dimension. Arrindell, Kolk, Pickersgill, and Hageman (1993) argues that the validity of Hofstede’s Mas/Fem dimension relies on the idea of the bipolarity of masculine and feminine roles, however, as has been repeatedly shown by older and modern research (Ballard-Reisch & Elton, 1992; Bem, 1981; Heilbrun, 1976; Marsh, 1985; Ridgeway & Smith-Lovin, 1999) men and women’s roles cannot be so strictly dichotomized. As argued by Ballard-Reisch and Elton (1992), research has long acknowledged the existence of the androgyny of the sexes and in turn gender roles, therefore to state that a country or culture can be either Masculine or Feminine requires an in depth explanation of the interaction of each of the cultural traits Masculinity and Femininity and a more comprehensive description of this dimension. This is not an argument unknown to Hofstede, in response to this critique Hofstede suggests that as shown by de Mooij (1998) his dimension Power Distance may be a more reliable predictor of cultural gender norms and attitudes.

As suggested, this study found that Hofstede’s (1980) cultural dimension Power Distance did predict the relative gender role attitudes of a country. Hofstede (1980) explains
that a country’s position on the Power Distance dimension reflects whether the population are socialized to be more accepting of, or reject societal power inequalities. Accepting power inequalities, according to Hofstede (1998), makes it more likely that a population will also be socialized to accept power inequalities between the sexes. Accepting power inequalities between the sexes can then impact the power distribution one experiences and expects within a sexual relationship, which may in turn leave one more vulnerable to sexual health issues such as STDs and unplanned pregnancy (Pearson, 2006). This pattern was supported by this research study, whereby Power Distance predicted a country sample’s level of support for gender equitable norms, and, in turn, level of support for gender equitable norms predicted sexual health elements such as unplanned pregnancy, STD’s and contraceptive use. More specifically, this study’s findings complimented the findings of Deardorff et al., (2013), Boer and Mashamba (2007), the WHO (2004), and Paiva (1993) in that those who had less support for equitable gender norms showed higher levels of STD contraction and unplanned pregnancy, and were more likely to report not using any contraceptive method despite being sexually active. Therefore the author suggests that identifying a link between Hofstede’s (1980) Power Distance dimension and gendered sexual roles is important in order to provide youth sexual health educators with a reliable tool for estimating the relative position of males and females within a sexual relationship cross-culturally, and in turn could help predict the relative sexual health of the youth in their sample. This could allow for the appropriate tailoring of sexual health education programs to incorporate the cultural role of gender with more accuracy than Hofstede’s (1998) Mas/Fem dimension or as demonstrated by this study the human development index. As suggested by Inglehart and Norris (2003) human development index was a predictor of support for equitable gender norms cross-culturally, however, it showed to be a weaker predictor than Hofstede’s (1980) Power Distance.

Additionally, Hofstede’s (2011) dimension Indulgence/Restraint showed to predict the level of sexual activity cross-culturally. This was also stated by Alon (2012) who compared Hofstede’s Indulgence/Restraint dimension to Gelfand, Nishii, and Raver’s (2006) cultural value “Tight vs Loose”. Both Alon and Hofstede argue that more indulgent societies such as Sweden, Argentina and Ireland, according to Hofstede’s ratings allow relatively free gratification of basic human needs and desires to do with leisure, friendships, consumption and sex, whereas, more restrictive societies such as Peru, aim to curb and regulate such gratification through strict societal norms. Therefore given that Sweden, Ireland, and Argentina are all placed on the indulgence side of Hofstede’s bipolar dimension, as expected
these three student samples did indeed show to be more sexually active than the more restrained cultural sample from Peru. Accordingly, this dimension could serve as a reference providing information to youth sexual health educators and healthcare providers on the importance of contraceptive and sexual health education availability and access cross-culturally.

**Country Level Findings**

However, while in the overall analysis, support for equitable gender norms predicts unplanned pregnancy, STD contraction, and contraceptive use, with evident sex differences, country level analyses in this study provided more specific information regarding the factors related to unplanned pregnancy, STD contraction and contraceptive use in Peru, Argentina, Ireland and Sweden.

**Peru.** When designing sexual education for youth in Peru, the results of this study encourage educators to consider a number of factors. Firstly, it was discovered that participants who were more accepting of intimate partner violence against women, less supportive of women suggesting or carrying condoms, and less supportive of couple’s joint contraceptive and reproductive decision making reported more unplanned pregnancies and STDs. In addition to these factors, support for the idea that it is a woman’s responsibility to avoid pregnancy, and that a child is not the responsibility of both the mother and father relate to non-use of any contraceptive methods in those who are sexually active.

Other important factors to consider include the difference between males and females. Among sexually active students, females showed more support for equitable gender norms, however, males reported more condom and contraceptive use than females. The reasoning for less contraceptive use in females was not assessed in this study, however, previous research (Kost, 1993) has shown that Peruvian women are skeptical of hormonal contraceptive methods, fearing that contraceptives such as the pill may lead to infertility or birth defects. As a result, Kost (1993) reported that Peruvian women commonly use the rhythm or calendar method. This method is non-hormonal and involves periodic abstinence during the most fertile period of a woman’s reproductive cycle, women identify their ovulation stage by noting changes in basal body temperature and inspecting vaginal mucous excretion (CDC, 2011). While this method avoids the use of hormones, according to the Centre for Disease Control (CDC, 2011) the rhythm method is one of the least reliable methods of birth control with approximately 28% of women who employ this method experiencing an unplanned
pregnancy. Furthermore, this method does not protect against the contraction of STDs (CDC, 2011).

As a result of the factors outlined above, this study recommends that youth sexual health education in Peru should include the importance of equal power division in sexual relationships regarding contraceptive decision making and responsibility, strongly discourage violence within relationships, provide tools for women to learn how to acknowledge and deal with a violent relationship, further investigate the factors which contribute to women’s non-use of contraception, and encourage all students to acquire further education past second level.

**Argentina.** Unlike the Peruvian sample, there was no significant relationship between level of support for equitable gender norms and sexual health in the Argentinian sample. However, when looking at correlations between the GEM scale items and contraceptive use, the results revealed that those who are sexually active but do not use contraception in the Argentinian sample were more likely to believe that a woman is “easy” if she carries condoms, that men need other women even if their relationship with their partner is fine, and that men should hold the authority in relation to sex and home-based decisions.

In light of the above findings, this study suggests that youth sexual education in Argentina should strive to include the importance of male and female condom use with any sexual partner. Additionally, the educational program should address gendered sexual power division and overall relationship power division highlighting the importance of an equal distribution of power within a relationship.

**Ireland.** Interestingly, in the Irish population sample unplanned pregnancy related to the ability for women to suggest the use of condoms, indicating that youth sexual health education in Ireland should address joint contraception decision making and aim to reduce the negative stigma related to women suggesting condoms. In relation to STDs the factors which related most to STD contraction were intimate partner violence items and the idea that a child is not the responsibility of both parents, thus it should be advised that sexual health educators in Ireland should strive to educate youth on what constitutes a healthy and unhealthy sexual relationship. Non-use of contraceptives related to more agreement with the idea that men are the decision makers, intimate partner violence items, and disagreement with the idea that it is important for the father to be present in the lives of his children regardless of relationship status with the child’s mother. Additionally, among this sample of Irish youth
males reported more condom use than females. As above, this study further emphasizes the need to address the issue of healthy and unhealthy sexual relationships among Irish youth as well as emphasizing the importance of condom use by both males and females in order to prevent STD contraction.

**Sweden.** Among the Swedish youths included in this sample, unplanned pregnancy correlated with more agreement for the idea that men are the decision makers, that you do not talk about sex you just have sex, and intimate partner violence related items. Similarly, non-use of contraception correlated with the statements implying that men need other women even if their relationship with their partner is fine, and that it is a woman’s responsibility to avoid pregnancy and men and women should not necessarily decide together about contraception or children. The above variable relationships indicate that sexual health education for youth in Sweden should include information regarding joint contraceptive decision making, encourage youth to talk more openly about sex with their sexual partners and discuss what constitutes a healthy and unhealthy relationship. These suggestions are in line with the previous suggestions made by Ekstrand, Tydén, Darj, and Larsson (2007) who also discovered the attitude among youth that women have more responsibility to use contraception than men.

Additionally, despite there being no sex differences in condom use, as stated earlier, the Swedish sample showed a very low percentage of condom use. In light of these findings it is suggested that sexual health education programs should put more emphasis on the health outcomes of STDs and the importance of condom use. For student suggestions on how to improve condom use among youth please see Appendix 7.

Unsurprisingly, as was previously found by Fennell (2011), Darroch (2000), and Grady, Tanfer, Billy, and Lincoln-Hanson (1996), gender related contraceptive use responsibility was a factor present in each of the samples in this study. However, surprisingly, intimate partner violence items related to youth sexual health in Peru, Ireland, and Sweden. The extent of the problem of intimate partner violence was recently brought to light by the European Union Agency for Fundamental Rights (FRA, 2014), in which each country included in this study showed to have significant problems with physical, psychological and sexual partner violence. The results of this study, the recent findings by the FRA (2014) and the findings of May-Cripe et al., (2008), highlight the need to address the
issue of intimate partner violence, power division in heterosexual relationships, and healthy and unhealthy relationships in youth cross-culturally.

**Limitations and Future Research Suggestions**

The results of the present study should be interpreted carefully taking into consideration the potential limitations. The data collected for this study are based on perceptions about the behaviors and responsibilities of men and women mainly with regards to relationship power division and sex; participant's responses therefore reflect ideology more so than actual behaviors or the actual division of power in their own relationships. Thus, for example, while about 28.5% of the participants indicated that they at least partially agree with the idea that one does not talk about sex just does it, it cannot be assumed that these participants never talk about sex before engaging in sexual intercourse. However, as stated previously by Grady, Tanfer, Billy, and Lincoln-Hanson (1996), and in accordance with Ajzen’s (2011) theory of planned behaviour, it is likely that the attitudes expressed by the participants in this study are influenced by and in turn influence their own behaviour.

Secondly, the scale used in this study mainly assesses gendered power division relating to relationships and sex, therefore, limiting the ability to assess the relevance of Hofstede’s cultural dimensions Mas/Fem and Power Distance to more general aspects of gender norm attitudes. Moreover, given that this study included only four of Hofstede’s tested countries, two on the Femininity side and two on the Masculinity side, it cannot be concluded that Hofstede’s Masculinity/Femininity dimension would not have related to gender norm attitudes in a larger sample of countries.

Additionally, due to sensitivity requests from the schools in Peru to avoid questions regarding student sexual orientation and casual sex, and in order to keep variable consistency, no student was asked to report their sexual orientation or level of casual sex in this study. This may impact the reported level of contraceptive use and responses on the GEM scale, therefore if possible it is advised that future studies should include participant sexual orientation and casual sex items.

Finally, the sample sizes collected for each country, particularly Argentina, are not large enough to be representative of the general trends in youth sexual health attitudes and behaviours in each country, therefore generalization of the results is not advised. However, that being said, the results of this study still provide valuable information regarding youth sexual and reproductive health cross-culturally.
In light of the results and limitations of this study the present author recommends that further research should be conducted into the area of gender power division in youth’s relationships assessing how this impacts youth sexual health cross-culturally including intimate partner violence. It is also recommended that future studies should aim to use a mixed method qualitative-quantitative design in order to attempt to understand the extent to which youth attitudes reflect their actual relationship behaviours.

In conclusion, the results found by this study have added to our knowledge base regarding how culture relates to relationship gender norm formation, how those gender norms in turn impact how youth perceive their roles and responsibilities in a sexual relationship, and the outcome these perceptions may have on their own sexual health. With further research Hofstede’s cultural dimensions theory may indeed show to be a reliable indicator of youth sexual activity and gender norms cross-culturally, thus greatly benefiting the field of sexual health education and intervention design.
References


Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S.L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care, 14*(6), 789-800.


Appendix 1: Participant Information Sheet

Dear Sir/Madam,

My name is Christine Lehane. I am presently completing my master’s degree in psychology with Lund University in Sweden. In order to fulfil this degree I am carrying out a cross-cultural research project in the area of youth sexual health. My study includes students in second and third level education between the age of 16 and 21 years. Students will be asked questions related to their sexual health and gender role attitudes. Participation is voluntary, you can cease to continue the study at any time and no participant will be asked for their reason for discontinuing with the study.

The study is completely anonymous. You will not be asked at any point for your name or any clearly identifiable information. Responses will not be used for any other purpose other than academic research.

Following completion of the study all participants will be debriefed in relation to the overall purpose of the study. All participants will be presented with a sexual health talk following the study with time to ask questions and discuss any issues students may have in relation to the topics brought up during the study. Contact details will be provided to those who request more information or information on the study outcome.

I would greatly appreciate your participation in this study and our step towards providing more information on youth sexual health cross-culturally. The research study is an independent research project conducted under the supervision of Dr. Una Tellhed at Lund University, Sweden. Please feel free to contact me should you have any questions.

Kind regards,

Christine M. Lehane
Psychology department, Lund University.
Appendix 2: Consent Form

Department of Psychology

In agreeing to participate in this research I understand the following:

This research project is being conducted by Christine Lehane, postgraduate master’s student at the department of psychology, Lund University, Sweden.

The method proposed for this research project has been approved in principle by the psychology department, which means that the department does not have any concerns about the research procedure as have been detailed by the student. It is, however, the above named students responsibility to adhere to ethical guidelines in their dealings with participants and the collection and handling of data. If I have any concerns regarding my participation I understand that I may refuse to participate or withdraw at any stage.

I have been informed that the study focuses on youth sexual health and gender role attitudes and I agree to voluntarily participate.

All data from the study will be treated confidentially, no names will be recorded in this project. The data from all the participants will be compiled in a report and submitted to the psychology department in the form of a master’s thesis.

At the conclusion of my participation any concerns or questions I may have will be addressed, please tick a box in agreement or disagreement.

I understand the conditions detailed above and I agree to participate: □

I understand the conditions detailed above but I do not agree to participate: □

Thank you.
Appendix 3: Demographic Questionnaire

Age: __________

Sex: Male □ Female □

**Education Level:** Second level □ Third level □ Other □

**Religious Affiliation:** _________________

**Religious Importance (For me religion is):**

- Not important □
- Little importance □
- Somewhat important □
- Very important □

**Employed (part-time or full-time):** Yes □ No □

**Is your father currently employed outside the home?** Yes □ No □

**Is your mother currently employed outside the home?** Yes □ No □

**Have you ever had sexual intercourse / Are you sexually active?** Yes □ No □

**Do you have any children?** Yes □ No □

**Have you ever had an unplanned pregnancy?** Yes □ No □

**Have you ever had a sexually transmitted infection?** Yes □ No □

**Do you use condoms when having sex?** Yes □ No □

**Do you use another form of contraception other than condoms when having sex?**

Yes □ No □
Appendix 4: GEM Scale

Please choose only one answer option per statement:

1. It is the man who decides what type of sex to have.
   - Agree □
   - Partially Agree □
   - Disagree □

2. A woman’s most important role is to take care of her home and cook for her family.
   - Agree □
   - Partially Agree □
   - Disagree □

3. Men need sex more than women do.
   - Agree □
   - Partially Agree □
   - Disagree □

4. You don’t talk about sex, you just do it.
   - Agree □
   - Partially Agree □
   - Disagree □

5. Women who carry condoms on them are “easy”.
   - Agree □
   - Partially Agree □
   - Disagree □

6. Changing diapers, giving the kids a bath, and feeding the kids are the mother’s responsibility.
   - Agree □
   - Partially Agree □
   - Disagree □

7. It is a woman’s responsibility to avoid getting pregnant.
   - Agree □
   - Partially Agree □
   - Disagree □
8. A man should have the final word about decisions in his home.
   Agree □
   Partially Agree □
   Disagree □

9. Men are always ready to have sex.
   Agree □
   Partially Agree □
   Disagree □

10. There are times when a woman deserves to be beaten.
    Agree □
    Partially Agree □
    Disagree □

11. A man needs other women, even if things with his partner are fine.
    Agree □
    Partially Agree □
    Disagree □

12. If someone insults me, I will defend my reputation, with force if I have to.
    Agree □
    Partially Agree □
    Disagree □

13. A woman should tolerate violence in order to keep her family together.
    Agree □
    Partially Agree □
    Disagree □

14. I would be outraged if my partner asked me to use a condom.
    Agree □
    Partially Agree □
    Disagree □

15. It is okay for a man to hit his partner if she won’t have sex with him.
    Agree □
    Partially Agree □
    Disagree □
16. I would never have a gay friend.
   Agree □
   Partially Agree □
   Disagree □

17. It disgusts me when I see a man acting like a woman.
   Agree □
   Partially Agree □
   Disagree □

18. A couple should decide together if they want to have children.
   Agree □
   Partially Agree □
   Disagree □

19. In my opinion, a woman can suggest using condoms just like a man can.
   Agree □
   Partially Agree □
   Disagree □

20. If a guy gets a woman pregnant, the child is the responsibility of both.
   Agree □
   Partially Agree □
   Disagree □

21. A man should know what his partner likes during sex.
   Agree □
   Partially Agree □
   Disagree □

22. It is important that a father is present in the lives of his children, even if he is no longer with the mother.
   Agree □
   Partially Agree □
   Disagree □

23. A man and a woman should decide together what type of contraceptive to use.
   Agree □
   Partially Agree □
Disagree □

24. It is important for men to have a friend with whom they can discuss their problems.

Agree □

Partially Agree □

Disagree □
Appendix 5: Tables & Figures

Table 1

Demographic data for each sample

<table>
<thead>
<tr>
<th></th>
<th>Peru</th>
<th>Argentina</th>
<th>Ireland</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>174</td>
<td>56</td>
<td>150</td>
<td>158</td>
</tr>
<tr>
<td>Sex %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>46.7</td>
<td>37.5</td>
<td>51.4</td>
<td>51</td>
</tr>
<tr>
<td>Female</td>
<td>53.3</td>
<td>62.5</td>
<td>48.6</td>
<td>47.8</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>17.6</td>
<td>18.8</td>
<td>18.4</td>
<td>19</td>
</tr>
<tr>
<td>SD</td>
<td>1.39</td>
<td>1.7</td>
<td>1.35</td>
<td>1.5</td>
</tr>
<tr>
<td>Education level %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second level</td>
<td>50</td>
<td>41.1</td>
<td>58.7</td>
<td>74.7</td>
</tr>
<tr>
<td>Third level</td>
<td>50</td>
<td>58.9</td>
<td>41.3</td>
<td>25.3</td>
</tr>
<tr>
<td>Religion %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not important</td>
<td>1.2</td>
<td>26.8</td>
<td>49.3</td>
<td>63.3</td>
</tr>
<tr>
<td>Little importance</td>
<td>8.1</td>
<td>32.1</td>
<td>17.3</td>
<td>27.2</td>
</tr>
<tr>
<td>Somewhat</td>
<td>19.8</td>
<td>19.6</td>
<td>26.7</td>
<td>5.1</td>
</tr>
<tr>
<td>Very important</td>
<td>70.9</td>
<td>21.4</td>
<td>6.7</td>
<td>4.4</td>
</tr>
<tr>
<td>Sexually active %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>52.3</td>
<td>67.9</td>
<td>62</td>
<td>75.3</td>
</tr>
<tr>
<td>Sexual health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>among sexually active %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD</td>
<td>6.6</td>
<td>5.3</td>
<td>2.2</td>
<td>10.9</td>
</tr>
<tr>
<td>Unplanned</td>
<td>9.9</td>
<td>2.6</td>
<td>3.2</td>
<td>5.9</td>
</tr>
<tr>
<td>pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td>71.4</td>
<td>86.8</td>
<td>81.7</td>
<td>44.5</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>74.7</td>
<td>57.9</td>
<td>48.4</td>
<td>75.6</td>
</tr>
<tr>
<td>Non-use of any contraceptive method</td>
<td>24.2</td>
<td>2.6</td>
<td>4.3</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Peru</td>
<td>Argentina</td>
<td>Ireland</td>
<td>Sweden</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>-----------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>61.42</td>
<td>66.34</td>
<td>66.91</td>
<td>66.66</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>6.72</td>
<td>4.11</td>
<td>4.49</td>
<td>3.64</td>
</tr>
<tr>
<td>Mas/Fem</td>
<td>42</td>
<td>56</td>
<td>68</td>
<td>5</td>
</tr>
<tr>
<td>Power Distance</td>
<td>64</td>
<td>49</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>Indulgence/Restraint</td>
<td>46</td>
<td>62</td>
<td>65</td>
<td>78</td>
</tr>
<tr>
<td><strong>HDI</strong></td>
<td>.741</td>
<td>.811</td>
<td>.916</td>
<td>.916</td>
</tr>
</tbody>
</table>

**Figure 1.** Peru, Argentina, Ireland & Sweden along the Mas/Fem & Power Distance Dimensions.
Table 2
*Population Reference Bureau (2013) Youth Sexual Health Statistics*

<table>
<thead>
<tr>
<th>% Women 20-24 years married by:</th>
<th>Peru</th>
<th>Argentina</th>
<th>Ireland</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age 18</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Births per 1000 women aged 15-19</td>
<td>48</td>
<td>54</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>% Women using contraception</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 yrs</td>
<td>44</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>57</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>% Knowledge of HIV/AIDS in 15-24 yr olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>% HIV/AIDS prevalence 15-24 yr olds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Female</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>% Women 15-24 yrs agree/agree partially with IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Appendix 6: GEM Item – Sexual Health Correlations

Table 3

*Peruvian - Spearman Rho GEM Item – Unplanned Pregnancy Correlations Controlling for Sex*

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Pregnancy Q10. There are times when a woman deserves to be beaten.</td>
<td>.222</td>
<td>.035</td>
<td>91</td>
</tr>
<tr>
<td>Unplanned Pregnancy Q23. A man and a woman should decide together what kind of contraception to use.</td>
<td>-.214</td>
<td>.042</td>
<td>91</td>
</tr>
<tr>
<td>Unplanned Pregnancy Q20. If a guy gets a woman pregnant, the child is the responsibility of both.</td>
<td>-.228</td>
<td>.030</td>
<td>91</td>
</tr>
<tr>
<td>Unplanned Pregnancy Q19. In my opinion, a woman can suggest using condoms just like a man can.</td>
<td>-.264</td>
<td>.011</td>
<td>91</td>
</tr>
<tr>
<td>Unplanned Pregnancy Q18. A couple should decide together if they want to have children.</td>
<td>-.242</td>
<td>.021</td>
<td>91</td>
</tr>
<tr>
<td>Unplanned Pregnancy Q15. It is okay for a man to hit his partner if she won't have sex with him.</td>
<td>.300</td>
<td>.004</td>
<td>91</td>
</tr>
<tr>
<td>GEM Scale Item</td>
<td>Correlation</td>
<td>Sig. (2-tailed)</td>
<td>N</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------</td>
<td>----</td>
</tr>
<tr>
<td>Q23. A man and a woman should decide together what kind of contraception to use.</td>
<td>-.426</td>
<td>.000</td>
<td>91</td>
</tr>
<tr>
<td>Q20. If a guy gets a woman pregnant, the child is the responsibility of both.</td>
<td>-.422</td>
<td>.000</td>
<td>91</td>
</tr>
<tr>
<td>Q19. In my opinion, a woman can suggest using condoms just like a man can.</td>
<td>-.264</td>
<td>.011</td>
<td>91</td>
</tr>
<tr>
<td>Q18. A couple should decide together if they want to have children.</td>
<td>-.583</td>
<td>.000</td>
<td>91</td>
</tr>
<tr>
<td>Q15. It is okay for a man to hit his partner if she won't have sex with him.</td>
<td>.388</td>
<td>.000</td>
<td>91</td>
</tr>
</tbody>
</table>
Table 5

*Peruvian Spearman Rho GEM Item - Contraceptive Use Correlations controlling for sex*

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Use Q7. It is a woman’s responsibility to avoid getting pregnant.</td>
<td>-.310</td>
<td>.003</td>
<td>91</td>
</tr>
<tr>
<td>Contraceptive Use Q10. There are times when a woman deserves to be beaten.</td>
<td>-.230</td>
<td>.029</td>
<td>91</td>
</tr>
<tr>
<td>Contraceptive Use Q18. A couple should decide together if they want to have children.</td>
<td>.345</td>
<td>.001</td>
<td>91</td>
</tr>
<tr>
<td>Contraceptive Use Q20. If a guy gets a woman pregnant, the child is the responsibility of both.</td>
<td>.257</td>
<td>.014</td>
<td>91</td>
</tr>
<tr>
<td>Contraceptive Use Q19. In my opinion, a woman can suggest using condoms just like a man can.</td>
<td>.282</td>
<td>.007</td>
<td>91</td>
</tr>
</tbody>
</table>
### Table 6

**Argentinian Spearman Rho GEM Item - Contraceptive Use Correlations controlling for sex**

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Use</td>
<td>Q1. It is the man who decides what type of sex to have.</td>
<td>-.422</td>
<td>.008</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q5. Women who carry condoms on them are “easy”.</td>
<td>-.521</td>
<td>.001</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q8. A man should have the final word about decisions in his home.</td>
<td>-.577</td>
<td>.000</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q11. A man needs other women, even if things with his partner are fine.</td>
<td>-.465</td>
<td>.003</td>
</tr>
</tbody>
</table>

### Table 7

**Irish - Spearman Rho GEM Item – Unplanned Pregnancy Correlations Controlling for Sex**

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned pregnancy</td>
<td>Q19. In my opinion, a woman can suggest using condoms just like a man can.</td>
<td>-.318</td>
<td>.002</td>
</tr>
</tbody>
</table>
Table 8

Irish - Spearman Rho GEM Item - STD Correlations Controlling for Sex

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>STDs Q20. If a guy gets a woman pregnant, the child is the responsibility of both.</td>
<td>-.293</td>
<td>.004</td>
<td>93</td>
</tr>
<tr>
<td>STDs Q10. There are times when a woman deserves to be beaten.</td>
<td>.703</td>
<td>.000</td>
<td>93</td>
</tr>
<tr>
<td>STDs Q13. A woman should tolerate violence in order to keep her family together.</td>
<td>.816</td>
<td>.000</td>
<td>93</td>
</tr>
<tr>
<td>STDs Q15. It is okay for a man to hit his partner if she won't have sex with him.</td>
<td>.703</td>
<td>.000</td>
<td>93</td>
</tr>
</tbody>
</table>
Table 9

*Irish - Spearman Rho GEM Item - Contraceptive Use Correlations Controlling for Sex*

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Use</td>
<td>Q8. A man should have the final word about decisions in his home.</td>
<td>-.226</td>
<td>.010</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q10. There are times when a woman deserves to be beaten.</td>
<td>-.492</td>
<td>.000</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q13. A woman should tolerate violence in order to keep her family together.</td>
<td>-.268</td>
<td>.009</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q15. It is okay for a man to hit his partner if she won't have sex with him.</td>
<td>-.492</td>
<td>.000</td>
</tr>
<tr>
<td>Contraceptive Use</td>
<td>Q22. It is important that a father is present in the lives of his children, even if he is no longer with the mother.</td>
<td>.215</td>
<td>.039</td>
</tr>
</tbody>
</table>
Table 10

*Swedish - Spearman Rho GEM Item – Unplanned Pregnancy Correlations Controlling for Sex*

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned pregnancy</td>
<td>Q1. It is the man who decides what type of sex to have.</td>
<td>.236</td>
<td>.010</td>
</tr>
<tr>
<td>Unplanned pregnancy</td>
<td>Q4. You don’t talk about sex, you just do it.</td>
<td>.329</td>
<td>.000</td>
</tr>
<tr>
<td>Unplanned pregnancy</td>
<td>Q8. A man should have the final word about decisions in his home.</td>
<td>.207</td>
<td>.024</td>
</tr>
<tr>
<td>Unplanned pregnancy</td>
<td>Q13. A woman should tolerate violence in order to keep her family together.</td>
<td>.188</td>
<td>.041</td>
</tr>
</tbody>
</table>
Table 11

*Swedish - Spearman Rho GEM Item - Contraceptive Use Correlations Controlling for Sex*

<table>
<thead>
<tr>
<th>GEM Scale Item</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Use Q7. It is a woman’s responsibility to avoid getting pregnant.</td>
<td>-.186</td>
<td>.043</td>
<td>119</td>
</tr>
<tr>
<td>Contraceptive Use Q11. A man needs other women, even if things with his partner are fine.</td>
<td>-.402</td>
<td>.000</td>
<td>119</td>
</tr>
<tr>
<td>Contraceptive Use Q23. A man and a woman should decide together what kind of contraception to use.</td>
<td>.192</td>
<td>.037</td>
<td>119</td>
</tr>
<tr>
<td>Contraceptive Use Q18. A couple should decide together if they want to have children.</td>
<td>.264</td>
<td>.004</td>
<td>119</td>
</tr>
</tbody>
</table>
Appendix 7: Student’s Condom Use Suggestions

Suggestions made by students in this study to improve condom use among youth are listed below in order of frequency from the most commonly made suggestions to least common.

1. The introduction of regular, detailed, sexual health education in schools including information on each type of STD, statistics on its frequency in the population and the symptoms shown by STDs.
2. Condoms should be made cheaper or even supplied for free to youth.
3. Make condoms more accessible, provide condoms to students in schools.
4. Introduce sexual health education to primary schools.
5. Redesign condoms to improve quality.
6. Use media campaigns to encourage the use of condoms, we need to build the association between sex and condoms so that when youth think of sex, they immediately think of condoms, sex = condom.
7. Bring in young people who are HIV positive to talk to students in schools.
8. Change society, make it normal for girls to carry condoms in their bags.
9. Introduce “condom vending machines” into nightclubs or have bar staff offer a free condom when someone buys a drink.
10. Change the scene surrounding sex, make sex less embarrassing, easier to talk about, in schools, via the media etc.
11. Introduce the use of condoms in mainstream films featuring sex scenes.
12. Change the name of condoms, the name condom has developed negative associations.
14. Encourage young men to take equal responsibility for contraceptive use.
15. Send home sexual health information to parents and children once a child has reached the age of sexual consent either from the school, medical clinics, or a national project.