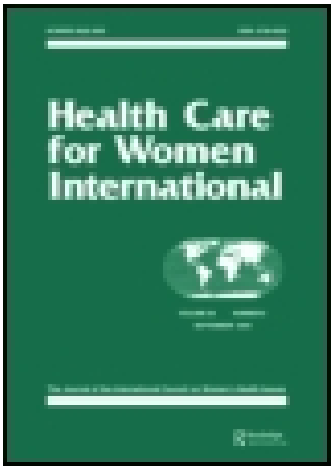

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Religiosity and Sexuality: Experiences of Brazilian Catholic Women

Luiza Akiko Komura Hoga [a], Cristiane Alves Tibúrcio [a], Ana Luiza Vilela Borges [b] & Luciana Magnoni Reberte [a]

[a] Department of Maternal and Child Nursing, School of Nursing, University of São Paulo, São Paulo, Brazil

[b] Department of Collective Health Nursing, School of Nursing, University of São Paulo, São Paulo, Brazil

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Religiosity and Sexuality: Experiences of Brazilian Catholic Women

LUIZA AKIKO KOMURA HOGA and CRISTIANE ALVES TIBÚRCIO

Department of Maternal and Child Nursing, School of Nursing, University of São Paulo, São Paulo, Brazil

ANA LUIZA VILELA BORGES

Department of Collective Health Nursing, School of Nursing, University of São Paulo, São Paulo, Brazil

LUCIANA MAGNONI REBERTE

Department of Maternal and Child Nursing, School of Nursing, University of São Paulo, São Paulo, Brazil

The purpose of this study was to describe the experiences of a group of Catholic women related to the orientations received from priests and parents and their influence on sexual attitudes. The oral history method was used to interview 17 Catholic women. Three categories summarize women's experiences: orientations about sexuality received from priests; lack of orientation or existence of open dialogue about sexuality: distinct experiences in the family context; adherence or repudiation; and distinct attitudes toward orientations received. Health professionals systematically should seek knowledge about women's religious principles, because this is essential for meaningful and ethical health care.

In this investigation, we focus on the experiences of a group of Catholic women related to the orientations received from priests and parents and how these influence their sexual attitudes. The Catholic Church has disseminated principles for sexual and reproductive behavior across history and around

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Address correspondence to Luiza Akiko Komura Hoga, PhD, Department of Maternal and Child Nursing, School of Nursing, University of São Paulo, Av. r. Eneas de Carvalho Aguiar 419, São Paulo 05403-000, Brazil. E-mail: kikatuca@usp.br

the world. We believe the research findings presented here are of interest to an international audience, so as to learn how these global principles have affected women in the Brazilian context. Knowledge of this issue can further the delivery of ethical and meaningful health care, according to women and their families' beliefs and values.

Studies on religiosity and its relationship with sexual attitudes are important to clarify factors involved and differences according to cultural background. Knowledge about these factors can enhance health professionals' capacity to deliver culturally specific and congruent care (Purnell, 2002).

Our focus on the relationships between orientations Catholic women received and their sexual attitudes was based on some premises. Adolescents and young adults around the world consider the church as the most important institution (United Nations, 2002), and the strongest predictor of sexual attitudes is religious behavior (Lefkowitz, Gillen, Shearer, & Boone, 2004). Religious institutions play a fundamental role in the construction and realignment of identities (Montero, 1995).

Religiosity, a comprehensive concept that includes the capacity to live a religious experience, mobilizes force and interferes in the sexual attitudes of human beings (Baier & Wampler, 2008; Kridli & Libbus, 2001). Researchers have observed associations between sexual attitudes and participation in religious services, adherence and importance attributed to religion, and fear of religious sanctions among Catholic and Protestant university students (Lefkowitz et al., 2004). On the other hand, no such associations were found between religious and sexual attitudes among Australian adults (Visser, Smith, Richters, & Rissel, 2007). This reveals that the relationships between religiosity and sexual behaviors are permeated by controversies.

Health care professionals are not paying due attention to religiosity as an important aspect of well-being (Astedt-Kurki, 1995). Meaningful health care according to women's perspective requires knowledge of their religious beliefs and values (Baier & Wampler, 2008; Kridli & Libbus, 2001; Lefkowitz et al., 2004).

Considering the importance of ethical and culturally congruent health care, this research was done to describe the experiences of a group of Catholic women related to the orientations received from priests and parents and how these influenced their sexual attitudes.

LITERATURE REVIEW

Successive popes expressed the conservative position of the Roman Catholic Church, which approves sexual abstinence and the rhythm method as the only forms of contraception, in two pastoral letters (Humanae Vitae, 1968). Based on the principle that human life begins at the moment the egg is fertilized, this church opposes abortion (Cross & Livingstone, 1997). Catholic

teaching about contraception has been a source of strong opposition and many Catholics have ignored it, considering it an unwarranted intrusion in their private lives and an attempt to impose a practice under the guise of religion (Bonney, 2004).

Seventeen percent of the world population is Catholic. In numerical terms, this proportion represents one billion 115 million people. Half of them live in an American or Caribbean country. The proportion of Catholic population according to world region is North America (25%), Latin America (88%), and South America (90%). In Brazil, 75% of the population is Catholic, concentrating the largest quantity (140 million) of Catholics in the world (Pontifício Instituto de Missões do Exterior (PIME), 2008). Most Brazilian Catholics go to mass at least once a week (Almeida & Montero, 2001).

The Brazilian Catholic population has decreased during the last decade, from 83% in 1991 to 73% in 2000 (Antoniazzi, 2003). This phenomenon is attributed to the migration of adepts of several religions to another track, with religious principles but without a specific religious denomination. Against this, the preaching of conservative doctrines, which include the prohibition of non-natural contraceptive methods and censure to abortion independently of the situation, is considered another influence on the decrease in Catholic Church followers (Castilhos, 2007).

Attitudes toward sexuality and the learning of appropriate sexual behavior standards begin early, during primary socialization. Children's attitudes are influenced by their home environment, as well as parents' values and behaviors (Berger & Luckmann, 1996; Rabuske, 2008).

Although adolescents adopt more permissive sexual attitudes, their parents' beliefs tend to reflect in their own. Church attendance and education both exert strong influence on maternal attitudes. Higher attendance and lower education levels have been associated with more restrictive sexual practices. Religious affiliation and mothers' church attendance have also influenced young adults' sexual attitudes and behaviors. The religious environment at home was one of the main determinants of adolescent attitudes toward sexuality (Thoraton & Camburn, 1987). A more conservative sexual behavior has been associated with the importance family members attribute to religion (Manlove, Terry-Humen, Ikramullah, & Moore, 2006; Méier, 2003; Paul, Fitzjohn, Eberhart-Phillips, Herbison, & Dickson, 2000; Visser et al., 2007).

METHOD

Research Design

The oral history method, which allows researchers to get access to an understanding and explanation of some dimensions of people's social life, was carried out in this research (Meihy, 1998). This method permits a systematic

description of personal, social, and cultural experiences regarding the orientations received from priests and parents and their influences on sexual attitudes. "Collaborator" is the denomination considered adequate to refer to persons who tell their own history. The base of this method is the recording of collaborators' lived experiences (Meihy, 1998).

Data Collection

Catholic women were collaborators for this research. They were included if they previously had not adhered to any other religion, were born in a Catholic family, and went to mass at least once a month. Limits related to age were not established as inclusion criteria because people of different ages have continuously demonstrated the importance of religion (Putnam, 2000).

We have focused on women's own experiences. Previous research findings have demonstrated that, when compared with men, women participate more regularly in worship services and youth activities. Women have also more frequently mentioned religion as an important aspect of their daily lives (Gallup & Bezilla, 1992; Johnston, Bachman, & O'Malley, 1999).

The first study collaborator was a Catholic woman who was acquainted with one of the researchers. An interview was scheduled, respecting her time and place preferences. The interview was held individually and fully tape-recorded. Personal data were obtained at the beginning.

The woman received clarifications about the comprehensive scope of the term "sexuality" and the meaning of the term "sexual attitude." Before beginning the interview, the interviewer also explained the concept of sexuality adopted in the study. It is not restricted to the man–woman relationship, but it also includes the way women themselves feel as persons living in this condition in family and social relationships. We considered in a comprehensive way the woman's attitude toward sex.

An in-depth interview was conducted and the following open-ended introductory question was used: "Tell me about the orientations you have received from the priest and parents in the scope of sexual attitudes." At the end of the interview, the woman was asked to indicate a female friend or relative. We adopted similar interview and indication procedures with all women, as recommended in the oral history method (Meihy, 1998).

Criteria of scientific rigor in the use of oral history method establish the inclusion of at least nine persons to obtain representative data (Leininger, 1985). In this research, we observed recurrent patterning and the occurrence of data saturation by the ninth interview. Despite this, we interviewed 17 women so as to guarantee theoretical saturation. Among the 21 contacted women, four scheduled the interviews but did not tell their histories. All of them used lack of time to justify their absence.

The histories were obtained between August 2007 and February 2008. All interviews were performed in a private room, at the women's house (14) or at their work or study settings (3). Interview duration ranged from 10 to 60 minutes, with an average of 30 minutes. The presentation of other collaborators by the interviewed women permitted the inclusion of people from different social classes, educational levels, and occupations. All women were living in the metropolitan area of São Paulo City, in the Southeast of Brazil. The authors of this article carried out all interviews and other research activities.

Data Analysis

The tape-recorded data were submitted to an editing process (Meihy, 1998). The first step was the integral transcription of each narrative, which resulted in 17 written texts. During this work, we identified the emphasis the women put on some aspects of their experiences.

The second step was the narrative's textualization. In this phase, we eliminated the questions and repetitive contents and wrote the content in the first-person singular. The final step was transcreation, when we attributed a logical sequence to personal experiences.

Before the process of narrative content analysis, we read all histories several times in order to become familiar with the women's experiences and to identify the key words and central ideas of each narrative. This facilitated the data analysis process.

During this phase, we extracted the vital tone from each history, which is an expression of the main aspect of the personal experience, observing similarities among some vital tones. In order to avoid repetition, only 10 vital tones will be presented. The exposition of the vital tones is essential in the use of the oral history method (Meihy, 1998). Then, we telephoned each woman to present the vital tone of her history. The women either confirmed it or suggested alterations, and we respected all requirements to make changes.

Descriptive categories of women's experiences were elaborated according to the stages of data coding described by Fereday and Muir-Cochrane (2006). The development of a code manual, which included the identification of the name of the code, definition of what the theme concerns, and description of how to know when it occurs, was the initial stage of analysis. Testing the reliability of the codes or the relationship between the code and the raw information was the second stage. The third stage covered the summarizing of data and the identification of initial descriptive categories, in which we read, heard, and summarized each history. The next stage was the application of the template of codes and additional coding when meaningful units of the histories were identified.

The connection between codes and descriptive categories and the identification of similarities and differences among separate groups of data were

identified in the last stage. In this stage, the previous data analysis was closely scrutinized to ensure that the clustered categories were representative of the previous codification.

After these stages, we constructed three categories. Their names were meant to express, in the deepest, most comprehensive and trustworthy way possible, the women's representations of their experience related to the received orientations and how they affected the women's daily life behaviors.

In order to render the experiences more realistic and to preserve rigor in the use of the qualitative method (Meadows & Morse, 2001), we have illustrated the categories' contents and meanings by small quotes extracted from narratives. Aiming to identify women who expressed similar experiences, we presented the number corresponding to each woman after each quotation. The preservation of the personal perspective is considered crucial in the use of the oral history method (Meihy, 1998).

Finally, we read each history once again in order to verify the absence of contradiction between the oral histories and the descriptive categories. This iterative data analysis is considered a significant feature to assure research validity and to make qualitative research a systematic and rigorous process (Meadows & Morse, 2001).

Ethical Considerations

All research steps were planned according to the ethical recommendations of the Brazilian Health Council. Each woman signed an informed consent form before the beginning of the interviews. All collaborators were informed about the need for tape-recorded interviews and the research purposes, and about the possibility of not collaborating. Full confidentiality of the material and data management, the security of tapes, and their destruction at the end of the research were guaranteed. We preserved women's anonymity by replacing their names by numbers.

FINDINGS

Personal Characteristics of Catholic Women

The women's personal characteristics are shown in Table 1. In order to avoid repetition, only 10 vital tones are presented. Under the descriptive categories, each example of the category's content is followed by numbers, which refer to the women who expressed similar experiences.

The Vital Tones

> W1: *When I got married, I did not know one was supposed to have sexual relations with the husband.*

TABLE 1 Participant Characteristics by Age, Years of Education, Marital Status, Profession, and Church Attendance

Woman	Age (years)	Education (years)	Marital status	Profession/ occupation	Church attendance
1	47	26	M	Nurse	01/w
2	53	10	M	Home aid	04/w
3	56	11	S	Home aid	05/w
4	50	05	M	Housewife	03/w
5	49	08	M	Home aid	02/w
6	26	13	M	Housewife	03/m
7	48	03	S	Housewife	05/w
8	68	05	M	Home aid	01/w
9	39	16	S	Lawyer	01/m
10	44	09	M	Elderly caregiver	02/m
11	48	11	M	Nursing auxiliary	02/w
12	19	13	S	Student	01/w
13	46	08	M	Housewife	07/w
14	45	11	M	Secretary	06/w
15	60	04	W	Housewife	02/m
16	22	17	S	Nurse	01/w
17	27	24	M	Physician	01/w

NOTE: S = single, **M** = married, **W** = widow, **w** = week, **m** = month.

W4: *We must follow what God orders, what is written in the Bible.*

W3: *I made many mistakes because I did not follow my parents' orientations. . . . Now, I am single, but happy with Our Lady!*

W6: *I learnt about sex from my friends, because from my parents, no way.*

W9: *My mother says it is better to be a virgin, but, if I have sex, we should use a condom.*

W10: *Virginity is a very serious thing for Church.*

W11: *A girl must be virgin until the marriage.*

W15: *I am even in favor of abortion.*

W16: *My parents always talked openly about sex; thus, these questions were never a motive of curiosity for me.*

W17: *I only have sexual relations with someone I love.*

The Descriptive Categories

Orientations About Sexual Attitudes Received From Priests

During religious worship and social meetings organized by the church, women received orientations about sexual attitudes considered appropriate.

They affirmed that some orientations were explicitly given, while others were implicit in worship or informal talks with priests:

> Some orientations given by priests were implied in worships and comments made on other occasions, while others were given in very explicit ways. (5, 12, 16)

Explicit orientations were related to sexual abstinence until marriage, the sacrament of matrimony only when there is love between the couple and the conception of children by married people only, abstention from using non-natural contraceptives, and the censure of abortion in all cases. Implicit orientations were related to women's daily behavior:

> The priest always preaches the preservation of virginity. (1, 12, 13)
>
> Priests say couples should be united by love. (1, 3)
>
> Children must be generated inside the marriage. (14, 15)
>
> The church is against the use of condom. (3)
>
> [It] is against abortion even in cases prescribed by law. (1)
>
> They said indirectly how a woman should behave in her daily life. (1, 12, 15)

Lack of Orientation or Existence of Open Dialogue About Sexuality: Distinct Experiences in the Family Context

Experiences related to orientations about sexual attitudes were very different and depended on the way religiosity was experienced in the family context. This difference permitted separating Catholic women in two extremes. On one side, there were the women who never received orientation and, on the other, those who had the opportunity to freely talk about subjects related to sexuality.

Women who did not receive orientation said their parents did not address topics related to sexuality in family dialogues. Speaking about this theme was embarrassing for mothers because, in these families, rigid moral values predominated, affecting communication between parents and children:

> My mother was embarrassed and did not speak about sexuality at home. (1, 10)
>
> At home, sexuality or sexual relations were not addressed; there was no atmosphere for that. (14)

These women referred to books and other sources available, such as female friends, to obtain information on this subject:

> I learnt about sexuality from books, talks with friends. My family and priests deprived me of these orientations. (5, 6, 8)

The beginning of these women's relationship with the opposite sex occurred without any knowledge regarding sexuality, especially sexual relationships. They started to understand this after marriage, through experiences lived with their husbands:

> I was not oriented when I started to date, I believed kisses could make you pregnant. (3)
>
> I got married without knowing that I had to have sexual relations with my husband. (2)
>
> All I know about sexuality I learnt from my husband. (15)

Curtailment regarding sexual attitudes provoked feelings of embarrassment in the first moments of intimacy with husbands and when they had to report their pregnancy to family and friends. Pregnancy represented a concrete sign of the consummation of the sexual relationship, and these women felt shame in admitting this practice:

> Even married, I was embarrassed to be naked in front of my husband. I was ashamed to tell I was pregnant because everybody would know there was sexual relation. (4)

On the other hand, some women had received several orientations about sexual attitudes in daily dialogues between parents and children. In their families, the manifestation of sexuality was considered a natural attribute of the human being:

> With the orientations I received from my parents, I incorporated the idea that sex is part of life. (9)
>
> My parents always talked openly about sex. (16)

In their orientations, parents had emphasized the preservation of virginity. This condition was considered important for the trajectory idealized by the parents as their daughters followed the sequence: date–engagement–marriage. Women who incorporated this family value followed the advice received:

> I had a rigid upbringing. I was raised to be a virgin until I got married and follow the sequence date, engagement, and marriage. I believe this is correct and I will raise my children in the same way. (1, 9, 11, 13)

In some families, starting a sexual relationship before matrimony was permitted. This was considered a concession, however, and the women were responsible for avoiding pregnancy and sexually transmissible diseases,

especially AIDS. The women repeatedly received this kind of orientation during youth:

> My mother always said that it was better to stay a virgin, but that I should use a condom if I had sex and be careful not to get pregnant or contract AIDS. (12)

They also received many orientations about how a woman should behave in daily social life. The family constantly stressed the need to preserve their personal image of a discreet and reserved girl.

Parents persistently recommended them to keep the image of "good girl," as men who wanted to get married preferred young girls with this characteristic. Women were aware that not following this principle would result in lowering their moral value. Preserving this image idealized by the family required attention to daily attitudes, such as wearing discreet clothes, little makeup, and other precautions so as not to evidence female sexuality:

> My parents taught me to be discreet in everything—clothes, behavior—because showing sensuality lowered the value and moral of the woman. Reserved woman is the one preferred by men to get married. (1, 9, 11, 13)

Adherence or Repudiation: Distinct Attitudes Toward Orientations Received

Women reacted distinctly to the orientations received in church or from family.

Some women incorporated the transmitted values, adhered to the orientations, and repeated them to their children. These women considered the orientations they had received very valuable, mainly related to maintaining sexual abstinence until marriage:

> Until I got married, I did not have sexual relations because that is what my parents advised me to do. I kept my values and that is what I will teach my children. (3, 4, 11, 13, 14, 16)

We observed the predominance of assertive behavior related to these orientations. However, some women did not follow the recommendations received from priests or parents. These women assumed, in a convicted way, attitudes opposite to family and church presuppositions, but they felt discriminated against or guilty for not corresponding to the expectations:

> I did not have a civil nor church marriage and it was very difficult for my parents to accept this condition. (7)

> I did not follow my family's orientations; I had a child without getting married and I am discriminated against for not being married in church. That is why I wear a wedding ring. (17)

Some women even adopted attitudes considered as insulting to family and religious standards. They remained firm in their convictions without fearing discrimination and its consequences, and they did not regret their choices:

> I see no problem in having sexual relations with the boyfriend, IF he is special and it is the ideal moment. (9, 15, 17)

> When a priest says that people who are not married in the church cannot take communion, I leave mass because I do not accept this, I am even in favor of abortion. (15)

On the other hand, some women regretted their previous actions, opposing orientations they received. They expressed they had made a big mistake regarding this aspect.

> I made a mistake because I did not follow my parents' orientations, I regret it and now I am single. (7)

Regarding contraceptive methods, the women's position was clear and also was polarized in two extremes: the ones who followed and the ones who did not follow the received orientations:

> Women should not use contraceptives; therefore, I never used them. (3, 5, 14)

> I use contraceptives because I do not agree with this kind of prohibition. (8, 10, 11, 12)

Women who went against recommendations justified that they used contraceptive methods because they did not have financial and structural conditions to raise many children. Some of them felt guilty about using contraceptives:

> I use contraceptives because I do not have conditions to raise many children. (8, 10, 11, 12)

> I am in favor of condom use. (15)

> I used contraceptive pills, and now I am tubal sterilized. (4, 12, 17)

> I use birth control pills, although I know it is a sin! (13)

INTERPRETATION AND DISCUSSION

The lack, inadequacy, or absence of orientations regarding sexuality-related issues in the family context made many collaborators in this research look for knowledge related to this subject from other sources, like books and friends. Researchers on this theme have reported similar situations, affirming that this is due to countless difficulties in addressing this topic in the family context (Baier & Wampler, 2008; Hoga, Alcântara, & Lima, 2001; Thoraton & Camburn, 1987).

Most Brazilian families address sexuality in a prejudicial way, independently of their cultural insertion (Santin, 1999; Werebe, 1998). Parents tend unconsciously to reproduce the situation in which they during their adolescence and adulthood, when knowledge regarding sexuality was obtained from books or talks with friends (Hoga, Alcântara, & Lima, 2001; Werebe, 1998).

Hoga (2008) has described that, in a sample of low-income families living in São Paulo City, mothers are mainly responsible for sexually advising their children. Santin (1999), Baier and Wampler (2008), and Werebe (1998) have demonstrated in their study findings, carried out in different cultural contexts, that mothers do not feel prepared to give orientations on sexuality to their children. Consequently, they are resistant or feel uneasy to address themes related to sexuality in dialogues with their children.

The establishment of dialogues about sexuality depends on the characteristics of the relationship between parents and children. Many times, conversations about this topic only occur when the mother or female child proposes so. Therefore, dialogues about sexuality between parents and children rarely occur. Besides that, parents prefer to leave the responsibility for the orientation of adolescents to the church or nurses (Baier & Wampler, 2008). This expectation of the family demonstrates that nurses, other health professionals, and educators should be well prepared to see to the demands of young people and their families.

Few women from this study had the opportunity to talk with their parents, about themes related to sexuality. The main orientations they received were the need to respect the standards their parents and the church idealized. As part of these, parents and the church expected young people would adopt reserved and even asexual attitudes. Some collaborators had incorporated the idea that the manifestation of sexuality by women goes against their image. It would be degraded when their sensuality is manifested in social contacts.

Some women were oriented to maintain sexual abstinence until marriage. Women who seemed to adhere more to religious values reported that their parents clearly expected they would follow this recommendation.

Researchers in different contexts have studied the relation between religiosity and the beginning of sexual relationships. High levels of confidence

were observed between mothers and female children as to the preservation of sexual abstinence until marriage in Baptist North American families (Baier & Wampler, 2008). Religion contributed to delayed sexual initiation of young New Zealanders until after 20 years of age (Paul et al., 2000). Religiosity affected the beginning of sexual relationships, and this significantly influenced the attitudes of North American adolescents in relation to sex (Méier, 2003). North American teenagers who attended church weekly remained sexually abstinent longer as compared with teenagers who went monthly (Lefkowitz et al., 2004).

Regarding participation in the family's religious activities, more committed White adolescents of both sexes started sexual activities later. A similar attitude was not observed among Black adolescents (Manlove et al., 2006). The family degree of religiosity also is related to adolescents' late start of sexual activity and to the lower number of sexual partners (Manlove, Logan, Moore, & Ikramullah, 2008).

Many study collaborators adopted behaviors the church and families consider appropriate. This shows the influence of values that exist in the family and social contexts. These values are rooted in the family and pass on to the next generation (Hoga, 2008; Hoga et al., 2001; Werebe, 1998).

A researcher observed that a sample of Brazilian women adopted behaviors considered audacious or ignored the model established by family and church, such as sexual initiation before marriage, and were discriminated against because of that. This phenomenon can be due to the fact that several Catholic women consider their personal values to be incompatible with religious values and therefore choose to follow other directions and give their own interpretation to religious discourse. These women adopt habits and parameters considered ethical and "modern" (Rodrigues, 2003).

Values transmitted by the media, related to the intense urbanization seen in several countries in the last decades and women's massive entrance in the labor market, can be the cause of progressive modernization and configuration of new female roles in Brazilian society (Werebe, 1998).

As for contraceptive practices, we observed polarized behaviors among the women participating in this study. Thus, some women rigorously followed the position of the Catholic Church, clearly against the use of nonnatural contraceptive methods. On the other hand, other women used many contraceptive methods.

Adolescents from very religious North American families more frequently used contraceptive methods in their first sexual relation (Manlove et al., 2006). In another study, however, the family's degree of religious commitment was related to the consistent use of contraceptive means among adolescents. These relations were associated with age of sexual initiation, positive family environment, and greater guidance by parents (Manlove et al., 2008).

A research study carried out with American women of Mexican heritage showed that Catholicism, by itself, was not associated with practices related to contraception, sex, and abortion. Attitudes in this sphere mainly were related to socioeconomic factors and the degree of religious commitment (Amaro, 1988).

Controversies continue to exist in results about associations between religiosity and the use of contraceptive methods. These show that health professionals should seek knowledge about and take into account religious beliefs and values and act according to the individual, family, and sociocultural dimensions of health care. For example, they should avoid recommendations to use contraceptive methods when they are not appropriate or go against women's religious principles.

Respecting free choice in sexual and reproductive decisions is part of sexual and reproductive rights, as recommended by the United Nations (2002). Professionals should take precautions by verifying if women's decisions and choices are conscientious. They can result from a deep reflection on the personal and family situation or be a consequence of unconscious subordination to the values and standards recommended by the Catholic Church. Professionals should focus their attention and promote reflections on this topic with health service clients, so that the second possibility does not come true.

Many Brazilian cultural groups are concerned with preserving family image and values, as we show in this research (Hoga, 2008; Okada, 2007). In another research study carried out in the Brazilian context, researchers reported on beliefs that contraceptive practices are an exclusively female responsibility (Manhoso & Hoga, 2005). Most times, the fault for an unplanned pregnancy due to the lack of contraceptive method use falls back on women (Hoga, Alcântara, & Lima, 2001; Jeneral & Hoga, 2004). The low prevalence of male contraceptive means, such as male condom use (12.2%) and vasectomy (5.3%; Brasil, 2009), which persists in the Brazilian population, confirms the low male involvement in contraceptive practices. Health and educational professionals and institutions still need to adopt many strategies to promote a deeper male involvement in sexual and reproductive health, as recommended in recent international population, development, and women's conferences (Berquó, 1998).

Some women considered abortion a fatal sin. Abortion-related themes create great polemics, and it is difficult to address them in the collective dimension. In Brazil, abortion is permitted only in cases of rape or risk to the mother's life. Catholic religion exerts an important role in the public debate, condemning abortion and any explanation for its occurrence. Many followers of this religion vehemently incorporate this principle (Kalsing, 2002; Santin, 1999; Werebe, 1998).

In this research, we showed the need for adequate sexual and reproductive health orientations in terms of religiosity. Orientations in this field

should not be standardized, and women cannot be fit into health education and promotion activities in a rigid or hegemonic way. These precautions are essential for significant care according to health service clients' perspective.

Health care providers are not sufficiently prepared to deliver care when religious needs are involved (Salgado, Rocha, & Carvalho, 2007). This problem is due to the superficial and not very comprehensive approach of the spiritual dimension in research and education (Heliker, 1992; Salgado, Rocha, & Carvalho, 2007). There are not enough opportunities to discuss, in a judicious and unprejudiced way, religious questions in the professional environment, which makes professional improvement in this care sphere more difficult (Salgado et al., 2007). These deficiencies should be reduced by further research on the theme and the insertion of content about religion in professional training. These strategies are essential for comprehensive care, considering the physical, psychological, social, and spiritual dimensions (Astedt-Kurki, 1995).

Health care theories and conceptual modes state that professional performance should be based on the results of a systematic analysis of the countless personal, family, cultural, and socioeconomic factors involved in health practices. Professionals should be aware of beliefs and values and consider peoples' sociocultural insertion when performing interventions (Andrews & Boyle, 2002; Leininger, 2003; Purnell, 2002). They should take differences in peoples' attitudes seriously, influenced by socioeconomic and religious factors, when delivering sexual and reproductive health care (Amaro, 1988). The concept of "normal" can vary according to people's degree of religious commitment. This variation occurs mainly when the expression of habits is related to invisible religious forces (Johnson, 2004).

Professionals around the world should consider the differences between religion and culture. Cultures are concerned with increasing human control over change and adopting a relativist approach. Religions seek to harmonize change and are hostile to relativism. This question requires much debate because there is no consensus about its differences. Whether the revelation of God via the mechanism of the world's religions is culture relative or culturally independent depends on debates and can be clarified by further research findings (Bonney, 2004).

Our aim was to contribute to deeper knowledge on the relations between religiosity and women's sexual attitudes. We hope it can contribute to promote high-quality and ethical sexual and reproductive health care, which includes knowledge, respect, and consideration for the religious dimension of the person receiving care.

Limitations of This Study

Four women invited to participate in the interview did not attend. Some women's intimate experiences cannot be exposed. Others factors that can

influence the women's sexual attitudes, such as socioeconomic status, were not focused on in this research. The boundaries between religion and culture were not considered in this study, and clarifying these limits needs further study. Research focusing on other religious backgrounds is necessary in order to identify similarities and differences among them.

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