CHAPTER 1

INTRODUCTION

Statement and Significance of the Problem

In Thailand, sexual risk behaviors among adolescents have become an increasing social and public health concern. Pre-marital sex among adolescents is rampant and on the increase. Adolescents are inclined to have pre-marital sex at an early age and frequently with steady partners. Although they often have only one partner because they believe it is safer, they do not practice protective techniques. A recent survey of 3,283 youths (ages 15-24) in Bangkok and 12 regions around the country found that two-fifths of females and three-fifths of males reported having had sexual intercourse (MOPH & Boonlour, 2003). The median age for first sexual intercourse declined (Chuprapawan, 2000) from the age of 17-18 (Havanon, 1993; Ford & Kittisuksathit, 1996) to the age of 15 (Chuprapawan, 2000; MOPH, 2002). Particularly, boys now turn to have their first and regular sexual experience with girls who are friends and classmates instead of going to commercial sex workers (Boonmongkon, Jaranasri, Thanaisawan-Yangkoon, & Limsumphan, 2000).

Correspondingly, it is also noted that the proportion of pre-marital sex among female adolescents has risen steadily over the past decade. For example, according to the latest study of adolescents aged 11-21 by Srinual (2003), a school-based survey in one province found that the proportion of male adolescents having sexual experience are approximately one-fifth in lower secondary school, one-fourth in upper secondary

school, and two-thirds in vocational college. Among female adolescents, they are less likely to be engaged in premarital sex compared to male adolescents. The largest proportion of sexual experience among vocational female students is 34.3%. Similarly, this result corresponded with previous findings of the rising trend of sexual experience by time and specific group. Allen et al. (2002) found 43 % of female college students in the city of Chiang Rai reported having experienced sexual intercourse, Powwattana (2002) found that 38 % of female college students in the central region, and Rugpao (1995) found 42 % of young factory workers in the city of Chiang Mai having experienced sexual intercourse.

Furthermore, even though knowledge of AIDS is widespread in Thailand, the level of consistent condom use is still low in sexually active adolescents and the number of partners among heterosexual adolescents has increased (MOPH & Boonlour, 2003; Issarapukdee, 1995). Based on Durex Global Survey 1999 in a sample of 4,200 young people in 14 counties (Karnjanajittra et al., 2003), it revealed that 52 percent of Thai adolescents have multiple partners, comparing with a world average (34 %), and only 23 % reported that they used condom at first intercourse, comparing with a world average (57 %).

Taken together, these findings indicate that both male and female adolescents are placed at greater risk of AIDS, STDS, and unplanned pregnancy. To date, sexual risk behaviors (increasing sexual activity, having multiple partners and unprotected sex among adolescents) have already had devastating effects on the health of Thai adolescents. The HIV/AIDS epidemic, in particular, is shifting disproportionately to young people numbers are rising. Since 1999, rates of HIV/AIDS have escalated in adolescents (MOPH, 2002) and the Ministry of Public Health report suggests this

trend may continue. According to the National AIDS Surveillance data for 1999 and 2002, the MOPH in Thailand has noted that the rate of HIV infection among teenagers rose from 11 % to 17 %. The majority of young people contact HIV through sexual contact. More specifically, the 15-19- year-old adolescent females are increasingly at risk for HIV. The male-female ratio of AIDS cases decreased from 3.3:1 in the age group of over 30 to 1:1 among those under 20. Additionally, AIDS is the leading cause of death in young women aged 15 to 24 (Chuprapawan, 2000).

In accordance with the increased incidence of AIDS, the rate of sexually transmitted diseases is the highest among adolescents, comparing with other age group. (Chuprapawan, 2000). The latest epidemiological report in 2003 found that one-thirds or 32 percent of AIDS cases is young people aged 15-24 (MOPH, 2003). Moreover, it is recognized that girls who are sexually active usually have unwanted pregnancies and often end up with unsafe abortions. As a result, the maternal mortality as a consequence of pregnancy is higher in the 15 to 19 age group than among women aged 20 to 30 (Boonmongkon, et al., 2000).

This evidence underscores that sexual behaviors in adolescents requires immediate efforts to prevent its negative consequences. Presently, the best way to prevent STDs/ AIDS and pregnancy among young population is sexual abstinence, but this situation it is idealistic and the real situation is that many adolescents have pre-marital sexual activities while in high school (MOPH, 2002; Srinual, 2003). Therefore, ways to prevent those negative outcomes through reducing risky sexual behaviors regarding unprotected sexual encounters is an urgent matter for study. Understanding sexual risk behavior is essential for developing and evaluating health promotion and risk reduction activities. In order to do so, many researchers are

challenged to better understand and address the determinants that contribute to sexual risk behaviors among young people. There is need of deeper and broader information about these behaviors.

Studies of predictors of risky sexual behavior have rarely been found in a Thai context. Thus, the findings from Western studies are also reviewed in this study. Major predictors of risky sexual practices include age at first intercourse, alcohol use, the perception that one's peers are participating in risky behaviors, and behavioral attitude (negative attitude toward condom use and positive attitude toward premarital sex) (e.g., Allen et al., 2002; Bond et al, 2003; Isarabhakdi, 1997; Thato et al., 2003). Some research includes other factors such as socioeconomic status and family characteristics (e.g., Isarabhakdi, 1997; Miller, Forehand, & Kotchick, 2000). However, even in combination, these predictors explain only small amounts of the variance in sexual risk behavior (Miller et al., 2000; Sheeran et al., 1999). Hence, there may be other factors included to explain sexual risk behaviors.

Sexual risk behaviors are not similar to other health risk behaviors such as eating behaviors and smoking behaviors because they are inherently private, stigmatized and situation specific. In general, male adolescents have a greater number of sexual partners than their female peers, and engage in sex at an earlier age, which may place them at risk for HIV (Bond et al., 2003; Ford & Kittisuksathit, 1996; Srinual, 2003). Female adolescents may be particularly vulnerable, however, because of gender-power dynamics that may constrain their ability to refuse sex with males or negotiate condom use (Amaro, 1995; Wingood & DiClemente, 1995). Female adolescents, in particular, have been found to be less comfortable using condoms and less likely to buy and use condoms than their male counterparts (Boonmongkon,

2000; Ford & Kittisuksathit, 1996; Havanon, 1996; Kanjanajitra et al.,2003). Therefore, as male condom use still is the most effective method for AIDS prevention, safe sex practices in female adolescents are not completely under their own control. Consequently, sexual risk behaviors of males and females have their specific contexts.

Specifically, in contemporary Thai society, the social and economic situations are changing and have a direct impact on adolescents and youth in terms of gaining more independence economically, in their living arrangements, and in their lifestyles (Ford & Kittisukasathi, 1996). Urbanization tends to create more employment opportunities and greater access to education and health services, but it may also bring about the loss of traditional cultures and separation from extended families. In particular, “pop culture” has become popular among adolescents. As a result, the patterns of sexual behavior among Thai adolescents have been changing from the past. Women are less likely to keep their virginity until their marriage, and boys are more likely to marry to non-virginal women (Srinual, 2003). Thus, there are the conflicting and confusing pressures from old traditional norms and values about sexuality in modern culture that needs to be explored to explain high and low risk taking among adolescents. Therefore, only understanding in terms of motivational orientation toward performing a behavior could not fully explain sexual risk behaviors. Cultural and other contextual factors are thought to weaken the power explaining social cognitive models (Amaro, 1995, Kirby, 1999; Kotichick, Shaffer, Forhand, & Miller, 200; Logan et al., 2002).

Over the past few decades, there has been much research and intervention in response to the AIDS epidemic in Thailand, and the research has been

multidisciplinary. However, problem of sexual behavior, especially in adolescents, is increasing. Unfortunately, very little of previous research explicitly explores and examines sexual risk behaviors and the determinants of high- and low-risk sexual practices among sexually experienced adolescents. In addition, in the limited research on HIV-related sexual behavior among youth, most studies typically employ univariate measures of HIV risk as dependent variables for HIV risk. (e.g., condom use, or number of sexual partners, age at first intercourse, or a series of separate sexual activities and condom use) and rely on simple statistical test. However, the risks of sexual transmission of HIV occur as a result of a combination of sexual activity (multiple partners and frequency of sex) and unprotected sex (non condom use). A multivariate approach may help us determine if a different constellation of sexual activity and condom use are associated differentially with other behavioral, psychosocial, and gender-based determinants among male and female adolescents. Particularly, little research has explored sexual risk behavior and determinants of risk from the perspectives of adolescents themselves.

The present study attempts to deepen and diversify our understanding of adolescent sexuality, particularly the social contextual issues and conditions that shape and constrain it. In order to work toward this goal, variables representing a range of contexts, including psychosocial, and gender-based, were examined in relation to their ability to explain sexual risk taking. Gender-based factors (gender role perception and power in sexual relationships) extend this study beyond the individual-level factors from psycho cognitive models. Furthermore, the well-accepted psychosocial determinants, namely, attitude and beliefs about sex and condom use, peer influences, and sexual self-efficacy, were included in the present

study. In addition to quantitative methods, qualitative methods were also being conducted in order to obtain insights into sociocultural contexts that might underlie sexual risk behaviors, and from the perspectives of individuals within their own subculture. Hopefully, the results of this study will provide better understanding of the complexity of the sexual risk behaviors of adolescents and provide a direction for interventions regarding risk reduction and AIDS prevention programs for adolescents.

Objectives of the Study

The purpose of this study is to describe adolescent sexual behaviors and to examine the determinants of risks, particularly the psychosocial and gender-based factors. The following three specific aims:

1. To describe sexual risk behaviors among adolescents;

2. To identify the relationships among psychosocial factors (attitude and beliefs, peer influences, and self-efficacy), gender-based factors (gender role perception, and power in sexual relationships) and the sexual risk behaviors of adolescents –i.e., sexual experience and sexual risk taking; and

3. To explore adolescent perspectives of underlying reasons for sexual risk behaviors.

Research Questions

1. What are the sexual behaviors of adolescents?

2. What is the relationship among beliefs of sexual intercourse, peer influences, sex-refusal self-efficacy, intercourse intention with sexual experiences among adolescents?

3. Does gender role perception relate to sexual expereinces among adolescents?

4. What is the relationship among sexual risk behavioral attitudes and beliefs, peer influences and safe sex self-efficacy with sexual risk behavior among sexually experienced adolescents?

5. Do gender role perception and power in seuxal relationships relate to sexual risk taking among sexually experienced adolescents?

6. What are the underlying reasons for sexual risk behavior among sexually experienced adolescents?

Scope of the Study

This study was conducted with a sample of male and female students in schools. The target population is students who are studying in upper secondary public schools, vocational public colleges, and the regional public university in a province in the eastern area of Thailand. The data were obtained from July 2004 to January 2005.

Definition of Terms

Sexual Risk Behaviors

Sexual risk behaviors are defined, according to work of Bachanas et al. (2002), as several key behaviors- early of sexual intercourse, frequency of intercourse, having multiple partners, inconsistent use of condoms and other forms of contraception. Sexual risk behaviors are operationally defined in terms of having sexual experience and sexual risk taking.

Having sexual experience is operationally defined as ever or never having sexual experience during adolescent year before.

Sexual Risk Taking is operationally defined as the scoring composite variables indexing the overall degree of sexual risk taking on the sexual health history questionnaire developed by researcher, which were composed of having sex in the past 3 months, using condoms at first sex, using condoms in the recent intercourse, inconsistent using condoms in the last 3 months, inconsistent using dual protection (birth control pill and condom) in the last 3 months, having multiple partners in the last year, having multiple partners during the last 3 months.

Psychosocial Determinants

Psychosocial determinants are defined**,** according to psychosocial behavioral theories (Kok, Schaalma, De Vries, Parcel, & Paulussen, 1996), as four main psychosocial constructs relevant to risk behavior for HIV, STD and pregnancy: attitudes or beliefs and peer norms about sexual involvement, protective behavior, and sexual self-efficacy. Each construct is described in the following.

Sexual risk behavioral attitudes are defined as perceived sex norms and perceived birth control use including condom and contraceptive pills. Sexual risk behavior beliefs are also defined as pros/cons of intercourse, hedonistic beliefs and barrier of condom use. Sexual risk behavioral attitudes and beliefs are operationally defined as the total score on the Sexual Risk Behavior Beliefs Scale developed by the researcher, which based on the work of Basen-Enguist et al. (1999).

Peer influences are defined as both descriptive norms and normative beliefs of close friend (Sheeran et al., 1999). Descriptive norms are perception of the prevalence of sexual intercourse among their peers, and the prevalence of protected sex among their peers. Normative beliefs are perception of close friends' approval of having sex and sexual risk taking.

Sexual self-efficacy is defined, according the work of Murphy et al. (2001), as people's difficulty to successfully refuse sex and have safe sex in specific situations. Ssexual self-efficacy was operationally defined as the score of Sexual Self-Efficacy Scale modified from Safe Sex Self-efficacy Scale (Murphy et al., 2001).

Intercourse intention is defined as adolescents intend to have intercourse during adolescent year.

Gender-Based Factors

Gender-based factors are defined , according to notion of gender and power, as the result of cultural socialization process through gender-power imbalance in social structure and affecting sexual behaviors, which consist of gender role perception, and power in sexual relationship in this study. Each construct is described in the following.

Gender role perception is defined as people's awareness of their maleness or femaleness that are based on the particular gender roles they play. Gender role perception is operationally defined as the total score of the scale for perception of femininity and perception of masculinity-Thai version, which was developed by Srinual (2003).

Power in sexual relationship is defined as individuals' s sense of relative ability as a partner to act independently, to dominate decision making, to engage in behavior against a partner's wishes, or to control a partner's action. Power in sexual relationship is operationally defined as the total score on the Power in Sexual Relationship Scale (PSRS) developed by Pulerwitz et al (2000a).