CHAPTER 2

LITERATURE REVIEW

The literature review is intended to help set the context for the current study. It is organized based on western and Thai studies. Chapter II is divided into four sections. First, description of the sexual risk behaviors of the adolescent is provided. Second, limitations of existing research on sexual risk behavior were analyzed. Third, theoretical perspective, psychosocial behavioral models and notion of gender and power, are briefly described. Finally, determinants of sexual risk behavior among adolescents research focusing psychosocial behavioral factors and gender-based factors are discussed.

Sexual Risk Behaviors of Adolescents

The public's view of STDS prevention is primarily wearing a condom, and secondly reducing the number of partners (Wight, 1992). Indeed, adolescent sexual risk behaviors are determined by several key behaviors- early of sexual intercourse, frequency of intercourse, having multiple sexual partners, inconsistent use of condoms and other forms of contraception, and the use of alcohol or drug prior to or in conjunction with sexual activities (Kotichick, Shaffer, Forhand, & Miller, 2001; Murphy, Rotheram-Borus, & Reid, 1998; Santelli, DiClemente, Miller, & Kirby, 1999). Generally, most studies often separate disease prevention (HIV-risk behavior)

apart from pregnancy prevention. Thus, safe sex practices focusing on STDS prevention are often defined as consistent condom use and having multiple partners rather than other sexual risk behaviors. Few studies have been measured by multiple sex-related outcomes. Sheeran and colleagues (1999) reported in a meta-analyses of psychosocial factors associated with heterosexual condom use that there are five types of HIV-risk behavior (condom use) measurement in 121 studies: 44% frequency of condom use; 16% consistency of condom use; 13% multi- item measures of frequency and consistency of condom use; 15% current condom use (one item); and 12% using condom at last occasion of intercourse. However, some more recent studies have refined sexual risk behavior related to pregnancy, HIV, and STDs (e.g., frequency of sex without any kind of contraception) (Bond et al., 1999; Coyle et al., 2001l; Miller, Clark, & Moore, 1997; Poulin & Graham, 2001; Murphy et al., 1998), because expectancies of disease and pregnancy outcomes in adolescents are related per se (Whaley, 1999).

With regard to literature from both pregnancy prevention and HIV/AIDS prevention programs targeting adolescents (Whaley, 1999); it becomes clear that adolescents are more concerned about pregnancy prevention than disease prevention. This finding is similar to Thai studies (Allen et al., 2002; Havanon, 1993), which found Thai adolescents are afraid of getting pregnant rather than getting disease from sexual intercourse. As a result, some HIV-prevention programs failed to improve protective behavior outcomes (Gillmore et al., 1997: Kirby et al., 1997). On the other words, methods of protecting female adolescents against HIV/AIDS are currently confounded by concerns about control over pregnancy. More specifically, though, in general, consistently and correctly using condom can be expected to reduce the rate of

unintended pregnancy and STD and HIV infection in sexually active adolescents, in fact, condom use doesn't ensure prevention of unintended pregnancy or STD or HIV acquisition (American Academy of Pediatrics, 2001). More recently, use of condom together with hormonal contraception has been the optimal approach to preventing unintended pregnancy, STDs and HIV infection in those who are sexually active (American Academy of Pediatrics, 2001).

Number of sexual partners is also the significant behavioral risk factor. Both Thai male and female adolescents are more likely than adults to report having multiple sexual partners in the recent past (Chuprapawan, 2000). Among adolescents, having multiple partners is associated with early age at initiation of sexual intercourse, alcohol use, illicit drug use, and being unmarried (Durbin, DiClemente, Siegel, Kramsnovosky, Lazarus, & Camacho, 1993; Miller, Forehand, & Kotchick, 2000). Additionally, a large proportion of sexual intercourse among teenagers is thought to be a result of coercion or force, especially among young females. Thai females are more likely than males to claim their first sexual experience was coercive or involuntary (Tepthsitha, Thonghong, Saengwanloy, Chunsiriyakorn, & Auegchusuk, 2002). A recent national survey (MOPH, 2001) reported 37.1 % of female secondary school students reported ever having sex, and have involuntary sex. More interestingly, unplanned sexual intercourse under the influence of alcohol or other drug was the important risk factors for having sex and unsafe sex (Allen et al., 2002; Ford & Kittisukaasathit, 1996; Poulin & Graham, 2001; Soonthorndhada, 1996).

As discussed earlier, it is noted that limiting the conceptualization of sexual risk behaviors ignores other factors that contribute to the level of risk of an

individual's sexual behaviors such as pregnancy prevention, and having multiple partners**.** Furthermore, there is also no current "gold standard" of assessment of sexual behavior (Catania et al., 1990; Weinhardt et al., 1998) and there have been few studies designed to examine evidence for validity of self-report sexual behavior measure (Weinhardt et al.). The crucial reason is that sexual risk behaviors are not similar to other health risk behaviors. Sexual behaviors are inherently private, stigmatized, and situational specific. Consequently, it is difficult to access or directly assess sexual risk behavior. In doing so, the reliability and validity of self-report measure of safe sex behavior is still questionable.

Following the Burkholder and Harlow's study (1996), the authors attempted to compare five methods of assessing HIV/AIDs sexual risk in a large prediction model. The result indicated that multiple measures or latent factor model has been noted as the best fit of conceptualization for HIV risk - anal unprotected sex, vaginal unprotected sex, partner risk, and multiple partners. Further, as Shreeran and Abraham's (1994) review based on 72 studies of HIV-preventive behavior, they found that definition of sexual risk behavior rarely included indication of partner characteristics, and when questions were asked about partner characteristics, the data were rarely used in statistical analyses of predictors of condom use. Therefore, the combination of either unprotected anal and vaginal intercourse or sex with multiple partners should be considered.

Moreover, several recent studies have attempted to refine sexual risk behaviors as a combination of multiple behaviors related to sexual risk taking (Bond et al, 1999; Bachanas et al., 2002; Raffaelli, & Crockett, 2003). For example, Raffaelli and Crockett measured the degree of sexual risk taking by scoring the

different sexual behavior variables (high risk; i.e., sexually active, sexual debut before age 15, two or more sex partners in the last 12 months, no condom use at last intercourse). Bond et al. measured behavioral risk taking in term of sex risk index (activity with sexual partner; i.e., having sex, using contraceptive pill, disease prevention, ever being pregnant), a drug/alcohol risk index, and multiple partner risk index.

Thus, assessment of sexual risk behavior in this study focuses on STDs prevention behavior and pregnancy prevention. Particularly, this study moves from individual sexual behavior to interpersonal-oriented sexual behavior. Hence, sexual practices among young people is viewed as not a behavior (e.g. condom use), but represents the multi-behaviors including experience of sexual intercourse, sexually active within 3 months, consistency of condom use, dual protection (birth pill control and condom use) within 3 months, and having multiple partners.

Limitations of Existing Research on Sexual Risk Behaviors

Sexual risk behaviors and AIDS are not only a medical phenomenon, but also link to sex and gender. This problem is shaped by interpersonal relationships and social mechanics (Wingood & DiClemente, 1995). An important question that may be overlooked in risk factor studies regards the gender specificity of risk (Amaro, 1995; Jenkins, 2000; Kotchick, Shaffer, Forland, & Miller, 2001; Logan et al., 2002). Often, risk factors are posited as if they were universally applicable across populations. It is unlikely, however, that any one factor, or set of factors, is equally relevant across all groups of youth. Indeed, few studies have reported different HIV

risk factors among youth by gender in Thailand (Ford & Kittisuksathi, 1996; Isarabhakdi, 1997). Additionally, few researchers have explored the meanings and determinants of risk from the perspectives of youth among the populations under study (Boonmongkon et al., 2000).

One consequence of overlooking the population specificity of risk may be a lack of focus on addressing the importance of gender and culture (e.g., gender roles, norms, cultural values, unequal power) and how these factors may adversely affect an adolescent's ability adopt and maintain HIV-preventive behaviors. In fact, several researchers have pointed out that gender-based power relation and social expectations impact on young people's sexual behavior, especially in young women (Ford & Kittisuksathi, 1996; Havanon, 1993; Muangsom, 2000; Pattaravanitt, 1995; Srinual, 2003; Soonthrondha, 1996). Nonetheless, there has not been a great deal of empirical investigation of these factors as a factor that influence on sexual behavior directly.

An important feature of most studies of risk taking behavior among adolescents is that assessment of adolescent sexual activity has frequently been limited to one dichotomous variable such as sexually active versus not sexually active (Allen et al.,2002; Bond et al., 2003). Furthermore, they tend to focus on specific risk behavior such as condom use rather than the measure of cumulative sexual risk (Thato et al., 2003). The further research regarding the possible effects of cumulative sexual risk taking is needed. More importantly, broadening the range of sexual risk taking should allow for the development of more meaningful intervention.

Much of previous research related to gender-based factors has been focused on women, but it is important to include men in such research because the relationships in which women are involved are dyadic. The inclusion of men in sexual research is

imperative because many women are resentful about taking responsible for their male partner's behavior, especially when they do not feel that they have the power to affect change (Havanon, 1993). Furthermore, men often place themselves at risk for negative outcomes by having multiple sexual partners. If men have multiple partner then that puts the women who are in relationships with these men at increased risk as well. This study considers both male and female standpoint and examine gender-based factors in heterosexual relationships in the context of sexual risk practices.

Finally, in the Thai context, we have numerous deficiencies in the theoretical based survey on the determinants of sexual risk behaviors, especially among heterosexual young people. Even though there are attempts to apply behavioral theories to sex research, such studies still employ a mono-theoretical perspective. Theories can be very useful from a practical point of view. A one-sided focus on one, or only a few theories, however, can lead to suggestions that may not contribute to a reduction or solution of a practical problem (Kok, Schaalma, De Vries, Parcel, & Paulussen, 1996). Additionally, previous research misses crucial information about gender and power factors such as attitude on sexuality or gender role perception, power in sexual relationship. To address these issues, the present study proposes a conceptual framework adopted from three psychosocial theories of health behavior, and seeks to fill the gaps in the literature by looking carefully at the relationship of gender-based factors to the more complex combination or profile of behavior in sexual risk practices in young people.

Theoretical Perspectives

The proposed study was drawn upon three of the most prominent health behavior models and notion of gender-power relation for its understanding of the effect of gender-power related factors on sexual risk behavior. Health Belief Model (HBM)((Rosenstock, 1974), Theory of Reason Action/Planned Behavior (Ajzen, 1985, 1991), and Self-efficacy theory (Bandura, 1997) focus on shared process and contents of individuals, which they bring into the situation. Meanwhile, notion of gender and power deals with un-exploring factors related to interpersonal and gender related factors because the result in gender difference in sexual experience, expectations, and the ability to adopt HIV/STDs are forced by social, cultural and economic pressure. Thus, studies or theories that focus on a single predictor or a small subset of related predictors may miss critical information about the complexity of sexual behavior. Multivariate approach in this study will be developed by grouping the variables conceptually into two domains: psychosocial behavioral domain and social and cultural domain (gender-power relation constructs). This section briefly describe about main behavioral models and their limitations, as well as the notion of gender-power relation.

Psychosocial Theories of Health Behavior

The prominent behavioral theories that have been used to better understand HIV-related risk behavior during adolescence and youth are three main theories: Health Belief Model, Theory of Reason Action/Planned Behavior, and Social

Cognitive Theory. These theories have informed the HIV- prevention literature in a several behavior change and by providing individual level constructs that are important to target in behavior. More notably, these models have very narrow range of theoretical perspectives to explain sexual risk behavior, especially in female population (Amaro, 1995). The models do not focus on interpersonal relationship and do not address the gender nature of sexual behavior and of risk reduction. Similarly, both a review of prevention of HIV among adolescents (Rotheram-Borus et al., 2000), and recent meta-analyses of HIV prevention targeting women (Logan et al., 2002) found that none of the models consider the gender role and social context.

Health Belief Model

The HBM Model (Rosenstock, 1974) has been accepted by many health researchers and has usually been used more than other health behavior change model (Fisher & Fisher, 2000). It predicts an individual's health-related behaviors from his or her beliefs about the behaviors and their consequences. The four categories of health beliefs considered relevant to health behavior change are perceived susceptibility to the health problem, perceived severity of health outcomes, perceived barrier to changing behavior and perceived benefits of behavior change. It focuses on outcome expectancies and suggests that individuals engage in cost/ benefit analysis. The HBM also incorporates sociodemographic factor and environment cues to action.

Within the areas of HIV prevention, the relations between most HBM constructs (e.g., perceived susceptibility, perceived severity, and perceived cost and self-efficacy construct) and HIV prevention have been much more consistent. However, when HBM variables have been tested in relation to health outcomes, the

percentage of variance accounted for has generally been quite low. In addition, review of HBM research found it to be consistently weak from a methodological and a measurement perspective (Harrison, Mullen, & Green, 1992). Because of equivocal findings and lack of specification, it is difficult to use the model in behavior change intervention (Fisher & Fisher, 2000).

The Theory of Reason Action/ Planned Behavior

The TRA/TPB (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) state that change in outcome expectancies and their values, subjective norms and intentions (motivation) are linked to change in behavior. TRA is a well-specified and well-tested model of the psychological determinants of volitional social behavior. The TRA also specified the basic psychological underpinning of the attitudinal and normative determinants of intention and behavior. In practice, the TRA is used to predict, understand, and change HIV prevention behavior. According to empirical evidence, it shows that there is consistent relationship between constructs but less success in efforts to change HIV prevention behavior (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Armitage & Conner, in press; Fisher & Fisher, 2000).

TPB is an extension of the TRA that adds the construct of perceived behavioral control to the model and is attempt to enhance ability to predict, understand, and change behavior in domains of action which are not entirely under volitional control. The TPB has considered the influence of factors-- such as sexual arousal, gender-based power differentials, and alcohol and drug use-- affects an individual's complete personal control, but there is lack of examination and testing.

Social Cognitive Theory

The SCT has been developed by Albert Bandura (1986). It focused on behavior in context of the environmental events and personal factors that influence it and are, in turn, influenced by the behavior. Likewise, this phenomenon of the three elements (behavior, environment, and person) all influencing each other is known as reciprocal determinism. Bandura specified many concepts, including outcome expectations, values, beliefs and self-efficacy which have no specific measures. Additionally, this theory is very complex; it is not possible to test theory as a whole in a single study. Thus, it may be this reason that researcher often choose simpler model to use in developing and testing health behavior (Baronowski, Perry, & Parcel, 1997).

The construct of self-efficacy is recognized as one of Bandura's most important contributions to psychology and the field of health behavior change in general. It affects whether people will attempt to change at all, how much effort they will exert, and how much they will present in change attempt without giving up. 'Self-efficacy' is the sense that one can control his or her motivation and environment, and especially, his or her behaviors. J.D. Fisher & W.A. Fisher (2000) conclude that the most significant work involving the SCT in the HIV risk reduction domain has involved SCT inspired intervention, not model test. Additionally, meta-analytic studies suggest that intervention containing SCT elements have been quite successful at changing HIV risk behavior. However, it must be noted that the credit for this must be shared with other models that share elements in common with SCT (e.g., TRA, TPB).

In conclusion, although these models include a broad range of variables, basically three general categories of behavioral determinants can be distinguished

(Ajzen, 1998; Bandura, 1998 see also Abraham et al., 1998; Kok et al., 1996) : (1) attitude (beliefs and evaluations about advantages and disadvantages of behavior); (2) social influence (direct social pressures and subjective beliefs about social norms and expectations); and (3) self-efficacy (beliefs about perceived behavioral control, or self-efficacy expectations).

Notion of Gender and Power

Definition of gender, sexuality, and power. Gender is a cultural-specific construct (Gupta, 2000). It is the significant term that often mentioned within women sexual relationship and closely related to power. Especially, this term is still used inappropriately and incorrectly. Gender is not a synonym for sex. As Gupta (2000) defined, "It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and role." (p.1). Like the sociology definition, Connell (2002) defined "gender is the structure of social relations that centers on the reproductive arena and the set of practices (governed by this structure) that bring reproductive distinctions between bodies into social process" (Connell, 2002, p.10). Gender differentiates women from men and determines the ways in which women and men interact with each other. Indeed, women and men interaction in one culture cannot compare to another due to gender specific culture. Nevertheless, what always appears across cultures is that there is a distinct difference between women's and men's roles, access to productive resources, and decision-making authority (Gupta, 2000).

Based on the review of gender, racial, ethnic, sexual and class identities (Frable, 1997), exact definitions of gender identity vary. Traditionally, in aspect of

medicine it refers to the people psychological senses of being male or female. The literature in social and personality psychology understood gender identity as a social category. For example, Spence (1985) defines gender identity as a " fundamental existential sense of one's maleness or femaleness" and "primitive, unarticulated concept of self, initially laid down at an essentially preverbal stage of development and maintained at an unverbalized level" (p. 79-80). Gender identity existing in social psychology refers to men's and women's awareness of and feelings for their gender category or some researchers define gender identity an individual's self-conception based on the specific gender role. For this study gender identity refers to individual's perception of maleness or femaleness based on the particular gender role.

Sexuality defers from gender but significantly linked to it. It is the social construction of a biological drive. Gupta (2000) defined an individual's sexuality as multidimensional and dynamic concept. Gender, age, economic status, ethnicity and other factors affect an individual's sexuality. Sexuality consists of the Ps of sexuality: practices, partners, pleasure/pressure/pain and procreation. The first two refer to domains of behavior-how one has sex and with whom. The others refer to desires. The feminist theorists, Jackson and Jones (1998), defined sexuality as a desire, identity and practices. This study will use measure of sexuality perception about femininity and masculinity to reflect gender identity because in Thai context issues of gender and sexuality are so complicated. Thus, gender and sexuality cannot be studied separately (Cook & Jackson, 1994, p. 4; Van Esterik, 1999, p. 280)

Power is defined in different ways (Blanc, 2000). Power is the key concept in feminism, but psychologists have largely ignored it due to its ambiguity. As Yoder and Kahn (1992) wrote in “Toward a feminist understanding of women and power,”

definitions of power should focus around “power to” and “power over.” “Power to” is defined as personal empowerment or the ability to act, and “power over” refers to interpersonal power or the ability to assert one’s wishes and goals even in the face of opposition from another (p. 383-385). Power and gender are also closely related and never independent, so power relations involve macro and micro levels: societal, organizational, interpersonal, and individual. However, based on reviews in both psychology and social science, power in face-to-face relationships is a challenging topic to study in women’s HIV risk (Jenkins, 2000). Interpersonal power refers to “powerful behavior toward others,” which “may be motivated by a felt need for power, but may also originate in other personal motives or social circumstances at other social systems levels” (Jenkins, p. 477).

Gender-based power derives from the social meaning given to biological differences between men and women. Notion of gender-based power relation comes from theory of gender and power developed by Connell (1987, 2002). This theory focuses primarily on gender and power imbalance between men and women. It proposed three overlapping but distinct structures characterized the gender relationships between men and women: the sexual division of labor; the sexual division of power; and the structure of cathexis (or affective component of relationships). Wingood and DiClemente (1998, 2000) have applied the theory of gender and power to examine HIV risk factors in women as follows: the sexual division of labor is viewed as socioeconomic inequality; the sexual division of power is viewed as interpersonal power to avoid unhealthy behaviors; and the structure of cathexis is defined as social norms and affective attachments. With regard to three major structures rooted in society, gender based inequalities in women daily lifestyle

practices remain largely in women's economic potential, women's control resources, and gender-based expectation of women's role in society. According to theory of gender and power, gender relation encompasses interpersonal power in sexual relationship, which plays an important role in women's HIV risk behavior (Amaro, 1995, Amaro & Raj, 2000; Wingood & DiClemente, 1995; Weiss et al., 2000).

By now, many scholars acknowledge that social and cultural socialization process places young people at a heightened risk of HIV infection (e.g. Amaro, 1995; Gupta, 2000; Weiss et al., 2000; Wingood & DiClemente, 1992, 1995). The construction of male and female sexuality represents the inequalities of the social and economic sphere of life, particularly in the cultures where virginity is highly valued. The traditional norm of virginity for unmarried girls still exists in the Thai society. Sexual role socialization of Thai young people may be somewhat different form that of western adolescents. Therefore, gender role socialization in Thai context is briefly described here.

Adolescent, Gender and Sexuality in Thai Context

It cannot be denied that Thailand is a man-dominated, patriarchal society, because males have always occupied political and corporate leadership. By contrast, the power of Thai women, especially in the rural societies, takes shape in their domestic role as the mothers-nurturers (Taywaditep, Coleman, & Dumronggittigule, n.d.). Young males often grow up within the context of few responsibilities and socialized freedom, for instance to try alcohol, tobacco, and become sexually experienced. On the other hand, a young female is given stricter training on how to behave, more responsibilities towards the family and household and much less social freedom (Archavanitkul & Havanon, 1990).

Consequently, many young Thai women find it very difficult to acknowledge their sexual feelings or desires. Moreover, the use of effective contraceptives often involves a communication and negotiation process between a woman and a man (Havanon, 1993). However, the cultural expectation that a Thai woman should be sexually "innocent" and reserved has worked against her ability to negotiate the need for taking precautions during sex. One complex fear in the young woman's mind is that by openly expressing the need to take precautions (e.g. condom use) she conveys an image of being sexually knowing, possibly experienced, and sexually and preventatively active rather than passive in the interaction with her male partner. This makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex.

In addition, the Thai society is coming to the turning point of social change; hence, adolescents today are shaped by the changing society that has strongly shifted from the traditional to the modern values and norms (Taywaditep et al., n.d.). Young males and females are intensely attentive to the new "modern" (foreign) patterns of sexual interaction; even if the young women were resistant to admit that they would themselves actually engage in such practices. This dynamic has shifted from the healthy traditional sexual norms towards the ill-defined 'modern' behaviors of an unknown origin that underlies much of the adolescent sexual behavior. The difficulty here is that young women experience conflicts between their norms and social expectations. These contexts provide the clear picture of how important social and cultural factors influence adolescents' sexual behavior.

Determinants of Sexual Risk Behaviors among Adolescents

With respect to combination between the psychological theories approach and notion of gender and power to sexual behavior in adolescents, a way of organization and explaining the variety of constructs that may influence sexual risk behavior are the combination of well-accepted constructs from the main health behavior models and constructs from gender relation studies. Amaro (1995) and J.D. Fisher and W.A. Fisher
(2000) noted that health behavioral theories are still useful in understanding some psychological and social factors associated with high-risk behaviors and behavioral change even if there are some limitations as discussed earlier. Moreover, concepts from gender dynamics (e.g. gender role perception and power relationship) are needed to incorporate in a new formulation of which factors affect risk for adolescents, especially women (Amaro, 1995). Several influences that are associated with sexual behavior can be categorized as attitude and beliefs, social influence (peer norms), self-efficacy, behavioral intention and social-contextual influence focusing gender-based factors.

Attitudinal/Belief Influences

In the individual-oriented approach, attitude and beliefs are the focus of theories. The prominent theories that propose that adolescent sexual behavior is determined by cognitions and attitudes are HBM, the Theory of Reasoned Action (TRA) (Ajzen & Fishbein, 1980), Theory of Planned Behavior (TPB)(Ajzen, 1985,1991), and Social Cognitive Theory(SCT) (Bandura, 1989,1992,1997). All

these theories indicate that self-reports of potentially modifiable belief could explain how likely an individual is to undertake particular health behavior. For instance, adolescents who use condoms have more positive attitude about them. In case of sexual risk behavior, attitude and beliefs about sexual activity and safe sex regarding condom use initiation are specified as follows.

Attitude/ Beliefs about Sexual Intercourse and Condom Use

A recent meta-analysis of psychosocial correlates of condom use (Sheeran et al., 1999) reported that positive attitude toward condom is reliable predictors of condom use and there are many beliefs of condoms associated with actual condom use. More perceived barrier to use, more perceived negative consequences for self or partner, and greater embarrassment when buying condoms were associated with less condom use. The belief that condoms are attractive to use and do not interfere with sexual pleasure was associated with protected sex. Similarly, Jemmott et al. (1992) found that expectations about the hedonistic effects of condom use were an important influence on motivation to engage in health-protective practices. It is also noted that a vital structure of beliefs about condom use outcomes is pleasure dimension (Albarracin et al., 2000). Pleasure theme was strongly associated with actual condom use.

Apart from attitude toward condom use, attitude toward sexual intercourse also includes in the study to identify sexual risk behaviors. Empirical evidence indicates that less positive attitudes toward teenage sexual activity have been associated with not having sexual intercourse (Basen-engquist et al., 1999; Romer et al, 1994), having fewer sexual partners (Basen-Enguist & Parcel, 1992), and with

having a low value on an HIV risk behavior index (Walter et al, 1992). Additionally, Small et al. (1993) found that adolescents who were not sexually active perceived significantly more costs for engaging in sexual intercourse than their sexually active peers. The correlation between sexual intercourse status and perceived costs was r=.32. Female perceived more cost (Mean =17.30) for engaging in sexual intercourse than their male counterparts (Mean = 14.80). While, adolescent females perceived fewer significant benefits (Mean = 18.22) for engaging in sexual intercourse than their male peers (M =18.22). The correlation between sexual intercourse status and perceived cost was low but significant (r=.11).

In Thai context, although there are lacks such kinds of theoretical-based research, there are some studies provide evidence of the importance of attitude toward pre-marital sex and condom use affecting sexual practice. In a qualitative study of sexual networking among sexually active women and men (unmarried and married) in Central Provinces, Havanon (1993) found that attitude toward condom affected user of condom rather their knowledge. Based on data gathered from in-depth interview of 181 men and 50 women, the authors reported non-use condom men believed that condom reduce pleasure or sensation of sexual intercourse, whereas women did not use condom because they see condom as the man's privilege and condom may imply that they are not clean.

Thato et al. (2003) examined relationship between main constructs from Health Belief Model and actual condom use among 195 adolescent Thai vocational students who were heterosexually active (138 males, 57 females) in Bangkok. Using stepwise multiple regression, the results indicated that perceived benefits from using condoms, interaction of intention and gender, interaction of knowledge and peer

norms, and interaction of alcohol and age explained 27 % of variance in condom use. The perceived benefits explained 1.6 % of variance in condom use. This finding suggests that positive beliefs of condom use affect condom use.

In another theoretical-based study, VanLandingham et al. (1995) applied two models of health behaviors (HBM and TRA) to an analysis of unsafe sexual practices (inconsistent condom use with commercial sex workers) among northern Thai males. The sample consisted of 524 Chiang Mai university undergraduates, 55 soldiers, and 398 semiskilled/unskilled workers employed in Chiang Mai city. Data were obtained from a questionnaire survey, which had 100% response rate. Using logistic regression, the results showed that behavioral attitude, perceived severity, perceived barrier, and perceived benefits were significantly associated with condom use. This findings support that adolescents who have favorable attitude toward condom use are likely to engage in safe sex practices. In addition, the study suggests that application of theory of reasoned action fits to Thai context more than HBM. Constructs of TRA correctly classify a larger proportion of the cases into the correct condom use category than those of HBM (71% for TRA and 65 % for HBM).

Taken together, even though there are few theoretical-based studies supporting relationships between theoretical constructs from behavioral theories and sexual risk taking including condom use in Thai youths, the findings indicated that sexual risk behavioral beliefs and attitudes are still important to explain sexual behavior including condom use in young population. In particular, there is lack of studies linking attitude towards sexual risk behavior to low /high risk taking.

Social Influences (Peer Norms)

Indeed, there is no denying that friends might have an influence on adolescents' general attitudes toward sexuality and sexual behavior. Several studies support that the perception of peer sexual behavior influences adolescents' decision to engage in sexual behavior (Basen-Engquist & Parcel, 1992; Kinsman et al., 1998; Nahom et al., 2001; Romer et al., 1994; Walter et al, 1992). This evidence specifies that if youths believe that their peers are having sexual activities using the condom, they are likely to initiate a sexual relationship and use condom. Specifically, according to a meta-analyses of psychosocial correlation of heterosexual condom use, Sheeran et al. (1999) found that believing that one's friends and peer group use condom (descriptive norms) has a stronger association (r = 0.37) with one's own condom use than perceived social pressure (parent, close friend and partner approval) to use condom (0.26). Therefore, both descriptive norms (perception of peer's sexual behavior) and normative beliefs (close friends' approval of having sexual risk practices) were included in this study.

In Thai context, based on TRA VanLandingham et al.(1995) found that peer norms were the strongest predictors of condom use with commercial worker in men (Exp beta = 2.2, $p < .0001$). A study in a sample of young women by Bond et al. (1999), was conducted in northern Thailand, and collected data from 158 respondents through two approaches: ethnographic techniques and surveys. The result demonstrated that social norms exist within the gender subgroups, and therefore, revealed significant influence on the risk behaviors of their members. For example, friends initiate romantic and sexual partnerships; 40% of the female partners and 31

% of the male partners were introduced by a friend. The quantitative analysis confirmed that sexual risk of women was influenced by the sexual risk of their friends with their partners ($r = .27$, $p < .01$). On the other hand, the sexual risk of men was influenced by the drug and alcohol risk behavior of their friends ($r = .32$, $p < .01$). A focus group discussion from a study of female adolescent in students and factory workers (Soonthorndhada, 1996) also supported that peer norms were very important for young women because they learned about sexual activity from peer and media much more than any others. It can be said that the perceived peer norms have a significant influence on both male and female young people's safe sex practices.

Sexual Self-efficacy

In sexual practices, all multivariate models of sex behavior among homosexual men and heterosexuals of both genders include the concept of self-efficacy (Bryan, Aiken, & West, 1997). Perceived self-efficacy has emerged as one of the strongest predictors in many studies (Barkley & Burns, 2000; Brien et al., 1994; Diolorio et al., 2000; Waulfert & Wan, 1993). However, several researchers have suggested that in heterosexual relationship men have greater power than women (Holland et al., 1990, 1992; Wight, 1992). This may mean that self-efficacy is not relevant to women because women can not use condom without male cooperation. More than that, generally, using condom is under only male's control. In addition, Bandura (1989) has acknowledged that self-efficacy theory is limited to explaining interpersonal situations where the cooperation of two partners is required. "The weaker the perceived self-efficacy, the more such social and affective factors can

increase the likelihood of risky sexual behavior (Bandura, 1989, p.129).” Some studies conducted on a sample of young women have found no relationship between perceived self-efficacy and condom use (Bachanas et al., 2002; Basen-enquist, 1992; Bowleg et al., 2000; Resenthal, Moore, Flynn, 1991). By contrast, a number of studies have found that women with low levels of self-efficacy in using condoms (Gutierrez et al., 2000; Hale & Trumbitta, 1996; Kasen, Vaughan & Walter, 1992; Lauby, Simaan, O’ Connell, person, & Vagel, 2001; Sionean et al., 2002) and being able to avoid HIV (Harlow et al., 1993) are also more likely to engage in HIV related sexual risk taking. It has shown that there are still mixed findings in the aforementioned studies.

Partners may be viewed in some cases as “barriers” to condom use, so that efficacy judgments are likely to vary depending on partner characteristics. For example, women’s self-efficacy for condom use with a main partner was lower than self-efficacy for condom use with other partners (Lauby et al, 2001; Galavotti, Cabral, Lansky, Grimley, Rilry, & Prochaska, 1995). Galavotti et al. (1995) have suggested that the measurement of condom use self-efficacy required separate assessments for main and other partners. Bowleg et al. (2000) found that young women who get married were not concerned about condom use as much as unmarried women.

Another concern about the perceived self-efficacy is a variety of approaches used to measure self-efficacy in condom use in different populations. As Sheeran et al. (1999) reviewed, there are two levels of self-efficacy measurement: HIV/AIDs prevention or safe sex in general, and condom use in particular. Each measurement provides a different correlation with condom use: safe sex self-efficacy in general yielded a smaller positive correlation (r = 0.12) than did condom use self-efficacy (r =

0.25). It seems likely that the measurement of self-efficacy affects the correlation with behavior. This finding supports the claim that self-efficacy is a “situation” concept rather than a general one, which means that each measure, must be tailored to the context and to the populations (Bandura, 1989).

Regarding adolescent self-efficacy, majority of the work has been done with college students (Brafford and Beck, 1991; Brien et al, 1994; Barkley & Burns, 2000). However, self-efficacy is still ignored about the context of the performance situation and level of difficulty to perform safe sex. A rigorous methodological study (Murphy, Stein, Schlenger, Maibach, & NIMHI, 2001) proposes the multidimensional assessment of safe sex self-efficacy that consist of two factors that strongly influence self-efficacy for safe sex regarding Bandura' s conceptualization: (a) the situation or scenario which the person often deals with (e.g. in intoxicated: is with someone with whom he or she has a history of unsafe sex) and (b) the graded difficult level of the behavior the person must perform to have safe sex (e.g. only needs to bring up the topic of safe sex; must convince a partner). More specifically, self-efficacy measures were developed from qualitative method (Focus group) and separated for men and women. This conceptualization supports the theoretical framework from which the sexual self-efficacy was constructed and was used in the study.

In the Thai context, Thato et al. (2003) found that perceived self-efficacy, one of the strongest predictors of condom use, did not enter the model based on HBM in a sample of vocational students. To explain the absence of a relationship between self-efficacy and condom use, Thato et al. argued that the western instrument might not be appropriate within Thai culture, even though they verified the instruments in back translation. They suggested that instruments needed the focus group to verify the

question because back translation alone could not detect the differences in the conceptual understanding of the question, and so could not ensure a psychological equivalence between items in a scale or a questionnaire (Kristjansson, Desrochers, & Zumbo, 2003). More specifically, even though the internal reliability of self-efficacy instrument was quite high (alpha = 0. 86), the component of self-efficacy in this study (communication, use consistently, use correctly) may not indicate some important components of self-efficacy in regard to condom use among Thai adolescents. Moreover, it is noted that a number of respondents, especially of the female students, was not sufficient to differentiate a statistical significance. In particular, gender was the only modifying factor that was significantly and directly predictive of condom use. Therefore, further research needs to explore predictors of condom use in each gender separately. The finding also noted that sexually active female students who had greater intention to use condoms reported greater condom use.

Likewise, VanLandingham et al. (1995) found that perceived self-efficacy remains insignificant in males. Based on the operational definition of self-efficacy in this study, it was defined as one item of global self-efficacy: how easy it was to use a condom. Measurement error may run through this study because self-efficacy is a cross-situational construct. Only one item cannot detect statistically significant. Moreover, the study focused only condom use with sexual workers which males were always concerned about using condom with such a sexual partner and familiar with using condom, whereas sexual worker usually encouraged male customers to use condom with them, as well. These may cause the absence of relationship between self-efficacy and condom use with sexual workers in males.

A clear conclusion about the influence of self-efficacy can not be drawn because there are few studies found in Thai literature that examine the relationship between these variables among both male and female adolescents. In fact, men are more familiar with condoms than women or perceived to be less inconvenienced by their use than women are. In turn, self-efficacy could be an important predictor of sexual risk taking, including condom use in women. However, within non-commercial sex partnership, both male and female adolescents are not convenient to introduce condom or refuse unprotected sex. Thus, sexual self-efficacy is supposed to associate with adolescent's sexual risk behavior.

To summarize, the findings about the relationship between self-efficacy in young people, especially in women and safe sex practices are still controversial when studying different cultural groups. Especially, all of the studies just cited either used a global measure of self-efficacy (e.g. Wulfert & Wan, 1993) or focused on behavior that were not within any situational context. More empirical investigation is needed in this area of sexual behavior in young people. Does self-efficacy affect on safer sex in universal across cultures? Further empirical work will provide the answers that will enhance our understanding of the role of self-efficacy in young people and its role in the different cultural contexts of HIV risk.

Behavioral Intention

From TRA, we can speculate that behavior is determined by intention. Previous meta-analytic reviews have shown that intentions are good predictors of behaviors in a variety of domain. Across 88 studies, Sheppard, Hartwick and

Warshaw (1988) obtained an average correlation of .53 between intention and behavior, while Randal and Wolff's (1994) review of 98 studies obtained an average correlation of .45. There are reasons to suspect that intentions may not predict sexual behaviors, especially condom use since sexual behavior is not under only individual control but also need a joint behavior which requires the cooperation of a sexual partner (Kashima, Gallois & McCamish, 1993). The intender may not use condom because of not having a condom available or depending on sexual partner's perspective. The recent meta-analysis of the relationship between intentions and behavior in prospective studies of condom use (Sheeran & Orbell, 1998) has shown that intention-condom use relationship are weaker among adolescent samples and suggested that intentions to use condom are very unstable among adolescents. Thus, the behavioral intentions, only intercourse intention, were included in this study for outcome of sexual experience.

In conclusion, adolescents who have positive attitude toward sex and condom, supportive norm regarding sex involvement and condom use, behavioral intention and self-efficacy may not be sufficient to promote behavior change because sexual risk behavior in adolescents is complicated so that it could not only be understood in terms of motivational orientation toward performing a behavior or skillful practices. Sexual behavior requires cooperation from sexual partner, particularly in young women because safer sexual behaviors are still depended on male dominance and may have different intention or non-volitional control. Thus, gender-based power influence is thought to weaken the power explaining of social cognitive models (Amaro, 1995).

Gender-Based Determinants

Although the psychological constructs have utility in explaining determinants of behavior, several researchers have criticized these models and other models that focus on individual level factors, including lack of applicability to women due to ignoring gender relational factors (Amaro, 1995: Jenkin, 2000). The following constructs, gender role perception, and power, are used to expand the scope of this study beyond the limit of the behavioral theories.

Gender Role Perception

To date, an impact of gender is the key to vulnerability to HIV/AIDS in young women other than young men (Amaro, 1995; Gupta, 2000; Wingood & DiClemete,1995, 2000; Weiss et al., 2000). Young women in many parts of the developing world, including Thailand, have little control over how, when and where sex takes place (Weiss et al., 2000). The high social value placed on virginity in unmarried girls may pressure parents and the community to ensure that young women are kept ignorant about sexual matters. Female ignorance of sexual matters is often viewed as a sign of purity and innocence while having 'too much' knowledge about sex is a sign of 'easy virtue' (Gupta, Weiss and Mane, 1996). Indeed, there were empirical findings that gender role perception was associated with sexual risk taking. In a study of the first-year college students in US, Caron and colleagues (1993) found that women who adhered less to the traditional sexual double standard were more likely to suggest using condom and to actually provide condoms. Several studies within Thai context (Ford & Kittisuksathit, 1994, 1996; Havanon, 1996; Rugpao,

1995; Soonthorndhada, 1996) have explored gender roles and attitudes and the ways in which these influence risk perception and behaviors.

Through quantitative and qualitative approaches, research shows that young women and men experience different patterns of socialization; and expectation regarding sexual behavior, responsibility and risk are perceived quite differently (Ford et al., 1994; 1996). Results provide strong evidence of sexual double standards: male are expected to engage in causal sexual relations without concern of consequences. Females, in contrast, are expected to be naïve in sexual matters, accepting of their partners' other relationships and complaint in terms of initiating safe sex practices. Another study among female and male factory workers in Northern Thailand similarly pointed to huge gender disparities in patterns of sexual behavior, with males consistently more likely to engage in risky behaviors and consistently less likely to use condoms with their regular partners (Rugpao, 1995). In a same vein, Havanon (1996) interviewed 181 men and 50 women in a central province nearby Bangkok, employing an in-depth interview method with flexible, open-ended questions. This study has confirmed that the standard of a passive female role in sexual relations create a potential health risk for women. Women do not understand or even know about their partners' sexual behavior. They do not question or discuss their concerns or suspicious about contracting STDS.

Similarly, a sexual behavior survey of 577 unmarried males and 517 females aged 15 through 24 years who lived in rural area of the North and the Northeast of Thailand, Isarabhakdi (1997) found from ordinary least squares regression and multinomial logistic regression that sex-role attitude was significant associated with sexual attitudes and sexual experience in the past among males, whereas in female

there was no report about that due to having small sample size. Moreover, findings from qualitative data clearly emphasized the impact of social norms supporting a double standard related to sexual attitudes and behavior among young rural Thai men and women. Parent rarely discusses sex with their children, while continuing to reinforce sex-role stereotypes that identify male promiscuity as acceptable, whereas female sexuality is expected to follow marriage.

A study of 500 unmarried female adolescents living in Bangkok, which compared students (250) and factory workers (250), examined the influence of attitudes toward premarital sexual behavior on sexuality (Soonthorndhada, 1996). There were differences in opinions toward premarital sex between the workers and the students. The attitude toward premarital sex was defined as self-concept development (Self-image and self-esteem) and sex-role identity (perceptions of masculine and feminine behavior in a particular culture). It revealed that 40.4% of the students and 45.2% of the workers thought that having sex before marriage was disgraceful to their parents. In terms of cultural norms, 17.5 % of students and 13.1 % of workers viewed that premarital sex as culturally forbidden for girls. These findings may imply that Thai young women still hold a negative attitude toward sexuality and might be supposed to accept sexual risk taking because they are embarrassed to discuss sexual protective behaviors with their partners.

Correspondingly, another recent study of sexual violence among 1,292 secondary students and vocational colleges in central region, Srinual (2003) reported that 48 % of female students had sex with unintentional and 14 % had been forced to have sex. Based on data from in-depth interview (15 female and 12 male), 6 focus groups and a school-based survey, the author found that perception about sexuality

(masculine, feminine and lover sexuality) between male and female adolescents are different. The results suggest that men still want to be dominant and powerful in sexuality (e.g. having a lot of girlfriends at one time, and having experience before getting married) and expect to express their sexual action, whereas women never expect men to do so. This study defined masculine sexuality in term of dominance-power, sexual experience, decision making, activeness and aggressiveness; feminine sexuality as style of dressing, virginity, body right; and lover sexuality as situation that encourage males to have sex with females. In addition, the result from binary logistic regression also revealed that perception of masculine sexuality and perception of lover sexuality significantly associated with sexual abuse in males. There was no report such association in female because there was too small sample to detect statistical significance. However, the findings show that proportion of male adolescents who accept pre-marital sexual experience is less than one-fifth (17.9%), which is about 3 times higher than that of female adolescents. This indicates that both male and female adolescents in the present study are slightly linking sexual experience and masculinity. As mentioned earlier, concept of sexuality and gender cannot be separated in Thai context because both issues are intimately linked with each other. This result lends to link the association between gender role perception and sexual behavior in young people.

The evidence has indicated that there are gender differences with respect to sexual risk behavior in term of acceptance of gender identity and perceived control over the sexual encounter. More particularly, gender relation that favors men reflects an unequal power balance in heterosexual interaction. For instance, men link sexual experience with being competent and powerful (Srinual, 2003). An understanding of

individual safer sexual behavior, especially both males and females, thus, necessitates an understanding of increasing the vulnerability to HIV in young people constrained by role of gender. Based on this review, there is only one study (Srinual, 2003) attempted to develop perception of sexuality and examine association between perception of sexuality (feminine and masculine sexuality) and sexual abuse. None of Thai study examines relationship between gender role perception and sexual risk behavior.

Power in Sexual Relationships

Lack of power in relationships has been offered as the key explanation for why women do not always engage in safe sex behavior with male partners (Amaro, 1995; Wingood & DiClemente, 1995, 2000). Although many studies have shown that power imbalance in sexual relationships between men and women is related to sexual behavior and risk reduction, few have examined the effect of power in sexual relationships on sexual risk behavior in young women. It is also unclear how to define the power construct and how relationship power operates to influence sexual decision-making. Hence, this review of literature includes both qualitative and quantitative analyses of the relationship between power construct and condom use or partner risk. The literature review is based on both western studies and Thai studies.

In sexual risk behavior, several studies have attempted to integrate the theoretical issues of gender and power (Fullilove, Fullilove, Haynes, & Gross, 1990; Holland et al., 1990, 1992a, 1992b; Wight, 1992; Wingood & DiClemente, 1993, 2000). A focus group study with 28 lower-income African American women (aged 35-45) and teenage girls (aged 15-19) (Fullilove et al., 1990) found that there were

traditional sexual roles in the black community, which allow men to have sexual freedom but prohibit women from engaging in the same activities. The traditional sexual roles constrain relationships between men and women and cause women to internalize an imbalance of power between sexes and accept the lack of effective communication. The study provided insight into information on women's power in their relationships with men by investigating the extent to which disempowerment and economic dependence on men were evident and whether they affected sexual decision-making.

These findings are similar to those in the work of Wingood and DiClemente (1993). They explored the process of sexual communication and barriers toward effective sexual negotiation. The author found that black women perceived themselves as powerless in getting partners to use condom during intercourse. Based on data from focus group with 18 African American female adolescents aged 18 to 25, they found that more than 90% of them believed that their partner had more control over condom use during intercourse. In addition, most of them feared to resist their male partner's power.

In a review of qualitative projects from different geographical location in Britain by Wight (1992), it was found that there were no differences in beliefs or values of impediments to safer heterosexual sex Britain among young people (16-21 years old) between different regions. The result commonly highlighted that the power imbalance is an important impediment to safer heterosexual sex in young women. Based on feminist theories, Holland et al.(1990, 1992a, 1992b) reported that the power of young women to control sexual practices plays a key role in sexual risk taking and noted that unequal power between men and women is the crucial barrier to

promoting safe sex in women. Empowerment process is needed to put into practice ways of negotiating safe and pleasurable sexual encounters with men.

Although there is a vast body of qualitative literature showing that power inequality between men and women is an important barrier to having safe sex in women, there are not many studies that examine the relationship between the construct of power and HIV sexual risk behavior. In addition, as Amaro and Raj (2000) and Jenkins (2000) have indicated, there is currently no standardized concept and measure of power. Therefore, researchers defined innovative approaches such as Empowerment Theory, Theory of Gender and Power, and Feminist perspective. In this section, the literature surrounding the various aspects of power construct in HIV behavior risk research and its relation to HIV sexual risk behavior are discussed.

Jorgensen, King, and Torry (1980) conducted on study in 147 females (12 to 18 years old) attending county health and family planning clinics in both rural and urban areas of Arizona. The study examined dyadic and social network influences on adolescent exposure to pregnancy risk among college-age population. The author defined interpersonal power as decision dominance in four dimensions: decision-making, conflict, sex, and contraception. Results from multiple regressions demonstrated that female power (sexual relationship) was negatively correlated with the frequency of sexual intercourse (β .418, $p < .01$) and positively correlated with contraceptive use (β =. 254, $p < .05$). The result suggests that power in sexual relationships has a positive driving force in the process of safe sex practice.

Research on Latino and non-Latino women by Gomez and Marin (1996) revealed a similar picture of the impact of gendered power on condom use. The study was conducted with a large population of 2,221 adults aged 18 to 49 years using a

random non-Latina White women (64 percent married). Multiple regression results indicated that there were the positive relationships between perceived sexual power and condom use with a steady partner ($\beta = .11$, $p < .01$). The result also points out the importance of the role of gender role, and role of contraception in HIV sexual risk behavior, which have been little addressed in previous research in this area.

Like others, Soet, Dudley, and Dilorio (1999) found that the women (college students aged 18-25) in their samples with dominant partners (determined based on the women's responses to the question, "Who is/was the most dominant partner in your relationship?") expressed less self-efficacy; more negative expectations about the prospect of discussing safe sex with their partners; and made fewer sexual decision.

Similarly, results from prospective study among by 128 economically disadvantaged African-American women aged 18-29 years in one community (Wingood & DiClemente, 1998a) found in women who were inconsistent condom users, women who were consistent condom users were more likely to have high sexual self-control over condom use (OR = 7.6, $p<.001$), perceive having control over their partners' use of condoms (OR=6.6, $p<.001$), be younger (OR = 5.8, $p<.001$), and report having a partner that was not committed to the relationship (OR =3.3, $p<.001$). This result support the findings that power dynamics within a sexual relationship are strongly associated with HIV sexual risk. Additional study by the authors (1998b) found additional evident that gendered power affects sexual negotiation. Over 45 % of their sample of low income African American adult women (18-29 years old) hadn't used condoms in the three months prior to study and they are more likely not to negotiate with their partner to use condom.

Related to sexual communication, Saul et al. (2000) has examined power as a resource and function. The study divided the power influence into two groups: resource power as a function of resources, and relationship power as a function of various interpersonal reactions. Resource power was measured with two variables: level of education achieved by the women and whether they were currently employed. Relationship power was measured with five variables: (1) more decision making by the women; (2) more perceived alternatives to the relationship; (3) less commitment to the relationship; (4) less investment in the relationship; and (5) absence of abuse in the relationship. Based on self-report data from from187 Puerto Rican women, aged 18-35, the authors found that higher level of employment resources, decision-making, and perceived alternatives to the relationship predicted a higher level of HIV-related communication and condom use, while lower commitment to the relationship, investment in the relationship and abuse predicted higher level of self-protective behavior. For HIV-related communication, the resource power variables uniquely accounted for 8% of the variance, and the relationship power variables uniquely accounted for 12 %. For condom use, the resource power variables uniquely accounted for 16 % of the variance and the relationship power variables uniquely accounted for only 2 %. Despite in fact that the magnitude of the predicting relationship power was small (2%), the result supported the positive relationships between relationship power and condom use.

Based on this evidence, it underscores that the concepts of power presented here are proposed in two main aspects: decision making and relationship control. Correspondingly, there is recent interesting scale of power in sexual relationship regarding such aspects. A recent methodological advance, cited numerous times

throughout the meeting of reproductive health promotion, was the development of a Sexual Relationship Power Scale (SRPS) by Pulerwitz et al. (2000) based on the data collected from mostly Latina women in a community health clinic in the United Stated. The SRPS was developed to assess power in intimate relationships. Pulerwitz et al. (2002) defined power in sexual relationship as "the relative ability of one partner to act independently, to dominate decision making, to engage in behavior against a partner's wishes, or to control a partner's action"(p. 791). The SRPS was found to be internally consistent. As part of the original psychometric evaluation of the SRPS, additional data were collected from study subjects on physical abuse and forced sex in their current relationship, condom use, relationship satisfaction, and a variety of socio-demographic variables. The SRPS was inversely associated with physical violence and directly associated with education and consistent condom use ($p<.05$). Women who reported satisfaction with the primary relationship were more likely to report high scores on the SRPS ($p<.01$) (Pulerwitz et al.).

Additionally, there is one extension of this analysis of power in sexual relationships by Pulerwitz et al. (2002). The study applied a new measure, the sexual relationship power scale (SRPS) to determine the degree to which power in sexual relationships influences women's safer sex (dichotomous measure of condom use) among 388 Latino women aged 18-45 years in a community health center. The result has demonstrated that the SRPS is strongly associated with consistent condom use with a primary partner over the last three months. Women with a high level of relationship power were 4.95 times ($p<.05$) as likely as women with low levels to report consistent condom use, after controlling for sociodemographic and

psychosocial variables (STD/condom knowledge, condom use self-efficacy, personal condom attitude).

Furthermore, some researchers proposed that measures of power should include the actual behavioral outcomes that result from exerted influence. In other words, power is the ability to affect another's outcomes. Work by Tschann, Adler, Millstein, Gurvey, and Ellen (2002) used the term relative power to mean discrepancy between their perceptions of their partners' desires for emotional intimacy and perception of their own desire. They also measured global emotional intimacy power, and decision-making power. Based on data from 228 males and females aged 14-19 years, who visited an STD clinic in San Francisco, the authors found that adolescents who had more emotional intimacy power were more likely to have their condom use desires enacted (combining information about relative condom use desires within past 6 months and actual condom use at last time) (OR = 1.89, $p < .05$). Decision-making power was not related to condom use desires enacted. This result also reported that gender difference was related to power, but not related to condom use desires enacted. Young men had more decision-making power than young women. In addition, young men had nearly significantly more intimacy power than young women when global emotional intimacy power was used. These findings suggest that relative desire for emotional intimacy is an important aspect of interpersonal power in adolescents.

However, other studies have found that hypotheses regarding the impact of power on condom use are not supported by their data. Gutiérrez et al. (2000) have used an empowerment lens to examine sexual behaviors, focusing on domains such as personal power, interpersonal power and relationship power. Participants in this study

were 333 African American and European American urban youths from an urban public health clinic and an urban juvenile detention facility, aged 14-19 years, who were heterosexually active. The conceptualization of personal power is very similar to Bandura's (1982) concept of self-efficacy, yet differs from efficacy by focusing less on expectations of outcomes regarding one's behavior, and more on the understanding the actual choices, skills, and options one has in a situation. Cross-sectional regression analyses suggested that perception of power is not associated with condom use. However, the findings demonstrated a statistically significant difference between males and females in interpersonal power and supported the claim that adolescent women experience themselves as less powerful than men with respect to interpersonal power.

Similarly, Bowleg et al. (2000) hypothesized that women (the Black and Latina community samples of heterosexual women (ages of 18 and 50 years) would want to practice safer sex, but would be impeded by gender-power relation. Otherwise, they found that the women in their community sample were not motivated to have safer sex and that gender roles, power differences, and self-efficacy were insignificant if women were not interested in condom use. Such studies suggest that theoretically, there exists relationship between gender-power relation and condom use; however, this link is as not strong, simple, and discovered as anticipated.

In summary, the gender-based factors in young people, especially in women may help explain why women with the same demographic backgrounds will behave differently with respect to the issue of protective sex. Regardless of the controversial evidence in support of the relationship between power in sexual relationships and HIV when studying different cultural groups, there is sufficient evidence to support the

positive relationship between power and safe sex (e.g. Pulerwitz et al, 2000, 2002; Tschann et al., 2002). In addition, based on empirical evidence, researchers use different lenses of the power construct to examine the relationship between power and sexual risk behavior. However, in the case of sexual behavior, power is considered to be a multidimensional construct in that both relationship control and decision-making are important. It can be concluded that both theoretical and empirical evidence suggests that there is need for further research investigating the linkage between powers in sexual relationships influencing sexual behavior.

Gender-based Power in Thailand.. Several qualitative studies within the Thai context have explored gender, power and the ways in which these categories influence risk perception and behaviors (e.g. Ford & Kittisusathit, 1994; Havanon, 1993, 1996). For instance, Havanon (1996) interviewed 181 men and 50 women in a central province nearby Bangkok, employing an in-depth interview method with open-ended questions. The sample consisted of married and single men and women working in white-collar and blue-collar jobs, as well as some students. All of them had had more than one sexual partner in the previous year. This study suggested that the standard of a passive female role in sexual relations create a potential health risk for women. Women don't understand or even know about their partners' sexual behavior. They do not question or discuss their concerns or suspicions about contracting STDS. Most studies mentioned about gender role, and sexuality rather than power, which were discussed in aforementioned section related to gender identity. No study has attempted to link relationship between construct of power and sexual behavior.

Overall, evidence based on qualitative analyses within the contexts of western culture and Thai culture underscores that the constructs addressing the gender

and power imbalance between women and men are central and important factors that influence sexual behavior and risk reduction in young women. This conclusion is similar to the findings in a review of research conducted by International Center for research on Women (ICRW), Washington D.C., by Weiss et al. (2000). It has reported that power imbalance characteristics of sexual relations among men and women affect young women's risk behavior (Weiss et al.). Unfortunately, within Thai culture, there is lack of large-scale surveys examining the effect of sexual relationship power on sexual risk behavior among young women. Even in the western studies, the research in support of a relationship between power in sexual relationships and sexual risk behavior, including health protective behavior of the young population, is limited to a few large surveys.

Summary

The present study advances existing research on integrates cultural factors into a behavioral theory and examines the effects of gender power related factors using multivariate analyses. The study particularly focuses on gender-based factors - gender role perception and power in sexual relationship- that have been little studied. Traditional psychosocial constructs, namely attitude, peer influences, self-efficacy and behavioral intentions have also been included to form the predictive analyses. For example, the study investigates whether power in sexual relationships directly predicts sexual risk behaviors, or whether such a relationship is mediated by other factors such as self-efficacy. To our knowledge, research that links a concept of gender-power relation with sexual risk practice in young population has not yet been

conducted in the Thai culture. However, given the strong association between sexual double standards in the Thai society and sexual risk behavior, it seems likely that a relationship exists.

Conceptual Framework

The literature review from prior empirical studies of adolescent sexual behavior, which were beyond psychosocial constructs have suggested that cultural factors are important in influencing sexual risk behavior. It is evident that gender-based factors may jointly influence attitude, norms, self-efficacy, intention and sexual risk behavior.

Due to the lack of integrating gender-based factors into behavioral models in the study of youth sexuality in Thailand, psychosocial constructs based on prominent behavioral theories were borrowed for the purpose of this study. In the current application, psychosocial constructs such as attitude and beliefs, social influences, and self-efficacy are believed to play significant roles in influencing adolescents' sexual risk behavior. The cultural factors in terms of gender role perceptions and power in sexual relationship are available to be incorporated into the present study.

In this study the gender role perception and power in sexual relationship are seen as the result of cultural socialization process through gender-power relation imbalance in social structure, which affect sexual behavior. This assumption is different from behavioral theories. Most of the models assumed the individual performs specific behavior according to his/her attitude toward behavior, influence of one's sense of self control over the outcomes of his or her behavior, and the influence

of friends, and close friends. However, for example, TPB has also considered the influence of other factors such as sexual arousal, gender-based power differentials, and alcohol and drug use affects an individual's complete personal control, but there is lack of examination and testing. Cultural socialization process may moderate influence of psycho-cognitive factors in the model (Amaro, 1995)

The forgoing review demonstrated that norms of masculinity is expected to be associated with higher sexual risk taking in males; norms of femininity is expected to be associated with higher sexual risk taking in females (Gupta, 2000; Srinual, 2003); high power in sexual relationship is associated with lower sexual risk taking in males and females (e.g. Pulerwitz et al, 2000, 2002; Tschann et al., 2002). The main psychosocial components of behavioral theories – attitude, norms, self-efficacy, and intention - have been significantly associated with sexual risk taking (Albarraacin et al., 2001; Basen-Engquist et al., 1999; Coyle et al., 2001; Sheeran et al., 1999; VanLandingham et al., 1995). All of these findings represent direct effect of each construct on sexual risk taking.

The current study expands on these previous studies by exploring direct effect of gender role perception and power in sexual relationship on sexual experience and sexual risk taking in young people. The conceptual model for the current study is represented in Figure 1 & Figure 2. As shown in Figure 1 gender role perception is expected to have direct effect on sexual experience. These direct links may also be affected by beliefs of pros/cons in intercourse, peer norms, refusal self-efficacy. As shown in Figure 2 gender role perception and power in sexual relationship are expected to have direct effect on sexual risk taking. These direct links are also affected by the mediating factors of psychosocial factors (sexual risk behavioral

attitudes & condom use beliefs, peer norms, and safe sex self-efficacy). On the other words, gender role perception power in sexual relationship works through psychosocial/attitudinal domain to exert indirect effect on sexual risk taking.

Theses models assess some of the processes by which gender role perception and power in sexual relationship influence sexual experience and sexual risk taking in young people. It is only through an examination of process that we can begin to understand how best to prevent this risky behavior. Once we begin to understand the concrete behaviors and characteristics that are most related to sexual risk taking, we can more successfully inform and target population efforts. Hopefully, prevention programs based on such knowledge will significantly decrease STDS/HIV infection/ pregnancy caused by risky sexual behaviors.

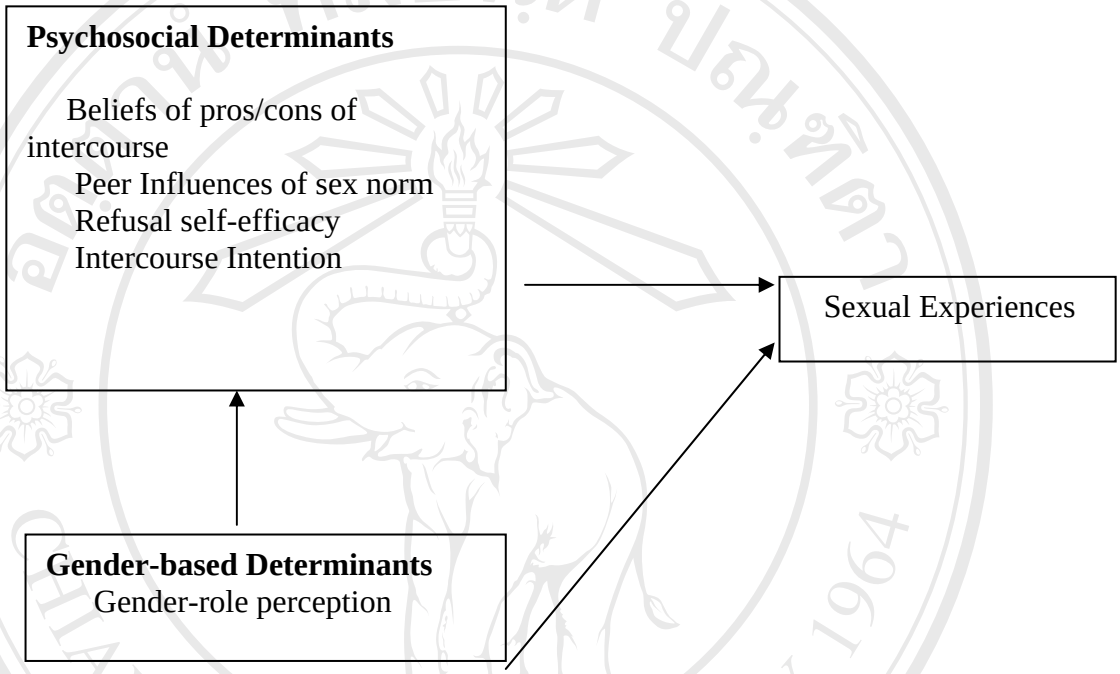

Figure 1 Conceptual Model of Sexual Experience for Thai Adolescents

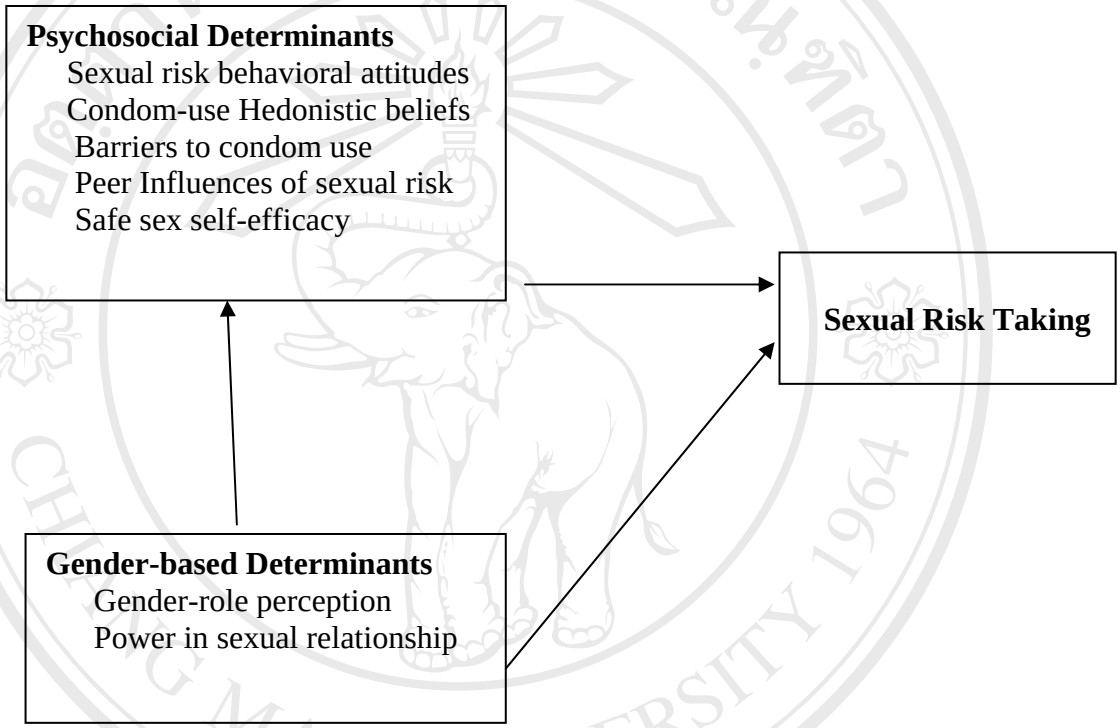

Figure 2 Conceptual Model of Sexual Risk Taking for Sexually Experienced Adolescents