CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This final chapter begins with a discussion of the findings in relation to existing literature, research and practice in the domain of adolescent sexuality; followed by conclusions, practical implications, strengths and limitations of the study, as well as recommendations for further study.

Discussion of the Main Research Findings

The primary objective of this study was to examine the sexual risk behaviors among Thai female and male adolescents in the public educational systems. Multiple outcome measures were employed so that a wider range of behaviors than those typically examined in previous research could be analyzed. The investigation was guided by behavioral theories (Kok et al., 1996), which emphasize basically three general categories of behavioral determinants (attitudes, social influence and self-efficacy) and notion of gender and power, which emphasizes the importance of considering the impact of social context on sexual behaviors. Although most studies of adolescent sexual behavior include both males and females in their sample, only a few directly examined gender differences in sexual risk practice or reported the results of separate sex analyses. Hence, these factors were examined to determine a new aspect of adolescent sexual behavior among females and males separately.

In addition, the use of multiple outcomes measures indicates that, just as the dichotomous categorization of adolescents into sexual experienced/not sexually experienced obscures the diversity of adolescent sexual risk behavior, the use of a single measure such as number of sexual partners or condom use during recent intercourse fails to present full picture of sexual risk practices among adolescents.

The Prevalence of Sexual Risk Behaviors

The Prevalence of Sexual Experience

The results of the cross-sectional survey in upper secondary schools, vocational colleges and a university showed that all 1,169 respondents were in age range of 15-22 with mean age of about 18 years old. It was also found that young women were less likely to engage in sexual encounters than were young men as presented in previous findings (Bond et al., 1999; Isarabhakdi, 1997; Norapat, 2000; Sartsara, 2001; Srinual, 2003). It is also recognized that the prevalence of sexual experience among young women is quite higher than the past, while the trend of sexual experience among young men is increasing by the year. The study found almost half of males (46.2%) had experience with intercourse, while one-fourth (27.5%) of unmarried females reported coital experience. Other studies, which found 25.18 % of males, and 4.07 % of females among high school and vocational students in Chiang Mai (Norapat, 2000), 35 % of males and 2 % of females in Thai youth (Sartsara, 2001), 67.6% of males and 34.3 % of females in vocational college in central region (Srinual, 2003) have had sexual experience.

Furthermore, premarital sexual activity is common in many parts of the world and is reported to be on the rise in all regions. According to the World Health Organization (2000)- sponsored survey in 1997-1998, which involved more than 128,000 students in 28 countries in the United State and Europe. For all countries, from 10 % to 38 % of 15-year-old girls and 23 % to 42 % of 15 year-old- boys said they had experienced intercourse. Especially in the United State, 38 percent of both boys and girls said they had experienced sexual intercourse. It is apparent that sexual activity among young people is the crucial indicators of sexual health problems in the future around the world, not only Thailand. .

However, it is noted that almost all young people either males or females reported having the first sexual intercourse with their own girl/boyfriends. Thus, the trend of sexual activity in females was probably lower than the fact. In addition, there were the qualitative findings supported the possibility.

> 70-90% of female students in vocational colleges have had sexual experience. They usually start having sex at age 15.
> (Group discussion, female students in vocational college)

Indeed, over-and underreporting sexual behaviors according socially desirability response should be considered in the area of sexual research. Males tend to overreport sexual activity and females tend to underreport (Catania et al., 1990). However, the paper and pencil format and providing refusal for sex questions may reduce social desirability effects. In addition, the prevalence of sexual practices found in this study were similar to those reported by other researchers (e.g. Allen et al., 2002; Bond et al., 1999; Srinual, 2003). Importantly, the refusal rates reported in this study were not high: only 3% for entire respondents; 3.7 % for females; and 2.2 % for males.

It was lower than Srinual's study of sexual violence, (2003), which reported refusal rate 21% for females and 1.6 for males. It implied that the respondents included in this study felt more social acceptable and less confrontational to report their private behaviors.

In addition, in each sex, the prevalence of sexual experience varies according to educational level. There was the largest proportion of sexual experience among vocational female (39.2%) and male students (54.7%). This result corresponded with previous findings of the rising trend of sexual experience among young people (Srinual, 2003), which found 34.3 % of females and 67.6% of males in vocational colleges have had sexual experience. It can be explained that students who are studying in vocational colleges mostly are poor at Grade Point Average and delinquent students as shown in table E10 in the appendix E. Thus, by the nature of students, they are more susceptible to have sexual experience than students elsewhere. Additionally, the results also supported that students who have low GPA have higher trend of sexual activity than students who have higher GPA, and those who never had behavioral risks (i.e., alcohol drinking, smoking, substance use) were less likely to have had sexual intercourse, compared to those who ever had behavioral risks. Particularly, there are significant differences between vocational school students and university or secondary school students in some psychosocial factors and gender-based factors except barrier to use condom, hedonistic beliefs about condom and power in sexual relationship (see table E11 in appendix E).

However, looking at the logistic analysis of sexual experience among vocational school students as shown table E11 in appendix E, the significant determinants for sexual experience in both male and female vocational school

students are not much different from the result of analysis for total students as shown in table 4-15 and table 4-16.

Moreover, it was interesting that the intercourse proportion of secondary school students was higher than university students in both females and males. For female students, 23.5% of upper secondary school students and 18.3 % of university students have had sexual experience. For males, 45.7% of upper secondary school students and 36 % of university students have had sexual experience. This result is contrast to expectation. The previous studies found that the prevalence of sexual experience increase by age or educational level (Katianurug, 1992; Sartsara, 2001; Sriswang, 2002). There may be two reasons for this finding. The first reason is that the characteristics of public university students in this study are good students who were selected from the entrance examination, as shown in tableE8 in the appendix. The largest proportion of students who had GPA > 3.00 and had never had behavioral risks was the group of university students. Meanwhile, secondary students are mixed types of students who are both good and poor. Furthermore, almost university respondents were the first year students so they have to stay in the university dormitory. They had no chance to go out at night. The following qualitative results also supported those.

> The university students usually start having sex with boy/girlfriends since they are up the second year students because they can live out of campus and feel that they are mature enough to have sex. However, there were some of them have sexual experience since they were in upper secondary schools, but not much.
> (Group discussion of university students)

Other explanations might be young men who were older like to have intercourse with girls who were younger. The results showed that the average of age at first intercourse in both males and females was the same (16 years old), but the

average of age of partner at the first intercourse for males was lower (16 years old) than those for females (19 years old). This might cause the rising trend of sexual activity among secondary school students, especially in females. In addition, there were qualitative data supported as below.

> We are looking for girlfriends who are very young and innocent because it is sure that those girls are virgin and clean. We think that right now most girls in the same age as us are not virgin. If we would like to get real virgins, we have to look for very young and good girls in secondary schools.
>
> (Group discussion of young men in vocational colleges)

Sexual Risk Behaviors

This study found that the median age for first intercourse for both male and female students was approximately 16 years. The lowest age at first intercourse was 8 years old for males, whereas for females it was 13 years old. According to no national statistics reporting average age of first intercourse, there are several studies report different average age of first intercourse among adolescents, which depends on sample and timing of study. For example, a survey of vocational students and secondary students in Bangkok by ABAC poll and Thai Health Promoting Foundation in 2003 (Population and Social Research Institute, 2003) found that children aged below 11 years old have ever had sexual experience, and a study in some other specific area revels that Thai adolescents have their sex encounter at a very young age, the lowest age being 12 years and mostly around 14 to 17 years (MOPH, 2000). However, among Thai adolescents, the median age at first sexual encounter is between 16 and 18 years (Poonkun, 1998). It is obviously clear that Thai adolescents

are more likely to have first sexual intercourse at earlier age, which is the common risk for STDS and pregnancy (Santelli et al., 1999).

This study also found that most of the young women and men reported trend of having first sex with condom use was very low (25.9 % in females and 34.7 % in males). Likewise, the previous studies, 23 % of Thai adolescents (Karnjanajittra et al., 2003), and 30 % of secondary students (MOPH, 2001) used a condom. Fortunately, the study results showed that the trend of using condom was rising when asking about the last intercourse among sexually experienced young people (33.5 % in females and 37.4 % in males). When asking about using condom in the past three month, 26.5 % of females and 38.3 % of males always used a condom. It should be noted that the young people in this study generally do not perceive the risk of disease because they only have sex with steady partners. They believe that abstinence from having sex with commercial sex workers is sufficient to guard against HIV infection, while unprotected sex with regular partner is safe (Havanon, 1993; Boonmongkorn et al., 2000). Further, many boys in schools did not think that they are at risk of AIDS since they were not sexually active (Boonmongkorn et al.).

In addition, the results of this study showed that most of the young women are afraid to get pregnant other than HIV infection, while young men are afraid of both pregnancy and disease. Thus, we found that consistently using dual protection among adolescents was very rare. The qualitative findings from in-depth interview also revealed that while young women are taking contraceptive pill, their partners don't want to use a condom. On the other hand, some women believe that there are negative side effects of pill so that they don't want to take it and they asked their partner for using condoms instead.

Additionally, young men were more likely to have concurrent multiple partners than young women. In fact, girls would have a longer duration of sexual relationships than boys and they tended to have sexual relationships with one boy at a time (Boonmongkon et al.). Another reason would be a social stigma associated with reporting this behavior for females. This indicates that young women might put their male partners at risk of infection without intention.

Overall, young men seem to be at higher risk than young girls, but this study found that young women reported several risk behaviors more often than young men. This result corresponds to a prior study (Bond et al., 1999), which found that overall reported sex risk was significantly higher among men than women, but unprotected sex was reported more often by women. In contrast, several previous studies (e.g., Isarabhakdi, 1997; Ford & Kittisuksathi, 1996) reported young men were at higher risk than young women. It is noted that those studies looked at different dimension of risk, which focused only behavioral risk of young men (i.e., alcohol drinking, substance use, cigarette smoking) and trend of sexual experience, but this study is looking at actual sexual risk behaviors and limiting to the context of relationship that is steady.

Influences of Psychosocial Factors and Gender-based Factors on Sexual Risk Behaviors

Sexual experience of friends, and intention were independently associated with sexual experience in both male and female groups. Interestingly, for females, close friends' approval of sexual intercourse and sex-refusal self-efficacy were

independently associated with sexual experience, while for males those variables were not. In addition, pros/cons of intercourse were independently associated with sexual experience among a male group not females. Such findings are consistent with other research demonstrating the particular importance of psychosocial factors (e.g., Allen et al., 2003; Isarabhakdi, 1997; Pattaravanitt, 1995; Sartsara, 2001). For example, Sartsara found in cross-sectional study that sex, attitude toward sexual relation, and peer influence could explain the variance of sexual experience among Thai youth (15-24 years old).

Regarding the effect of gender role perception, it was not independently associated with sexual experience. This finding has no evidence in Thai studies that found statistically significant association between gender role perception and sexual experience in multivariate analyses, but there have been reported in a variety of other studies such as qualitative studies support the contribution of gender role attitude or perception to sexual behavior (e.g., Ford & Kittisuksathi, 1996; Havanon, 1993; Srinual, 2003). It showed that gender role perception alone may be inadequate in explaining differences in sexual experience among adolescents. The indirect effect should be taken into account.

For sexual risk taking, sexual risk behavioral attitudes and safe sex self-efficacy influenced sexual risk taking for both boys and girls, but hedonistic beliefs of condom use influenced sexual risk taking for only girls. Analyses of gender-based factors yielded a set of provocative findings, some of which were expected (i.e., impact of power in sexual relationship on sexual risk taking for males, the moderation of safe sex self-efficacy by power in sexual relationship in males), and some of which

were not (i.e., the change among psychosocial components after the inclusion of gender role perception and power in sexual relationship in both females and males). The result supported the psychosocial factors, especially attitudes and beliefs and sexual self-efficacy remained important among sexually experienced people. Unlike sexual experience, it is noteworthy that the effect of peer influences disappears among this group. In addition, the significant interaction effect of power in sexual relationship and self-efficacy for male analyses was the interesting evidence for the role of gender-power on sexual behavior.

The findings revealed that the different patterns of predictors for the sexual experience and sexual risk taking in each sex point to the importance of subgroup difference. Discussion about each variable in subgroup of sex is presented in the following.

Sexual Risk Behavioral Attitudes and Beliefs

The results for sexual risk behavior attitudes and beliefs were consistent with expectation and past research. Theoretical expectation is that sexual risk behavior attitudes and beliefs (conceptualized as behavioral beliefs, pros/cons of intercourse, hedonistic beliefs of condom, and barrier to condom use) would be associated with having sexual intercourse and higher levels of sexual risk taking (e.g. more sexual partner, infrequent condom use). In partial support of these expectations in general, pros more than cons of intercourse was positively associated with having sexual intercourse. Among sexually experienced adolescents, the score for sexual risk behavior attitude was negatively associated with overall levels of sexual risk taking.

In analyses by gender, attitudes about sexual risk behaviors were negatively

associated with overall levels of sexual risk behaviors for both females and males. In addition, hedonistic beliefs of condom was positively associated with overall levels of sexual risk behaviors for only females, while for males, pros outweighed cons of intercourse were positively associated with having intercourse.

We speculate that there are at least two reasons for the disparity of various dimensions of beliefs associated with gender and sexual risk taking behavior in diverse ways. First, the double standard is in force, substantial gender differences in attitude and behaviors can be expected (Ford et al., 1994; 1996). The present results provide evidence that males are expected to engage in causal sexual relations without concerns 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. Women will hold more negative attitudes about causal sex than men will, so women will be less permissive than will men.

It is noteworthy that the present data do provide support for those double standards: sexually experienced males regarded having intercourse to be pros more than cons more often than experienced females; sexually experienced girls and boys (25.4% , 46.1%, respectively) reported less often than sexually inexperienced respondents (74.6 %, 54.9 %) that it is difficult to overcome obstacles of using condom; and sexually experienced boys (51.3%) reported more often than sexually experienced girls (42.3%) that using condom decreases pleasure (Table E2 in appendix E). Women may be more concerned with men's responses because women need to enlist the help of men to attain the goal of condom use (e.g., Amaro, 1995; Havanon, 1996) and in fact, they are less worried about potential decreases in sexual pleasure than men. The in-depth interview of young women and men in this study

also supported. The young men openly describing their sexual desire and wanting sexual pleasure without using condoms and the young women only wanting to please a partner, to express strong intimacy, trust and love, to present a special feeling of bonding and sharing. It implies that the partner's reaction has more effect on forming woman beliefs than their own direct experience. Hence, this study revealed that affective beliefs (hedonistic beliefs) had an association with sexual risk taking in sexually active females.

Second, in interviews for both girls and boys, Thai adolescents emphasized intimacy and length of the sexual relationship: the longer they have had a satisfying and secure sexual relationship, the more positive their attitudes and beliefs towards sex can be, including condom use. In a stable relationship it can be easier to discuss with one's partner and solve the technical and psychosocial problems which using condom might have caused previously. It may cause the absence of the association between barrier beliefs of condom and sexual risk taking in this study.

This finding suggests which specific beliefs and attitudes about sex and sexual risk behavior were most important to girls compared with boys. Furthermore, attitudes and beliefs of sexual risk behavior are multidimensional and indicate that these various dimensions are related to gender and sexual risk taking behavior in diverse ways.

Social Influences

The abundance of previous research using the TPB shows that norms are an important component of theories of reasoned action and planned behavior. The results for the sexual risk composite indicate that specific components of normative

development influence sexual behaviors and lead to difference outcomes. The findings through both bivariate and regression analyses revealed that peer influence (both perception of a number of friends' sexual behavior; and perception of close friends pressure) had a strong effect on having sexual intercourse. A second finding was that peer norms did not influence levels of sexual risk taking among sexually experienced group. This first finding is consistent with surveys of sexual behaviors among unmarried Thai youth (e.g., Bond et al.,1999;Isarabhakdi, 1997; Norapat, 2000; Sartsara, 2001; Soonthrondhada, 1996) in which both male and female youth who reported having friends who had premarital sexual intercourse were also more likely to have sexual intercourse than those who did not have sexually experienced friends. Alternatively, young people may have multiple partners if the friends with whom they associate also have multiple partners. For example, they go out together, meet women, and frequently change partners.

For males, only perception of friends' sexual intercourse had an impact on having sexual intercourse, while both perception of friends' sexual intercourse and perception of close friend's pressure were significantly associated with having sexual intercourse for females. One possible explanation is that sexual risk between men and women is influenced differently by the social norms (Bond et al., 1999; Ford & Kittisuksathi, 1994; 1996; Isarabhakdi, 1997). Male friendships provide a sense of belonging, enjoyment, camaraderie, and protection, and enforce stereotypes of masculinity. However, male friendships offer less opportunity for men to discuss problems or other serious issues with other men. On the other hand, female friendships emphasize intimate conversation; the sharing of gossip, problems, and other issues they regard as personal, so that they can consult with each other about

problems, especially with close friends. It is clear that these findings support the notion that perceptions about peer behaviors motivate change. As adolescents perceive their peers to have initiated a new behavior, they alter their own behavior to reflect their perceptions of normative behavior. However, since we do not have peer reports, we do not know whether this reflects reality, but it is an important question. As teens struggle with their identity formation, and as their peer groups become increasingly important to them, it makes sense that they may perceive their peers to be increasingly like them, or may try to act in ways similar to their peer.

Nevertheless, this study did not find significant relationships between perceived peer norms of sexual risk taking and level of behavioral risk. This result was contrast to several previous studies from the literature. It may be a reflection of how the question was asked. The respondents were asked to rate how many persons your age you think always use condom with steady partner and how your close friend approve of you having sex with condom. It may have been more pertinent to assess peer support for condom use in specific type of partner and frequency. It is possible that individuals do not know exactly how often their friends use condoms. So, the answer may be underestimated. The use of infrequent condom use without considering type of partner may also have compromised the ability to identify significant relationships. An alternative explanation concerns the crossover effect of attitudes and peer norms, especially subjective norms. A crossover effect may cause the absence of relationship between peer norms and sexual risk taking (Sheeran & Orbell, 1999). This study found there was high correlation among attitudes / beliefs and peer norms and sexual risk score (r= 0.4).

Another consideration is that qualitative data make it clear that many Thai men and women do not believe that their friends' sexual risk taking affect their sexual risk taking at all. A major theme in all six focus groups and in many of the individual interviews is that a Thai man and woman make their own decision; many of the participants dismissed the suggestion that peer expectations might have an influence. They all said that having unsafe sex is the individual situation rather than friends' influences. This tendency to discount the potential impact of group norms may instead lead to an underestimation of peer group effects on sexual risk taking such as infrequent condom use among sexually experienced adolescents.

Sexual Self-efficacy

These findings are largely consistent with past research, although some differences emerged. The findings show that lower levels of refusal self-efficacy were associated with more frequent in sexual experiences for females, but not for males. Among youngsters who had already engaged in sexual intercourse, there was a significant effect of safe sex self-efficacy on sexual risk taking: adolescents who reported having low levels of safe sex self-efficacy were more likely to engage in higher sexual risk taking in both Thai females and males.

One possible explanation for the lack of a direct relationship between self-efficacy regarding the decision to have sexual intercourse and engaging in sexual intercourse in males is the nature of the self-efficacy. This study found that females' sense of sexual mastery appeared to be of a higher degree than that of males regarding responsible about the consequences of sex and being able to say no to unwanted sexual activity. Indeed, since they had more experience of saying no to sex than do

males or they may have less desire for sexual involvement, female had greater confidence in sexual matters. Furthermore, females are more restrictive in their sexual activity and more concerned about issues such as safe sex precautions and there is stronger social stigmatization against sexual matters for women than men. In the other words, males were more able than females to assert their sexual needs and to initiate sexual activities. It is uncommon for men to refuse having sex if they have a chance. This may indicate a tendency to over-exaggerate on part of females for refusal self-efficacy, or to under-report sexual activity on part of male for that. Another concern is that the difference in scenarios of self-efficacy measurement might cause the difference in sexual self-efficacy in both boys and girls.

Likewise, Basen-Engquist & Parcel (1992) found lack of relationship between safe sex self-efficacy and having multiple partners. One possible reason is that there may be truly no relationship between self-efficacy and having multiple partners. An individual has ability to make a good decision about having safe sex, but view having multiple partners as positive. The other reason is that if individuals have high confidence to have safe sex, which based on their skills at sexual communication, they also may feel safe about having sex with more than one partner.

Similarly, in Thai studies, both Thato et al.(2003) and Vanlandingham et al. (1995) reported no association between self-efficacy and condom use. The difference in findings from the investigation might reflect the different conceptualizing of self-efficacy, different data analyses, or different age of study samples. The major difference, the different conceptualizing of self-efficacy, was deserves discussion. Thato defined self-efficacy as a one-dimensional construct that had little discriminatory power and based on an instrument verified from western culture, while

Vanlandingham and colleagues defined self-efficacy as global self-efficacy and used only one item to measure, which may result in measurement error and low statistical detection. A likely explanation for this comes from the literature. That is, there is evidence that self-efficacy is a "situational" concept rather than a general one, which means that each measure, must be tailored to context and to the population. Accordingly, the scale of multidimensional self-efficacy and development of a culturally sensitive instrument based on a specific group had higher discriminatory power (Murphy et al., 2001). More importantly, the previous studies didn't look the relationships within subgroup of gender. That is why the findings in this study are consistent with theoretical predictions as mentioned before. However, it is clear that more than one kind of skill is needed to deal confidently with sexual matters.

This pattern of findings leads us to speculate that adolescents who have poor sexual self-efficacy may be at increased risk not because they are more likely to have sex than adolescents who are good sexual self-efficacy but because they develop more risky sexual behavior patterns. In other words, sexual self-efficacy may influence choices the adolescent makes after becoming sexual active rather than the initiation of sexual activity per se, especially in boys. Future research is needed to examine the possibility the self-efficacy may be particularly important in affecting risky patterns of sexual behavior that unfold following sexual debut.

Intercourse Intention

These findings are in keeping with behavioral change theories of adolescent behavior, which postulate that the key predictor of behavioral performance was behavioral intention (Ajzen & Fishbein, 1980). This study found that sexual intention

was the strongest predictor of having sexual intercourse for females and was the important predictor for males. The data in the current study also point to important differences between boys and girls and between sexually experienced and sexually inexperienced teens. Sexually experienced adolescents had higher intentions to have sex during adolescent year when compared to non-sexually experienced adolescents, and females were significantly less likely to intend to have sex during adolescent year than were males.

Overall, adolescents with sexual experience in this study were significantly less likely than adolescents without sexual experience to intend to use condoms if they though they would have sex in the next three months. In addition, females reported higher intentions to use condoms than males. This finding may also be a result of the difference in the socialization process of boys and girls. Gender differences in condom use may stem from societal norms about the meaning of sexual activity for girls and boys. It is more socially acceptable for boys to desire sex, while girls are encouraged to stay virgins as long as possible. The societal pressure for girls to delay intercourse implied that it is inappropriate for girls, but not for boys, to desire sexual experience.

However, the measurement of behavioral intention in this study had limited to accurately predict behavior due to not specific length of time. Ajzen and Fishbein (1980) argue in their theory of reasoned action that intentions must correspond on each of the element of time, context, action, and target and refer to a single behavior. The question of sexual intention should be restated from “do you intend to have sex during the adolescent year?” to “do you intend to have sex in the next year?”

Thus, youth who have already had sex and who are thinking about continuing may benefit more from sexuality education addressing contraception or comfort with being sexual than those youth who have not experienced sexual activity. Girls may be better supported by sexuality education that provides sexual assertiveness training in which they learn to avoid intercourse when they really do not want to engage in it.

Gender Role Perception

The results for gender role perception were less consistent with expectations and past research. Prior research led us to predict that gender role perception would be associated with sexual intercourse and levels of sexual involvement (e.g., more sexual partner). In partial support of these expectations, bivariate findings support a significant relationship between gender role perception and having sexual intercourse for both females and males. Among sexually experienced respondents, there was a significant relationship between gender role perceptions. However, the multivariate analyses did reveal that gender role perception emerged as non-significant across all outcome regression analyses, when age, sex, alcohol drinking, cigarette smoking, substance use, attitudes/ beliefs, peer influence, safe sex self-efficacy, and intercourse intention were controlled.

One possible reason for the lack of a relationship between gender role perception and sexual intercourse and levels of sexual risk taking is insufficient reliability of a gender role perception scale. Results were interpreted with caution (α = 0.62 for female, α = 0.65 for males). Another explanation concerns indirect effects of gender role perception on sexual risk behaviors. Considering bivariate relations, it

suggests the existence of effects, but are unable to demonstrate, such effects clearly in the multivariate models. In other words, gender role perception may be the moderator of sexual risk taking rather than mediator.

Perhaps most important, the current analysis included demographic and contextual factors that may have attenuated the association between gender role perception and sexual risk taking. The connection between gender role perception and sexual risk taking merits further examination. These more subtle-aspects of gender role perception are difficult to document using standard survey approaches, since they are by nature non-salient, so we are also utilizing qualitative technique to investigate this issue in the this study, which is discussed later in this chapter.

Another explanation for this can be, in Thailand, there is a high level of equality between women and men. Girls' opportunities for proper education and economic and sexual equality are now better than ever, in particular in educated adolescents. Srinual (2003) found that gender differences are diminishing among students grade 7-11; girls are occupying more and more of public space, and they are adopting new behavioral patterns which were formerly acceptable for boys only. Our focus group discussion indicates that most girls accept that having sex during teenage years is common and both boy and girls approve of their intercourse during adolescent years. Having sex with boyfriends is not social stigma among girls and sometimes it represents the maturity and socializing process. Among boys, they would prefer having sex with their girlfriends instead of sex workers since they feel more safe and clean. They don't mind getting married to sexually experienced women if they actually fall in love and they can get along together. More than that, girls dare to ask partners not to use a condom because they were disgusted by it if

they have stable relationship. We found several couples of adolescents reported women were going to determine the method of protective sex rather than men in steady relationship. These data reflect that making choice of having sex or protective practice does not depend on males only as before. They suggest that there have been drastically changing perspectives on gender difference in sexuality among the new generation. Accordingly, the effect of gender role perception on level of sexual risk taking diminishes from Thai contemporary society.

Furthermore, in-depth interview data also indicate that other interpersonal and emotional factors such as having monogamy, partner attractiveness, length of relationship, may have direct effect on sexual risk taking than gender role perception. Sexual behavior is not similar to other health behaviors because sex is not an issue of individual control only. It depends on partner reaction, especially males' condom us. Hence, the antecedents of decisions to act based on understanding motivation are not enough to explain behavior change; attention should shift to specifying the interaction process involved in initiating action, managing action sequences and maintaining behavior change over time (Abraham, Sheeran & Johnson, 1998).

Power in Sexual Relationship

Unexpected, this study failed to find an effect of power in the relationship on sexual risk behaviors for females. For males, the bivariate findings did not support a significant relationship between power in the sexual relationship and overall levels of sexual risk behaviors. Nevertheless, the multivariate analyses for males did reveal that when GPA, alcohol use, cigarette smoking, substance use, sexual risk behavior attitudes, hedonistic beliefs, safe sex self-efficacy, peer influence and gender role

perception were controlled, power in sexual relationship and interaction between safe sex self-efficacy and power in sexual relationship emerged as significant factors. Power in the sexual relationship is inversely associated with sexual risk behavior scores and interaction between safe sex self-efficacy and power in sexual relationship is positively associated with the sexual risk behavior score.

The findings were in contrast to several past western researches, which reported that power in the relationships was significantly associated with condom use among women (Gomez & Marin, 1996; Jorgensen, King, & Torry, 1980; Saul et al., 2000; Tschann et al., 2020). The difference in findings might be a reflection of different background characteristics of the samples (e.g., age, ethnic minority, educational level), and variations of power measurement. Most previous studies examined the effect of power among older women aged up to 18 with stable sexual relationships, and included the high-risk nature of the sample in which ethic minorities such as Latinas, and African Americans. Only the study of Tschann et al. drew the significant results from male and female adolescents aged 14-19 years. In the current study, samples were students aged between 15-22 years old, and who came from the majority of Thai young people, especially they had similar socioeconomic status. According to the theory of gender and power (Wingood & DiClemente, 2000), the social mechanisms produce gender-based inequities and disparities (e.g., in women's economic potential, women's control of resources, and gender-based expectations of women's role in society). This would indicate that women with low socioeconomic status would have less control over the sexual relationship and take more risk of HIV. Inclusion of a younger sample with unstable sexual relationships and equality in power may lead to absence of the effect of power

in a sexual relationship on sexual risk taking including condom use in the present study.

Another reason for the lack of correlation between power and sexual risk taking is ceiling effects, where respondents may answer based on a “best case” scenario because the mean scores for power in sexual relationship were high (2.76 for females and 2.68 for males) with small standard deviation. The similarity of score could also indicate response bias from socially desirable state.

Finally, measurement of power in any domain is always complicated by the fact that power in a relationship is simply how one perceives it, and may not reflect reality. In particular, measurement of this construct varies study by study, so that there were often conflicting findings. Even though this study replicated the power in sexual relationship in the study of Pulerwitz et al. (2000; 2002), which found significant relationship between power in sexual relationship and condom use it, it did not reveal the similar results. To explain the absence of a relationship between power in sexual relationship and sexual risk taking, the arguments are that the western instrument might not be appropriate within Thai culture, even though the instrument was verified in back translation and focus group. In addition, even though the internal reliability of power in sexual relationship scale was sufficient reliability (alpha = 0. 70), the component of power in sexual relationship in this study (relationship control and decision making dominance) may not indicate some important components of power in sexual relationship in regard to sexual risk taking, including, condom use, concurrent multiple partners among Thai adolescents. Another explanation concerns a number of samples, especially of the female students, that was not sufficient to differentiate a statistical significance. Nevertheless, the findings were in keeping with

some previous research, which found no impact of power on condom among African American and European American urban youth (Gutierrez et al., 2000), and among Black and Latina community women (Bowleg et al., 2000).

Although significant relationships did not emerge in either the bivariate or multivariate cases across all regression analyses, an inspection of the results revealed interesting trends. The results indicate that adolescents who have higher safe sex self-efficacy have been shown to have higher power sexual relationship ($r=.14$, $p< 0.01$), and those of them who have higher safe sex efficacy reported having less risk taking ($r= -.19$, $p<0.01$). In particular, female adolescents reported significantly higher level of power in sexual relationship than did males (mean score of power in sexual relationship = 58 and 56.5 for females and males, respectively). Consistently, the female adolescents reported having higher levels of safe sex self-efficacy than did males. Although we could speculate that males put themselves at higher risks than females, indeed, females put themselves at increased sexual risks more than males. According to this result, even though females were less likely to have multiple partners in the past year, they reported less using condom in the past three months than did males. One possible explanation for these results may be in the stereotype of male sex drive. Sex is more often viewed as a biological drive for males than females and this drive may result in males' willingness to have unsafe sex if it threatens to dissolve the sexual encounter. That's why males reported significantly less power in sexual relationship than did females.

The other reason is the influence of social desirability. As a result of HIV, condom use has been heavily promoted as necessity for sexually active individuals. This would indicate that condom use is seen a highly socially desirable behavior. As

shown in the past research, high social desirability leads to overreporting of given behavior, attitudes, or beliefs (Ostrow et al., 1993 cited in Swan, 1999). It could be argued that, if social desirability results in over-reporting females' power, then even the females reported low taking risk behavior may over-report power in sexual relationship.

These findings may reflect a complex interaction between power in sexual relationship and safe sex self-efficacy among sexually active males, but not females. It should be noted that the female sample employed in the present study was small, possibly increasing measurement error, and may not be representative of the whole adolescent population, thus, we can't conclude from the absence of significant relationship that power in sexual relationship have not been related to sexual risk behaviors. On the other hand, the power in sexual relationship might have non-linear relationship with sexual risk behaviors.

Demographics and Behavioral Risks

Although not a central focus of the current study, demographic patterns confirm the distinctiveness of different aspects of sexual risk taking. Among the entire sample, male gender and vocational level were the important predictive variables for sexual encounters. This result was consistent with the former studies (Srinual, 2003; Thato et al., 2003). One explanation may be that older male students are more likely to be biologically primed to initiate sexual encounters. In addition, almost half of both boys and girls believe boys gains respect if known to be sexually experienced, compared with only one fifth who think the same for a girl. It is considered that gender differences in sexual behaviors are not wholly the result of biological

differences but also because of broader social influence that young people have adopted. Age was predictive of odds of being non-virgin among only men, not females. One possible explanation is that the age range in this study is very narrow, especially in female group. The distribution of age range was not diverse enough for females as the majority of females were in age of 15-18 years old.

Much research has focused on differences in sexual experience based on difference in school achievement and addictive substance use. In this study, GPA significantly predicted adolescents engaging in sexual encounters for both boys and girls. This finding may be explained by the fact that individuals with low school achievement are more likely to seek peer groups outside rather than concentrate on studying. They will become more attached to deviant peers who engage in risky sexual behavior. This pattern is fairy consistent with Jessor's theory of problem behavior (1991), which suggests that problem behaviors such as alcohol use , marijuana use, delinquency, and precocious sexual activity tend to be associated with each other in teens.

Further, adolescents' self-reported substance use significantly predicted adolescents engaging in risky sexual behavior: having sexual encounters for girls and having multiple partners in the past year for the entire sample. These findings are consistent with previous studies elsewhere in Thailand that have shown that female adolescents who reported having sexual encounters are more likely to use drugs or alcohol (Allen et al., 2002; Bond et al., 1999; Havanon et al., 1993; Soonthorndhada, 1996). It has been suggested that under the influence of drugs, female adolescents are less likely to delay intercourse or safer sexual practices as they lose ability to control themselves. Accordingly, girls might have unplanned intercourse without safe sex

considerations. Alternatively, girls who have unplanned sexual intercourse under the influence of alcohol or other drug are more likely to report having multiple partners and inconsistent condom use (Poulin & Graham, 2001). Although the correlation nature of this study does not allow for a causal relationship to be established, it is clear that girl teens that use substances are also more likely to engage in sexual encounters that put them at greater risk for HIV and STD and unintended pregnancy.

Conclusion

This study was designed to explore prevalence and level of sexual risk behaviors and the correlates of becoming sexually experienced and taking unsafe sex practices, especially psychosocial and gender-based factors of sexual risk behaviors in both sexes. The present study examined the extent to which attitudes and beliefs, norms and self-efficacy as well as gender-based factors (gender role perception and power in sexual relationships) formed an overall sexual-risk-taking composite. The interesting issue in this study includes what are various reasons which lead heterosexual adolescents to engage in high- or low-risk sexual practices. The in-depth response explaining the social and cultural basis affecting the beliefs, attitudes and expression towards sexual behaviors were also presented in this research.

The major findings of the study were the following.

The first findings revealed that women were less likely to engage in sexual encounters than were men. The overall prevalence of sexual experience was 36 percent of 1,169 respondents. Almost half of males (46.2%) had experience with intercourse, while one-fourth (27.5%) of unmarried females reported coital experience.

The median age for first intercourse for both male and female students was approximately 16 years. The lowest age at first intercourse was 8 years old for males, whereas for females it was 13 years old. In each sex, the prevalence of sexual experience varies according to age, educational level and school achievement. As predicted, young men tend to have more sexual partners, while women are less likely to report consistent condom use with their partners. However, considering several sexual risk behaviors, young women have engaged in more sexual risk practices than the males did so.

Controlling for demographic and behavioral factors, the most influential factors on becoming sexually experienced male and female students were having friends who have sexual experiences (OR =11.73; 95% CI 6.17-22.29 ; and OR = 27.56; 95 % CI 10.21-74.44, respectively) and intercourse intention (OR =4.00, 95% CI 2.08-7.69; and OR = 13.84; 95 % CI 6.54-29.28, respectively), but not gender role perceptions. Low sex-refusal self-efficacy directly influenced sexual experience among females (OR=5.88; 95% CI 2.54-13.62), but not males. Meanwhile, pros more than cons of intercourse affected sexual experience among males (OR=2.28; 95% CI 1.21-4.31), but not females.

Among female sexually experienced students, condom use hedonistic beliefs (B = 0.69, p<.05) and safe sex self-efficacy (B = -0.34, p<.01) - but not gender-based factors- were significantly (modestly) associated with overall sexual risk taking. For males, sexual risk behavioral attitudes (B= -1.35; p<.001), safe sex self-efficacy (B = -1.79: p<.01), power in sexual relationship (B = -2.89; p<.01) and interaction of power in sexual relationships and safe sex self-efficacy (B= 0.60; p<.01) were significantly (modestly) associated with overall sexual risk taking.

Finally, to provide a clearer picture of sexual risk taking, insights generated through analysis of the qualitative data are used to add more detail to the constructs. A variety of reasons for unprotected sex were revealed. The reasons for unprotected sexual activity emerging from female and male thoughts and feelings are extreme gender differences: psychosocial benefits of unprotected sex; sexual and social development; the features of the partner or the interaction; and obstacles of protected sex. It is obviously that the reasons for unprotected sex are upon unreasonable justification and feelings rather than rational decision. In particular, given important reasons are underlying social and cultural process of gender construction.

Implication for Developmental Theory and Practice

This study has important implications for theory and research investigating sexual risk behaviors among adolescents. The conceptual model proposed in this study (see Figure1) was based on several prominent behavioral theories of adolescent sexual behaviors. Support was found for these theories. The results of this study support findings from Theory of Planned Behavior (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and Social Cognitive Theory (Bandura, 1986) in that psychosocial factors (e.g., attitudes/beliefs, self-efficacy, and social influence) were found to directly impact adolescent sexual behaviors. Additionally, results supported findings from notion of gender and power (Amaro, 1995; Wingood & DiClemente, 1998; 2000) in that power in sexual relationship was found to moderate the relationship between self-efficacy and sexual risk taking among sexual active adolescents.

The unique contribution of this study to the knowledge base concerning the determinants of sexual risk behavior lies in the examination of subgroup differences by gender and examination of multiple risky sexual behaviors. For example, the study has found that peer influence has directly impact sexual experience in both females and males. Meanwhile, attitudes and beliefs about sexual intercourse directly influence on sexual experience in males and refusal self-efficacy directly influence on sexual experience in females. Among sexually experienced youngsters, risk-taking behaviors can be decreases by increasing safe sex self-efficacy and increasing unfavorable sexual risk behavioral attitudes. Thus, this finding reaffirms the important influences of attitude and beliefs, self-efficacy, and peer influence by showing that psychosocial constructs from behavioral theories contribute directly to decrease level of sexual risk taking. Additionally, these findings have demonstrated moderating effects by gender and power in sexual relationship, suggesting the important role of context in these relationships. For example, power in sexual relationship doesn't directly affect sexual risk taking for females as it does for males. Understanding these moderating relationships help prevention program tailor their efforts in specific ways to address these differences.

This dissertation also increases the knowledge base in the field of by clarifying the theoretical understanding of sexual risk behaviors. Differences predictors in each sex have important implications for the development of programs designed to delay sexual activity or promote the adoption of risk-reduction practices. To be more effective, intervention should be tailored to focus on those factors specifically associated with the targeted group. Therefore, both components of intervention and the gender-specific approach must be carefully considered. This

study also provided a rather strong first step toward remedying the omission of interpersonal characteristics in the study of sexual-risk behavior.

Policy Implications

The findings of the study obviously reflect the existing situation of sexual risk behaviors among young people in the present time. The issues of sexual problems are changing and do needed new perspective of strategies to deal with these problems. The clearer picture of sexual risk behaviors in this research recommends the practical following policies.

1. The findings help policymakers to identify which groups of young people are at risk for sexual engaging and which groups are at high risk taking. The study results revealed that both females and males were more likely to try engaging sexual intercourse and young females had more sexual risk taking than young males. Hence, both young females and males should be the first priority for the national goal of HIV prevention and risk reduction.

2. The policymakers should move forward to accept the current situations and to support programs for adolescents that are designed with messages about both abstinence and safe sex practices. In Thailand, one barrier to implementing sex and HIV programs is that social disapproval of discussion of sexuality and sexual behavior has seriously limited the amount of sex education that can be given to young people (Gray & Punpuing, 1999). Despite evidence that Thai youth are increasing risky sexual behaviors (i.e., are sexually active), most Thais think adolescent sexual intercourse is inappropriate. The belief that premarital sex is “wrong” may have led

many policymakers to oppose campaigns to distribute information about sexuality or contraception to adolescents. Disseminating information regarding sexuality and HIV prevention in national social marketing campaigns or through schools is often opposed on the grounds that it dismisses parents' right, legitimate nontraditional sexual behavior, and promotes sexual experimentation. Consequently, there is an increase in risky sexual behaviors among young people despite spreading HIV campaigns around the country.

3. Even though the quantitative findings show that the effect of gender-based factors on sexual risk behaviors doesn't obviously appear in each sex, the gender differences in the effect of psychosocial factors on sexual risk behaviors support that gender strongly affect sexual behaviors. Moreover, qualitative data absolutely show how gender has crucial impacts on sexual risk behaviors. Thus, sex education should refer to gender roles and seek to promote attitudes, beliefs and practices that establish sexual responsibility for males. In addition, health education can include activities that address social pressures on sexual behaviors and provide modeling and practice of communication, negotiation and refusal skills.

4. The findings show that peers' sexual practices and peers' approval of sexual experiences are the most powerful influences on young people who never had sexual experiences in both males and females. This reflects that young people deal with the facts about sexual decision through peer advice or peer pressure. Peer-delivered programs should be considered as an effective strategy to delay engaging in the first sexual intercourse of young people until they are mature enough to take responsibility. However, peer influences were not found to be the important role on taking high or low risk among sexually experienced young people. In addition,

qualitative data gave us the interesting details that young people usually deal with the risk taking decision through their feelings and interpersonal relationship rather than rational choices. Thus, looking at alternative ways of improving information about sex and contraception from professional experts should be considered for sexually experienced young people. For example, policymakers do establish specific sexual health services (out-reach service from health personnel). Outreach clinics should be set up, within existing primary care delivered services and in more innovative ways such as sexual health vans going to youth clubs and schools in high-risk areas.

Implications for Prevention and Risk Reduction

The results of the present study suggest sexual risk behaviors among females and males may be affected by different psychosocial factors. This supports the notion that gender-specific intervention may increase the efficacy of prevention efforts (Wingood & DiClemente, 1995). In addition, abstinence intervention and risk reduction intervention should be matched with each level of risk group (general adolescents or sexually active adolescents). Therefore, it can also be used to provide recommendations for the design of group-level interventions targeted toward women and men. The findings suggest, for example, that interventions regarding the dangers of sexual risk taking when using alcohol may be more relevant for adolescent males than females. Interventions for females, however, might use abstinence strategies that boost their preventive skill and self-control from peer norms. An emphasis on the desirability of virginity (from a social, individual and health risk perspective) is needed. In addition, education and skill building regarding refusal skill, condom use

and sexual negotiation that take into account gender role differentials may be vital for females. Safe sex interventions for sexually active females might use strategies that emphasize their attitudes and perception of condom as well as skill building regarding safe sex skills and sexual communication skills rather than relying on peer influences on decision. Both abstinence and safe sex may be relevant messages, but for different groups of adolescents (Jemmott et al. 1998). A multivariate approach for defining sexual risk behaviors may help provide a basis for tailoring appropriate intervention to relevant subgroups of adolescents.

The finding that adolescents' perception of their peer's sexual behavior was important to general adolescents should be considered. Consequently, discussion among youth verifying their perceptions could lead to more open communication and ideas about what is actually happening in peer groups, which may in turn change some youth' behavior. In addition, intervention should address this effect by targeting cohorts of adolescents rather than only focusing on individual teens and focus on teen's perceptions of normative peer behavior.

The argument for gender-specific or co-ed intervention can be made. Women and men differ in their beliefs and reasons for taking sexual risk and the way in which they behave, as well as in their level of real and perceived power in relationships and society in general. For those reasons, one model might be to have the first sessions in an intervention involve same-gender groups, and then later in the intervention, bring together both women and men. This type of arrangement might be especially important because women and men may feel freer in expressing their true thoughts and feelings in the company of same-sex peers. Also, women's voices may not be heard if the intervention were strictly co-ed because such a situation may bring

about a recreation of their status in their romantic relationships, wherein the men are more dominant and vocal. When the women and men come together, the group facilitator can bring up points raised in the same-sex groups to provide a forum for discussing topics such as gender rules and to challenge each group members' likely assumptions regarding the opposite gender.

Strengths and Limitations of the Study

The present study had a number of strengths. First, the study used a multi-method approach that combined both quantitative and qualitative methods that could help us to gain a better understanding of why women and men engage in sexual risk taking than either method could do alone. Because little is known about what influences Thai adolescents to engage in unsafe sex, focus group and individual interviews proved valuable to learn about individuals 'thought and experience. There are likely a range of reasons why individuals do or do not engage in sexual risk behaviors. Second, instrument development was based on specific groups, and interviewers were used who were sensitive to cultural issues. Finally, the utilization of separate sex analyses of predictors would help us to have more attention on gender differences in sexuality. This concern would be useful to develop more effective intervention addressing gender-specific issues.

Of course, this study had limitations that should be taken into account when interpreting results. One limitation of this study is that the cross-sectional analyses in this study focus on the within-time relationship among variables. Therefore, they do not provide an understanding of causality or temporal relationship among variables.

Nevertheless, cross-sectional analyses is the fact that retention rate does not affect the validity of the findings, and is especially appropriate for examining concurrent relationships among variables. Such analyses can inform intervention by suggesting how current relationship may serve as a protective factor for current risky sexual behavior. In addition, such a design allows for the relatively quick and inexpensive collection of a large amount of data. In case of sexual behaviors among young people, sexual relationship in each partner is short and unstable so cross-sectional study is suitable to explain their sexual risk in within-time period.

Another limitation of this study is that the patterns of sexual activity included only penile-vaginal intercourse for heterosexuals. Thus, the patterns of sexual practices may not be representative of other- and same-gender sexual relationship (e.g., heterosexual oral sex, penile-anal intercourse). Nevertheless, people with more complex sexual patterns may have substantial variation within groups, so it is more difficult to make behavioral estimates. Indeed, adolescents and heterosexual adults report less complex sexual patterns than do gay men and, therefore, reporting is probably more reliable. It is likely that with more variation in the sexual patterns, unreliable reports may also have been greater.

Another limitation is the fact that the sample in this study included only adolescents who were in public educational institutes in an urban area and was selected by purposive sampling. Thus, the sample may not be representative of all Thai adolescents. Adolescents who do not attend school regularly or work in the factories may be more likely to engage in greater sexual activity (Thaweesit, 2000). In turn, these youth may be at greater risk for HIV/AIDS. The present findings suggest it may be useful to reach out to youth not found in school settings to study adolescent

sexual risk behavior. In addition, adolescents who younger than 15 years of age are difficult to access as research subjects, especially for in-depth interview.

One final limitation was the small sample size of sexually experienced adolescents did not allow for complex analyses involving cross comparisons by group (e.g., those scoring low, moderate or high on certain variables). Such comparisons would aid in our understanding of sexual risk taking by revealing what type of people are most likely to take sexual risk behaviors. A larger N would allow us to use more powerful statistical techniques (e.g., structural equation modeling) to test the conceptual model. In addition, the sample of sexually active females was not large (n=164), especially when compared to the sexually active males (n=256). Thus, there may not have been enough statistical power to detect differences in some analyses, especially in females. Moreover, although significant regression equations emerged repeatedly, the amount of variance accounted for was modest in a sample of sexually active youth. This suggests that there are other predictors- such as interpersonal factors and situational factors that need to be identified.

Recommendations for Future Research

Several possibilities for future research suggested by this study are as follow.

1. There is need to duplicate this study in larger, more diverse sample. The community sample of adolescents should be studied. The sexual behavior scale used in this study focused on penile-vaginal intercourse among heterosexuals. Future studies might address this gap by investigating other- or same-gender sexual relationships among gay, lesbian and bisexual youth and young adults. Additionally,

to observe and gain more understanding of adolescent sexuality among younger adolescents (less than 15 years old) is vital for the area of sex research since there are tremendous changes in Thai contemporary society.

2. Conducting longitudinal studies would afford the researcher's ability to draw cause and effects of relationships. Since peer norms are the important factors for sexual experience, for virgins, longitudinal studies on sexual risk behaviors might focus on assessing which component of peer norms influencing the process of sexual initiation for young adolescents. Additionally,the issue is made more complex by the idea of conceptual overlap. Variables such as sexual risk beliefs, hedonistic beliefs, and barriers to condom had some obvious conceptual overlap. Is there conceptual overlap between this set of variables or are they each uniquely important to sexual behavior? It is difficult to propose a temporal order of variables. Future longitudinal work in particular should consider how all of these variables operate together, and the temporal order of these variables in relation to one another.

3. Sex is dyadic and studies of partners or couples are particularly likely to provide more insight into the complex process of sexual decision-making. Studying individuals cannot be fully captured the sexual complexity. Future research should include couples as a sample of the study in order to gain a greater understanding of the interpersonal nature of sexual behavior. Moreover, the future studies should consider systematically examining different types of relationships (e.g. dating relationships, monogamous relationships) to gain a better understanding of sexual risk behaviors in various relationship contexts. Such studies would allow researchers to assess the level of sexual risk taking between partners regarding various aspects of their relationships (e.g., level of trust in relationship). Researchers would have the

opportunity to explore the extent to which sexual risk behaviors are affected by similarities or differences in partners' visions of relationships.

4. The new approaches to youth prevention should involve investigation beyond risk factors to include identifying and establishing the prevalence of protective factors among adolescents and have more attention on comprehensive models regarding social contexts such as ecology model. Protective factors are positive characteristics, predispositions and influences in adolescents' lives that can buffer them from negative influences (Bernard, 1991 cited in Reinninger et al., 2003). This is significant because many risk factors, particularly environment contexts, may be outside of control of adolescents. Additionally, youth may experience a multitude of risks, making it difficult to address each and every risk factor. Therefore, research focusing on positive adolescent competencies, protective factors and resources may be valuable in reducing sexual risk behavior by supporting and enhancing protective factors.

5. Key question is how power affects sexual risk behaviors? In this study power factors had no linear association with sexual risk behaviors among female adolescents. Since women do not actually wear the male condoms, cooperation of the male partner is required. Several researchers have suggested that communication with male partner about condom use is an integral part of HIV self-protection for women (Quina et al., 2000; Saul, et al., 2000). Future studies should explore how power in sexual relationships influences sexual communications among females. This would provide evidence of how power construct and safe sex behaviors including sexual communications are related.