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Sexual Stigma, Sexual Behaviors, and Abstinence Among Vietnamese Adolescents: Implications for Risk and Protective Behaviors for HIV, STIs, and Unwanted Pregnancy

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Abstract

As rates of HIV increase in Viet Nam, there is a need for data on social relations and sexual risk and protective behaviors among Vietnamese adolescents in a context of rapid social and economic changes. We report findings from our qualitative interviews with 159 Vietnamese adolescents living in Ha Noi, Nha Trang City and Ninh Hoa District and survey of 886 adolescents in these same three sites. In the qualitative interviews, youth report a strong adherence to ideals and values regarding abstinence outside of marriage. Youth reported low rates of engagement in vaginal, anal, and/or oral sex with a significant difference in reported behaviors between males (29/469, 6.2%) and females (7/416, 1.7%) [$p=.000$]. 15/32 (46.9%) sexually active youth reported “rarely” or “never” using condoms. Females had significantly higher scores for perceived sexual stigma than males [$t=-10.22$ (95% CI -3.72 to -2.52), $p=.000$] while males scored significantly lower than females on a scale of perceived self-efficacy for abstinence [$t=5.31$ (95% CI 0.27 to 0.59), $p=.000$]. The stigmatization of sexual relations outside of marriage particularly for young women reinforces abstinence, however these same values decrease adolescents’ abilities to obtain accurate information about sexuality and HIV/STIs, and engage in safer sex.

Background

HIV, STIs, and Abortion in Viet Nam

The first case of HIV was diagnosed in Viet Nam in 1990 (Ivker 1996). Since that time, cases of HIV have been identified in all 61 provinces of the country. While estimates vary on rates of HIV infection in Viet Nam, international health agencies generally agree that approximately 0.4 percent of the general population between the ages of 15 and 49 years are HIV positive. This would indicate upwards of 360,000 persons living with HIV/AIDS (PLWHA) (UNAIDS, World Health Organization 2004). Among documented cases, 53.6 percent are in young adults between the ages of 15 and 24 (Policy Project 2003). A significant proportion of the cases are among injection drug users (IDUs) and female sex workers (FSWs). However, with more

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diligent and consistent surveillance in recent years (e.g., military recruits and prenatal clinics), there are indications of increases in HIV infection in the general population (UNAIDS, World Health Organization 2002; Policy Project 2003). Official statistics continue to emphasize the prevalence of the epidemic among IDUs and FSWs. In 2003, statistics indicated that 50.8 percent of reported HIV/AIDS cases were among IDUs and 1.3 percent were FSWs (Hien 2004). These statistics however also indicate that approximately 48 percent of cases are outside of designated “high risk groups.”

Our current research includes two sites in Khanh Hoa Province (Nha Trang City and Ninh Hoa District) and Ha Noi. Khanh Hoa Province currently has one of the highest rates of HIV infection in Viet Nam and is ranked 9th among the 61 provinces. In Nha Trang, the provincial capital of Khanh Hoa Province, the cumulative number of known HIV positive cases increased from 93 in 1993 to 944 in September 2005 including 447 individuals with AIDS and 397 deaths (Nha Trang City Health Services 2005). Over 55 percent of documented cases of HIV/AIDS in Khanh Hoa are in Nha Trang City though Nha Trang accounts for only 22 percent of the total population of the province. In Ninh Hoa District there are 91 documented cases of HIV/AIDS. As of December 2004, in Ha Noi there were 8,162 cumulative reported cases of HIV/AIDS with a prevalence among IDUs of 25.3 percent, and 14.5 percent among tested female sex workers (Hien 2004).

Sexual behaviors including unprotected vaginal, anal, and oral sex also increase risks for other sexually transmitted infections. In Viet Nam in 2000, it was estimated there were about 1 million new cases of STIs every year, including 150,000 syphilis cases, 150,000 gonorrhea cases and 500,000 cases of chlamydial infection (World Health Organization 2000). Research suggests that many women engage in self-treatment or no treatment for sexually transmitted infections (Nguyen, Vo, Mai 1997). In addition because there are no reporting or data collection requirements for private facilities, official figures are significantly lower than actual cases due to high utilization of private health care services for STI treatment (World Health Organization 2000). In 2003, in Nha Trang, a total of 498 cases of sexually transmitted infections were reported through public hospitals and the city clinics though again the actual number is estimated to be much higher (Nha Trang City Health Services 2004).

Viet Nam has one of the highest abortion rates in the world, with rates as high as 83.3 per 1,000 women aged 15–44 (Alan Guttmacher Institute 1999). Estimates suggest that 44 percent of pregnancies are terminated and approximately 300,000 abortions are performed annually for young women under 19 years (EC/UNFPA 1999). In 2003, in Nha Trang a total of 82 abortions were reported in young women under 24 years old. However, a majority of young, unmarried women seek abortions through private facilities through which there are no mechanisms for data collection and reporting (Nha Trang City Health Services 2004).

Sexuality and Stigmatization

Stigmatization occurs in a social, cultural, political, and/or economic context in which a particular behavior or condition of individuals or groups is targeted through public discourses as immoral and dangerous. Stigmatization may include overt and/or covert actions against these groups and individuals. “Self-stigmatization” is the internalized acceptance of these discourses, and resulting feelings of shame and inadequacy (Cunningham, Tschann, Gurvey 2002).

In relation to sexuality, stigmatization may focus on non-heterosexual relations (Preston, D’Augelli, Kassab 2004), commercial sex work (Rushing, Watts, Rushing 2005), or heterosexual relations outside of culturally defined institutions (e.g., marriage). In terms of the latter, sexual behaviors among youth may be particularly stigmatized especially if these behaviors lead to unwanted pregnancy, or contraction of sexually transmitted infections (Cunningham, Tschann, Gurvey 2005). In research among South African youth, Campbell,

Foulis, Maimane and Sibiya (2005) found that the effectiveness of HIV programs are compromised by stigma and the “pathologisation of youth sexuality”. Research among Chinese adolescents who had engaged in pre-marital sex suggests negative psychological sequelae among the study population and stigmatization leading to social barriers to reproductive health services (Wong, Lee, Tsang 2004). Also, in China perceptions among health workers in family planning are often “ambivalent” about providing services to unmarried adolescents and young adults (Tu, Cui, Lou 2004). There remains however a gap of information about stigmatization and heterosexual pre-marital relations among adolescents, and the potential effect on their engagement in protective or risk behaviors.

Both traditional Vietnamese culture and current government policies and propaganda strongly promote abstinence until marriage creating a social environment which stigmatizes adolescent heterosexual relations. While abstinence outside of marriage is considered important for both young men and women, a woman’s virginity is considered to be of particular value. While recently there has been more media and government attention to the needs for reproductive health education for youth, there continues to be a significant gap in actual delivery of these services. Parents are reluctant to discuss sexual issues with their adolescent children for fear this will increase risk of experimentation, while current school-based education programs are frequently plagued with problems in terms of relevant content as well as effective teacher training.

Methods

The reported research consists of three phases. The first phase included qualitative interviews with adolescents, parents of adolescents, community leaders, and healthcare providers in four communes in each of the three research sites (Nha Trang City, Ninh Hoa, Ha Noi). The second phase was a cross-sectional survey of adolescents in these same communes. The third phase which is currently underway will include the development, implementation, and evaluation of gender-specific HIV prevention curricula for adolescents, a parent education program, and a healthcare provider educational module. This paper reports on the first two phases of the study.

Research Site

In 2003 approximately 75 percent of the population in Viet Nam lived in rural areas (UNDP 2004). Viet Nam is ruled through a one-party Communist system. Communes are the geo-political units governed by Commune leaders, but are also under the auspices of the government at the provincial and national level. The population size within a commune varies considerably from under 3,000 in remote areas of Ninh Hoa to over 20,000 in densely populated areas of Nha Trang and Ha Noi. Since reunification in 1975, the country has gone through multiple social and economic changes. In the mid-1980s, “Doi Moi” [“Innovative Policies”] was implemented by the Vietnamese government allowing for greater flexibility in economic practices, and precipitating a move toward a market economy (Anh 1995). In the past few years, an increasing influx of tourists and greater access to non-State regulated media through television and the internet has brought about rapid changes. With these economic and social changes, youth have more access to expendable income, and recreational activities and social meeting places such as cafes, small restaurants, karaoke, and bars (Kaljee, Genberg, Minh 2004).

The current research includes four communes in each of the three research sites (Nha Trang City, Ninh Hoa District, and Ha Noi). Both Nha Trang City and Ninh Hoa are located in Khanh Hoa Province in South Central Coastal Viet Nam. Khanh Hoa Province is bordered to the east by the South China Sea and to the West by a rural mountainous region. In 2005 there were 132 communes in the province including 27 in the provincial capital of Nha Trang City (population 327,500) and 27 in the primarily rural region of Ninh Hoa District (population 227,630). Ha

Noi, the capital of Viet Nam, is located in the Northern region of the country. The population of Ha Noi is approximately 3.7 million.

Ethical Assurances

The University of Maryland Baltimore, School of Medicine, Institutional Review Board, and the Khanh Hoa Provincial Health Service Ethical Review Board (Nha Trang City), and the Ha Noi Medical University Ethical Review Board approved the protocol for this project.

Participants 18 years and older signed a consent form. Participants younger than 18 years signed an assent form, and their parent/guardian signed a consent form. All interviewers and staff were trained in ethical research and obtaining consent.

Research Population and Selection

Qualitative Research—The research population included adolescents between the ages of 15 and 20 years, parents of these adolescents, and healthcare providers and community leaders. Youth for the study were selected by community recruiters based on a series of variables provided to them to ensure diversity among respondents. These variables included gender, age, school-status, employment-status, and family socio-economic status. A total of 159 youth, 76 parents, 36 leaders, and 36 healthcare providers were interviewed across the three sites. In this paper, we focus our presentation of data on analyses of the youth interviews.

Survey Research—The survey was conducted in the summer of 2004. The survey included youth living in the twelve research communes between the ages of 15 and 21 years. Commune census data were utilized from which the youth were randomly selected to participate. Community recruiters were provided with a list of selected youth, and they arranged an interview time for the youth to meet with the survey staff. A total of 1225 youth were randomly selected for the survey and 886 (72.3%) of these youth completed the survey.

Instrument Development

Qualitative Interview Guides—The U.S. and Vietnamese research team developed interview guides which included topics and specific questions to be covered during the interview. Guide topics included Social and Economic Conditions, Experience with non-Vietnamese Cultures, Gender Roles and Relations, Parent-Child Communication, Resources for Reproductive Health, and HIV/AIDS Knowledge and Attitudes. These interview guides were reviewed and changes were made to the guides over the course of the one-year data collection period based on the data collected. This iterative process provided a forum for on-going review of the data by both the U.S. and Vietnamese team members and a means of addressing emerging themes in the interview data.

Survey Instrument—The survey instrument contained a series of items and scales designed to address issues of attitudes and perceptions of sexuality and risk behaviors, engagement in sexual behaviors, intentions to engage in sexual behaviors, communication with parents and partners, perceptions of gender roles and responsibilities, as well as scales to measure the social learning theory Protection Motivation Theory (Rogers 1983;Floyd, Prentice-Dunn, Rogers 2000) on which the intervention curricula will be based (Kaljee, Genberg, Riel 2005). Utilizing the qualitative data, we conducted searches on the coded data on key terms to obtain series of texts from these interviews. As key issues emerged, these items were incorporated into both existing scales and used to to create new scales [Table 1].

Prior to the actual survey, qualitative pilots and two quantitative pilots were conducted. The qualitative pilots included two series of six ‘focus groups’ (one male and one female in each of the three sites) of 8 to 10 youth who reviewed the survey instrument. These focus group participants were asked about their interpretation of items on the survey, as well as their

suggestions for improved wording of items which they perceived as difficult to understand. In addition, we had the survey scales back-translated in order to find any translation errors, and to feel confident that the original intention of the items was retained.

The two quantitative pilots were conducted in May-June 2004. These pilots included test-retest analysis utilizing intercorrelation coefficients (ICC) and Chronbach's alphas to determine survey reliability and internal validity. Items from the various scales were deleted or modified as necessary to maximize alphas prior to survey implementation.

Data Collection

Qualitative Data Collection—The qualitative data were collected by members of the research team from both the United States and Viet Nam. Those interview data collected by the United States staff were conducted with a bilingual translator. Questions were translated from English to Vietnamese, and the responses were translated from Vietnamese to English. Interview data collected by the Vietnamese research team were conducted entirely in Vietnamese. All qualitative data were audio-taped, transcribed into Vietnamese, and translated in English. While the numbers of interviews made back-translation of all of the qualitative text too cumbersome, selected sample interviews were back-translated and reviewed by an independent bilingual translator. In addition, regular meetings were held with the Vietnamese staff to discuss translation issues and to develop consistent translation of terms and phrases. The interviews were conducted one-on-one, and a majority of the interviews were conducted in the respondents' homes or place of employment (healthcare providers and community leaders). The interviews were approximately one hour. Each respondent received a small stipend at the end of the interview.

Survey Data Collection—The youth survey data were collected one-on-one in the respondents' home or at the commune health center. Respondents were provided with a copy of the survey instrument on which to mark their responses. The items were then read aloud by the interviewer from a separate interview form. This method provided the maximum level of confidentiality while decreasing problems in relation to differing levels of literacy among respondents. If a youth could not read and therefore could not follow along with the interview, the interviewer asked the respondent if he/she were willing to answer the items directly to the interviewer. This method was employed with only a very small number of youth as only 13 (1.5%) of respondents were unable to read and 40 (4.5) were determined to have "below average" reading skills. Each survey took approximately 45 minutes and each youth was paid a small stipend on completion of the survey. In addition, after the survey the HIV/AIDS knowledge items were reviewed with the youth and each youth was provided with a HIV/AIDS information pamphlet.

Data Entry and Analysis

Qualitative Data—Translated data were entered into Ethnograph version 5.08 (2001), a qualitative text organization program. A coding dictionary was developed by the research team including specific definitions for each code. The U.S. research team members coded the qualitative data, and initial reviews of each coders work were conducted to ensure consistent and reliable coding. In addition, "memos" were created to make note of interesting text and/or patterns emerging during the coding phase. Analysis was conducted by running searches on single and multiple code words. These searches were reviewed for themes and patterns across respondents and variations across groups, e.g., gender, residency. These data were also analyzed in relation to findings from the survey data as a means of providing context and validation (or contradiction) of survey data results.

Survey Data—Data was entered into the SpSS Data Entry Builder version 4.0.0 (2003) program. This program allows for double entry of data to minimize data entry errors. The data was analyzed in SpSS version 11.5 program (SpSS 2002). Demographic data were described via Pearson’s chi-square. Prior to inferential statistical analysis, variables were created for respondents’ total scores on the various scales (see Table 1) including the sexual stigma scale, self-efficacy abstinence scale, and self-efficacy condom access/use scale. Independent t-tests were utilized to assess differences between mean scores for defined groups, e.g., gender, sexual experience. Linear regression analysis was used to assess models of significant associations between sexual stigma scale, the self-efficacy scales, and demographics.

Results

Qualitative Interview Data

In our analysis of the youth qualitative interview data we found very strong sentiments in regards to relationships between young men and women, and sexual involvement of unmarried adolescents and young adults. These data indicate a clear dichotomous view of relationships in which “good” male-female relationships are considered to be non-sexual and “bad” relationships almost always involve sexual relations. As two youth noted,

“A good relationship is a pure one, and it is very healthy, and it has not bad intentions...(the bad intention) is a young man will have a sexual relationship with a woman....”

“[in a good relationship] both of them must respect one another and they must keep themselves from the wrong things...they should not go beyond the limit of love... when both of them fall in love with one another, they should avoid having [a] sexual relationship.”

Among these youth, non-sexual relationships are considered “pure” and healthy”, while those which involve sexual encounters are often considered “dangerous”. Some of this perceived danger is specific to risks of pregnancy. As one youth noted, “...sex is very dangerous... without contraceptives, that girl gets pregnant...” Another youth noted, “...if we just play, do not want to have pregnancy, we use condoms. If not it is very dangerous...” While youth know HIV can be transmitted through vaginal intercourse, they are generally unaware of other sexually transmitted infections, and risks of HIV/STIs through anal and/or oral sex. Also, for many youth, HIV remains a disease of ‘others’ in high risk groups and they often feel invulnerable as long as they are not injecting drugs or having relations with commercial sex workers. As one young woman stated,

“...I see in Viet Nam, there are few people knowing about HIV. Only people who research it like you know about it. But my friends and others don’t know...People like my mother work all day and people like us don’t need to care about it.”

Youth also expressed issues of the ‘danger’ of lose of status for self or shame for his/her family. As one female respondent noted, “Girls will have unexpected pregnancy...it is not good for the family. The family and she are disgraced.” Another young woman stated, “when young people are infected with HIV this will harm themselves and their families...this will make parents ashamed....”

Youth also express that there is a risk of “loosing control” in terms of sexual feelings. Sexual feelings are perceived as dangerous, as individuals may not be able to stop from engaging in sexual behaviors despite intentions to abstain. While both young men and women are expected to maintain control over their sexual desires, it is ultimately the young woman’s responsibility to “control” the sexual aspect of a relationship.

“[in circumstances of having sex] the man and woman agree, and they cannot control their feelings.”

“In a healthy relationship, women must control themselves, avoid excessive actions of the men, or they should not be bold in the relationship between men and women.”

“I’m not clear, but I feel strange when they talk to me about sex...they say ‘I do not want (sex) because I am a girl.’ It is also difficult but when involved, it is like getting an electrical shock, uncontrollable, and then (sex) happens. It is late for saying sorry.”

The social stigma in regards to sexual relationships outside of marriage decrease youths’ ability to prepare for the possibility of engaging in sexual behaviors. Youth and adults state that young people “dare not” engage in sex, and youth and parents feel that they cannot discuss issues of sexuality with one another. Thus, while youth are aware of condoms and that condoms can prevent pregnancy and risk of contracting HIV, they are both reluctant to prepare for having sex and have limited social access to information and to condoms.

“In order to decrease risk of contracting HIV...people must live faithfully. Also in sexual relationships there must be a way such as using condoms to prevent the disease from spreading....”

“...some people feel shy, and they dare not go there (commune health center) for condoms....”

Survey Data

Baseline Demographics—A total of 470/886 (53.1%) of respondents were male. The mean age of respondents was 18.2 years (SD = 1.8 years). There was no significant difference in age by gender ($t=.098$ [95% CI=224 to .248], $p=.922$). A total of 580/886 (65.5%) of the respondents reported that they were currently in school at the time of the survey and 222/886 (25.1%) reported they were employed. The mean grade of those in-school was 11.7, while the mean grade completed of those out of school was 9.3. Significantly more female respondents (296/416; 71.2%) were in school than male respondents (284/470; 60.4%) [$\chi^2=11.23$, $p=.001$], and significantly more male respondents (145/470; 30.9%) reported being employed than female respondents (77/416; 18.5%) [$\chi^2=17.90$, $p=.000$]. Of youth employed, the mean income for male respondents was 681,000 vnd/month (~US\$43) and for female respondents 453,000 vnd (~US\$29) [$t=4.887$ [95% CI 135,969 to 319,813], $p=.000$].

Male-female Relationships and Engagement in Sexual Behaviors—A total of 386/883 (43.7%) youth reported “ever having a boyfriend/girlfriend”. A majority of youth reported “ever” having one (212/382, 55.5%) or two (103/382, 27%) boy/girlfriend(s). The mean number of relationships was 1.9 (range 1 to 22), and the mean length of the longest relationship was 14.4 months (range less than one month to 84 months [7 years]). Of youth who were ever in a relationship, 242/383 (63.2%) reported currently having a boyfriend/girlfriend. There was no significant difference for ever having a relationship by gender [$\chi^2 = .698$, $p=.403$].

Youth were asked a series of questions regarding engagement in sexual behaviors including “sexual touching” (touching partner, being touched by partner), and engagement in oral, anal, and/or vaginal sex. Engagement oral, anal, and/or vaginal sex was coded into a variable for “anysex” and sexual touching items into a variable “anytouch”. The sexual touching items were developed as a means of assessing intimacy in relationships, particularly because of the strong social stigma against engagement in sexual intercourse outside of marriage. Rates of reported engagement in “anysex” were low, particularly among female respondents. Significantly more male respondents (29/469, 6.2%) reported engaging in oral, anal, and/or vaginal sex (“anysex”) than female respondents (7/16, 1.7%) [$\chi^2 = 13.03$, $p=.000$]. Likewise,

significantly more males (96/468, 20.5%) reported engaging in sexual touching (“anytouch”) than females (56/412, 13.8%) [$\chi^2=6.80$, $p=.009$]. Youth reporting “any sex” were significantly older (19.8 years) compared to those reporting no sex (18.1 years) [$t=-4.94$ (95% CI -2.09 to $-.90$), $p=.000$]. Youth reporting sexual touching were also significantly older (19.1 years) compared to those reporting no sexual touching (18.0 years) [$t=-7.52$ (95% CI -1.46 to $-.86$), $p=.000$]. We utilized linear regression to further assess demographic variables (gender, age, school status) and “anysex” and sexual touching. Differences by gender [$t=-2.82$ (95% CI -0.07 to -0.02), $p=.002$] and age [$t=4.06$ (95% CI 0.01 to 0.02), $p=.000$] continued to be significant for “anysex”. Significant differences by gender [$t=-2.72$ (95% CI -0.12 to -0.02), $p=.007$] and age [$t=6.96$ (95% CI 0.04 to 0.07), $p=.000$] also continued for sexual touching. There was no significant relationship between school status and engaging in “anysex” [$t=-1.72$ (95% CI -0.05 to $.004$) $p=.086$] or in sexual touching [$t=-0.31$ (95% CI -0.06 to 0.05), $p=.759$].

Reported Condom Use Among Sexually Active Youth—Youth who reported engaging in sexual intercourse (vaginal sex) were asked about use of condoms at last sexual encounter, frequency of condom use, and likelihood of using condoms at next sexual encounter. A total of 18/32 youth (56.3%) reported using a condom at last sexual encounter, and a total of 11/32 respondents (34.4%) reported “always using a condom. However, 15/32 youth (46.9%) reported “rarely” or “never” using a condom. A total of 14/32 (43.8%) of youth reported that they were “very likely” to use a condom at next sexual encounter, while 8/32 (25.0%) reported they were “very unlikely” to use a condom. Linear regression analysis for use of condoms at last sexual encounter show no significant relation to gender [$t=-1.31$ (95% CI -0.78 to $.17$), $p=.202$], age [$t=-1.89$ (95% CI -0.23 to 0.01), $p=.069$] or school status [$t=-.41$ (95% CI -0.31 to 0.46), $p=.682$].

Sexual Stigma and Engagement in Sexual Behaviors and Condom Use—On the six-item sexual stigma scale (see Table 2), higher scores (with a maximum score of 24) indicated greater perceived stigma associated with engagement in sexual behaviors in a “love relationship” outside of marriage. Overall, youth scored a mean of 16.6 (SD=4.8). Males respondents (mean 15.2, SD 4.8) scored significantly lower than female respondents (mean 17.3, SD 4.1) [$t=-10.22$ (95% CI -3.72 to -2.52), $p=.000$]. For both males and females there was a significant difference in perceived sexual stigma between those who were sexually active (“anysex”) and those who were not sexually active. Thus, for male respondents those who were engaged in “anysex” the mean score on the sexual stigma scale was 12.8 (SD 3.8) compared to those not engaged in “anysex” with a mean score of 15.3 (SD 4.0) [$t=2.79$ (95% CI -4.41 to -0.77), $p=.005$]. For female respondents engaged in “anysex” the mean score on the sexual stigma scale was 14.0 compared to 18.4 for those not engaged in “anysex” [$t=-2.80$ (95% CI -7.45 to -1.30), $p=.005$]. However, while male respondents engaged in sexual touching (mean=13.8, SD 4.3) score significantly lower (less stigma) than males not reporting sexual touching (mean=15.5, SD 4.8) [$t=-3.15$ (95% CI -2.78 to -0.65), $p=.002$] this significant difference is not evident for female respondents [$t=-0.81$ (95% CI -1.64 to 0.68), $p=.418$].

There was no significant relationship between using a condom at last sexual encounter (vaginal sex) and sexual stigma score. [$t=-1.04$ (95% CI -4.30 to 1.40), $p=.306$]. There was also no significant relationship for scores on the sexual stigma scale between those respondents who reported “never” using a condom and those who reported “always” using a condom [$t=1.16$ (95% CI -1.44 to 5.08), $p=.258$].

Self-efficacy and Engagement in Sexual Behaviors and Condom Use—Youth had a high level of perceived self-efficacy for abstaining from sexual relations prior to marriage. On the five-point scale (see Table 2) with a high score indicating greater perceived self-efficacy

for abstaining from sex, youth scored a mean of 4.37 (SD=1.2). Females respondents (mean = 4.60, SD 0.9) scored significantly higher (greater self-efficacy for abstinence) than males (mean=4.17) [$t= 5.31$ (95% CI= 0.27 to 0.59), $p=.000$]. Also, while males who reported “anysex” (mean = 2.75, SD 1.8) scored significantly lower than those males reporting not being sexually active (mean=4.26, SD 1.3) [$t= -5.81$ (95% CI= -2.02 to -1.00), $p=.000$], among female respondents there was no significant difference in score on self-efficacy for abstinence between those reporting “anysex” and those reporting no sex [$t= -0.48$ (95% CI =-.088 to 0.54), $p=.634$]. There were similar findings by gender for sexual touching. Among male respondents, those not reporting engaging in sexual touching (mean=4.32, SD 1.3) scored significantly higher than those males reporting sexual touching (mean=3.57, SD 1.7) [$t= -4.86$ (95% CI = -1.11 to -0.45), $p=.000$]. However, among female respondents those reporting not engaging in sexual touch did not score significantly higher on the self-efficacy abstinence scale than those reporting sexual touching [$t= -0.79$ (95% CI= -0.38 to 0.16), $p=.428$].

In terms of condom use at last sexual encounter (vaginal sex), there was no significant difference in score on the perceived self-efficacy abstinence scale [$t=-.58$ (95% CI= -0.95 to 1.72), $p=.564$]. A self-efficacy condom scale including eight items with high score indicating greater self-efficacy for condom access and use (see Table 2), however did not show a significant difference between those using condom at last sexual encounter (mean=6.5, SD 1.0) compared to those who did not use a condom at last sexual encounter (mean=5.1, SD 1.7) [$t= 2.95$ (95% CI = 0.44 to 2.42), $p=.006$].

Sexual Stigma, Self-efficacy Abstinence, and Self-efficacy Condom Use—Linear regression analysis of the sexual stigma, self-efficacy abstinence, and self-efficacy condom scales indicate significant relationships. Controlling for gender, as sexual stigma scores decrease (less stigma), self-efficacy for condom access and use scores increase [$t=10.29$ (95% CI 2.56 to 3.77), $p=.000$]. Alternatively, again controlling for gender, as sexual stigma scores increase, self-efficacy for abstinence scores increase [$t=9.63$ (95% CI 2.37 to 3.58), $p=.000$].

Discussion

In Viet Nam, there remains a strong adherence to “traditional” conservative values. These values include abstinence until marriage and faithfulness after marriage. These values are ‘protective’ in terms of reproductive health for adolescents as long as they are adhered to stringently. Alternatively, with changing attitudes and behaviors which are often contrary to these values, Vietnamese adolescents are at increasing risk for HIV/STIs and unwanted pregnancy. Our data show that Vietnamese youth continue to report relatively low levels of involvement in sexual behaviors including vaginal, oral, and/or anal sex, though young men and older youth are more likely to be engaged in these sexual behaviors than young women and younger youth. While approximately one half of sexually active respondents stated that they used a condom at last sexual encounter (vaginal sex), our data also show that over 46 percent of sexually active respondents “rarely” or “never” use condoms. Thus, a significant portion of youth who are sexually active are not engaging in safer sex.

More than 43 percent of total respondents reported “ever” having a boyfriend or girlfriend. Also, more than 20 percent of male respondents and 13 percent of female respondents reported engaging in sexual touching. While parents and youth often talk about “not going beyond friendship”, we find that youth are experimenting within their relationships. The denial that youth are in relationships and the simplistic characterization of “good” (non-sexual) versus “bad” (sexual) relationships can create significant barriers to realistic discussions with youth about sexual health and relationships.

Stigma associated with pre-marital sexual relations creates for youth an atmosphere of silence. This stigma creates a situation particularly for young women in which their behaviors are perceived as “bad” and “immoral”, and they experience shame and denial of their sexuality. Thus, even young women engaged in sexual touching continue to perceive sexual relations in a love relationship to be negative. Young women who are sexually active also continue to score equally high as young women who are not sexually active on the self-efficacy abstinence scale. This suggests the possibility that these young women even while sexually active are unwilling to accept their own sexuality and take responsible measures including use of birth control and discussing safer sex with partners. These young women may also be in coerced sexual relations. Either situation presents significant barriers in terms of young women’s abilities to negotiate and engage in safer sex, or to abstain from sex.

There is a need to balance reinforcing abstinence and youths’ abilities to engage in safer sex. It is important to de-stigmatize safer sex within consenting relationships. Our qualitative data further suggest that many youth do not feel vulnerable to HIV and have limited information about the risks for other STIs. The combination of stigmatization of sex and perceptions of invulnerability increase risky behavior. Overall, youth with high levels of perceived stigmatization for sexual behaviors outside of marriage have less perceived ability to access and use condoms. Sexually active youth who do not use condoms score lower on the self-efficacy scale for condom access and use. For all youth, skills and knowledge in relation to condom use needs to be presented and reinforced. Programs need to both increase social access to condoms and provide the knowledge necessary to use condoms correctly. In addition, these skills need to be presented in a context of accurate information about risks for youth of HIV, STIs, and unwanted pregnancy.

In a changing political, economic, and social environment, and in the context of the emerging HIV epidemic in Viet Nam, there remains limited information about youth, their social relations, and their attitudes and behaviors in regards to sexuality. This knowledge is essential to the development and implementation of reproductive health programs for adolescents and young adults. Now is the time to “dare” to talk to youth and increase their abilities to engage in protective behaviors including both abstinence and safer sex.

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Table One
Survey Scales with Number of Items and Chronbach's Alphas

Scale	Number of Items	Chronbach's Alpha
Alcohol Expectancy Scales (Brown, Goldman, Inn 1980)	8	.71
Global Positive Transformation	12	.65
Enhance or Impede Social Behavior	6	.62
Cognitive & Motor Abilities	7	.73
Enhances Sexuality	12	.74
Deteriorated Cognitive and Behavioral Functioning	8	.72
Promotes Relaxation or Tension Reduction		
Parent Child Communication (Miller, Norton, Fan 1998)	14	.50
Partner Communication	10	.76
Cultural Estrangement (Kohn, Schooler 1983)	4	.68
Sexual Stigma	6	.83
Adolescent Independence	17	.62
Browns Locus of Control (Brown 1990)	6	.58
Internal	6	.67
External, Social	6	.65
External, Other	6	
Protection Motivation Theory (Roger 1983; Stanton, Black, Feigelman 1993)	5	.67
Extrinsic Rewards	5	.82
Intrinsic Rewards	7	.79
Severity	9	.67
Vulnerability	8	.80
Self-efficacy Condoms	5	.79
Self-efficacy Abstinence	3	.80
Response Efficacy	6	.62
Response Cost		
Gender	12	.68
Family Roles	15	.61
Male and Female Roles	9	.60
Equality		
Ethnic Identity and Perceptions of the West	3	.75

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Table Two
Sexual Stigma, Self-efficacy Abstinence, and Self-efficacy Condom Use Scale Items

Sexual Stigma	<ol style="list-style-type: none"> 1 I could be in a love sexual relationship, and feel good about myself and self-confident. 2 If I were in a love sexual relationship, I would feel worried and anxious that other would know. 3 If I were in a love sexual relationship, I would be a disappointment to my friends. 4 If I were in a love sexual relationship, I would be a disappointment to my family. 5 If I were in a love sexual relationship, I would be a disappointment to Vietnamese society. <p style="margin-left: 20px;">If I were in a love sexual relationship, I would be a disappointment to people living in my commune.</p>
Self-efficacy Abstinence	<ol style="list-style-type: none"> 1 I can be in a serious relationship and not engage in sexual behaviors (vaginal, oral, or anal sex). 2 I can wait until I am married before I have a sexual relationship. 3 Even if my partner wants us to start a sexual relationship, I can convince him/her that we should wait. 4 Even if I feel desire for my partner, I can stop myself from engaging in sexual behaviors (vaginal, oral, anal sex) 5 I have control over my body, and can avoid engaging in sexual behaviors (vaginal, oral, anal sex)
Self-efficacy Condoms	<ol style="list-style-type: none"> 1 I can get condoms if I want to 2 I could put a condom on correctly 3 I could convince the person I am having sex with that we should use a condom even if he/she doesn't want to 4 I could ask for condoms at a pharmacy 5 I could ask for condoms at the commune health center 6 I could carry a condom or keep a condom with me 7 I could refuse to have sex if the other person will not use a condom 8 I could ask the person I am having sex with about sexual relationships that he/she has had in the past.