

Chapter 8

Health Compromising and Problem Behaviors

Health-compromising behaviors (also referred to as risk or problem behaviors) include motorbike racing, violence, carrying a weapon, substance abuse, unsafe sex and self-harm. All of these issues were explored in this survey and some are discussed below. Issues of substance use and unsafe sex are reported elsewhere in the report.

8.1. Motorcycle Racing and Traffic Injuries

A question about participation in unauthorized motorcycle racing was asked, and a low 1.2% of the sample reported this behavior. However, most of the racing participants were male (2.3% compared with 0.3% for females). The highest risk-taking group, in terms of motorbike racing, is urban males aged 18-21 (5.3%).

A number of respondents had experienced at least one traffic injury (14%), with higher rates reported by urban young people at 26.6% than rural at 10.2%. These figures highlight a particular problem facing urban young people, with one in four reporting that they have had a traffic accident. This was again far higher in urban males (23.3%, 33.6% and 41.7%, increasing respectively with each age group).

Traffic injuries are the leading cause of death for young people aged 15-24¹ and risk-taking behaviors on roads and motorbikes, especially by young males, is seen as one contributing factor that puts young men and other people at risk.

8.2. The Experience of Violence

While the number of respondents who reported to have been injured as a result of violence in the home by a family member was low (2.2%), this rate more than doubled for ages 14-17 urban males (4.6%). There also seems to be gender differences

in family violence, with very small numbers of girls reporting to be victims of family violence at 1.5% compared to boys at 2.9%.

Nationally, 2.3% of respondents had carried a weapon, and this group mainly comprised of young males (4% compared to 0.5% of females). However, again the younger 14-17 year old and 18-21 year old urban males reported double the figures for carrying a weapon (6.4% and 9% respectively). This finding is consistent with a school-based study in Ho Chi Minh City that identified over 10% weapon carrying by young urban males². Given the severity of injury that can be inflicted with weapons this 6-9% of weapon-carrying urban young men is not insignificant. Fewer than 3% of male respondents reported that they had injured someone enough for them to require medical attention.

While all young people reported having been injured outside the home at 8%, a rather high percentage of young males experienced this, and there may be some association here with weapon carrying and gang behavior in urban areas. While 2% of females had been injured, 15% of urban males aged 18-21 years and 15.7% of the same age in rural and ethnic groups reported injuries.

While 2.5% of young people reported that they had participated in a group riot, young males were the main players (4.7% compared to females at 0.5%). This increased to 8% for the 18-21 year old urban males. It should be noted that the reported violence figures may be lower than real figures because they included immoral and illegal behaviors of a kind that are always underreported.

While some of the percentages amongst the young urban male group may seem low, there appears to be a pattern of multiple risk behaviors within this group. A small group of urban young males may be at higher risk through their involvement in multiple risk factors including drinking, smoking, motorbike racing, carrying a weapon, and being involved in street violence and/or gangs. This area requires further research to better understand the real risks faced by this group of seemingly at-risk young men.

8.3 Self Harm and Suicide

An increase in mental health problems including

depression, self harm and suicide has been well observed and documented around the world over the past 20 years. Youth suicide became a major health concern in countries including New Zealand, Australia, Finland and Japan during the 1990s. Limited attention has been afforded to mental health in Viet Nam, although recently a suicide prevention conference included issues of youth³. In the present survey, a number of mental health questions were asked, including two about self-harm/violence. A total of 2.8% of respondents reported that they had tried to deliberately injure or harm themselves. The percentages were higher for young males; 6.4% for urban 18-21 year olds and 4.7% for the 22-25 age group. Rural rates for 14-17 year old females and 18-21 year old males were also higher than the average, at 3.3% and 4.1% respectively. Comparisons with Australia show that national self-harm figures for Vietnamese youth are lower at 2.8% compared with 5%⁴.

Respondents were asked if they had ever thought about suicide. 3.4% of the total sample replied 'yes'. Of note here is the higher percentage of young females reporting this seriously harmful thinking (6.6% and 7.8% of the 14-17 years and 18-21 years urban girls). Of the total sample, 0.5% or 42 young people reported to have attempted suicide. Some anecdotal evidence and hospital records suggest that suicide is a more significant cause of youth mortality and morbidity than SAVY suggests⁵. It is important to understand further these self-harm and self-destructive behaviors and thoughts, and consider what might be the contributing factors.

8.4. Peer Pressure and Problem Behaviors

Respondents were asked about peer pressure, including positive pressure to avoid or resist behaviors such as drinking, causing trouble and watching pornography, as well as negative pressure to participate in such behaviors.

To a greater degree, reported peer pressure was 'positive' and 'protective', in the sense that peers discouraged negative behavior, rather than encouraging or inviting others into bad behavior. For all problem behaviors, between 65-75% of respondents reported that their friends encouraged

them not to participate in negative behaviors, or to maintain positive behaviors to avoid smoking, premarital sex and drugs. This is a very positive finding of the survey, and worth a deeper exploration in order to better understand how young people respond to such negative and positive pressures. It is especially important in assessing the appropriateness of peer education approaches as a continuing investment in these approaches to promote peer support among young people.

Some young males 18-25 years did report negative peer pressure, especially to smoke (28-35%) and to drink (37-50%). Only a tiny 1.2% of all respondents reported negative peer pressure to use illicit drugs. More urban respondents (8-12%) report some pressure to have premarital sex than rural counterparts (5.2-8.3%). 8.5-13% of young males reported peer pressure related to watching pornography and again this was the group aged 18-25, with higher urban figures. Young females consistently reported no negative peer pressure with percentages of less than 1%. This shows that the gender aspect might be protective, particularly for young females in relation to peer pressure for a number of problem behaviors that are examined in this section.

Adults often cite peer pressure as the reason for negative behavior, as sometimes do adolescents and youth. However the positive peer influence is often





ignored. Some authors advise caution in taking too simplistic a view of peer pressure, preferring to highlight the internal and media pressures that create a desire in young people to behave, dress or mimic their peers' behaviors, values and attitudes⁶. The psychology around peer pressure demands careful consideration including both the internal and external pressures that operate on young people. Friendships make up an important part of young people's lives and SAVY showed around 85% of young people have a group of friends they keep regular company with, be it friends of the same sex or a mixed group. A thorough understanding of the peer influence will help with intervention programs for young people.

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