Sexual and Reproductive Health of Adolescents and Youths *in CAMBODIA*

A Review of Literature and Projects 1995 - 2003

World Health Organization
Western Pacific Region

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WHO Library Cataloguing in Publication Data

Sexual and reproductive health of adolescents and youths in Cambodia: a review of literature and projects 1995-2003.

1. Sexuality 2. Reproductive medicine 3. Adolescent 4. Cambodia

ISBN 92 9061 2118 (NLM Classification: WS462)

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Acronyms

AIDS	acquired immunodeficiency syndrome
ARHI	Adolescent Reproductive Health Initiative
ATS	amphetamine type substances
BMI	body mass index
CBEs	community-based educators
CDHS	Cambodia Demographic and Health Survey
CHEMS	Cambodia Health Education Media Service
CPR	contraceptive prevalence rate
CRC	Convention on the Rights of the Child
CSWs	commercial sex workers
EU	European Union
EVA	electric vacuum aspiration
FHI	Family Health International
HCC	Healthcare Centre for Children
HIV	human immunodeficiency virus
HU	Health Unlimited
IEC	information, education, and communication
ILO	International Labour Organization
IMR	infant mortality rate
IOM	International Organization for Migration
IUD	intrauterine device
KAP	knowledge, attitudes and practice
MSM	men who have sex with men
MVA	manual vacuum aspiration
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases
NGO	nongovernment organization
NHS	National Health Survey
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NMCHC	National Maternal and Child Health Centre
NRHP	National Reproductive Health Programme

PEs	peer educators
PSI	Population Services International
RHAC	Reproductive Health Association of Cambodia
RACHA	Reproductive and Child Health Alliance
RTI	reproductive tract infection
SCF	Save the Children Fund (UK)
STI	sexually transmitted infection(s)
TFR	total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Acknowledgement

WHO is grateful to the Government and Ministry of Cambodia and to all those who provided information and contributed their time to this document. We hope that sharing the country's experiences in implementing specific programmes and activities to address adolescent sexual and reproductive health issues will be of use to others both within and outside the Western Pacific Region.

Preface

This is one of the reviews on the literature and projects of sexual and reproductive health of adolescents and youths in eight Asian countries.*

Adolescents and youth make up one-fourth of the population in the Western Pacific Region. At least 17 out of 37 countries and areas in the Region have a median age below 25 years. The health of adolescents is, therefore, a key element and an investment for the social and economic progress in the Region. Many of the problems adolescents experience are inter-related and should be regarded in a comprehensive manner. However, adjusting to sexual development and protecting their reproductive health are the major challenges for adolescents.

Adolescents are vulnerable because they lack knowledge and skills to avoid risky behaviour and lack access to acceptable, affordable and appropriate reproductive health information and services. This is often compounded with environmental disadvantages such as poverty and unemployment. Social norms of sexuality have also changed in the past two decades and puberty comes 2-3 years earlier over one century, but the environment to support adolescents has not changed. There is still much to be desired in terms of governments' institutionalization and allocation of funds. Also families and communities are still unprepared to provide accurate reproductive health

** Cambodia, China, Lao People's Democratic Republic, Malaysia, Mongolia, Philippines, Republic of Korea, Viet Nam*

information and services necessary for adolescents. Risks of unwanted pregnancies, unsafe abortions, pregnancy-related complications, sexually transmitted infections and HIV/AIDS, all of which are important elements of Millennium Development Goals (MDG), continue to threaten adolescents.

Since the International Conference on Population and Development (ICPD) in Cairo in 1994, where the importance of adolescent reproductive health was acknowledged, many studies and programmes have been carried out by various national and international agencies and nongovernmental organizations. In order to assist governments to achieve the objectives of ICPD and MDG, the WHO Western Pacific Regional Office provided technical and financial support to several countries to conduct literature and programme reviews.

As a result of these reviews, countries now have evidence-based information for the development of national policies and strategies for adolescent sexual and reproductive health. I appreciate the practical and cost-effective use of existing information for increasing awareness of adolescent reproductive health and for improving our work. Here, I also would like to express my thanks to the governments, the reviewers and researchers for your contributions to improving the reproductive health of adolescents and youths.

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WHO Regional Office for the Western Pacific

1. Literature review methodology

1.1 Overview

Adolescent reproductive health literature published inside and outside Cambodia was researched and analysed for this review. The literature presented in this review relates to research and project documents published between 1995 and 2003. The Ministry of Health's National Reproductive Health Programme (NRHP) commenced in 1994, and prior to this date the Ministry's focus was on re-establishing basic health services, which had been completely destroyed after decades of war and civil unrest.

1.2 Methodology

Adolescent and youth reproductive and sexual health is a relatively new area of reproductive health programming in Cambodia. Until 1998 most research consisted of small-scale and project-specific research, such as KAP baseline surveys, and there were few large-scale national studies on sexual and reproductive health issues. Many aspects of adolescent sexual and reproductive health have not been researched in-depth, such as male reproductive health issues, female menstrual health problems, adolescents' and youths' understanding of the ethno-physiology of the reproductive health system and adolescent growth and development. There is a lack of empirical research on adolescent and youth reproductive health in Cambodia, with few studies published in peer review journals. In addition, no intervention studies have been implemented since 1995.

This review encompasses a range of subjects related to adolescent sexual and reproductive health, including: reproductive system and sexually transmitted diseases; knowledge, attitude and practice (KAP) of sexual and reproductive health issues and related factors; unmarried pregnancy; induced abortion; sexual and reproductive health education and services; use of contraceptives; and policies, laws and regulations. The age of the young people ranged from 10 to 24 years old.

The methods used to conduct the literature search were:

- literature database search, including Population Database (Popline),

Health Science Database and Medline;

- Internet search, including international agencies' websites about sexual and reproductive health services and education; and
- collection and analysis of research papers, reports, project documents, meeting compilations on adolescent health.

2. Current status of adolescent sexual and reproductive health

2.1 Demographic characteristics

Cambodia has a population of over 11 million and a population density of 64 people per square kilometre, with nearly 85 % of the population living in the rural areas (National Institute of Statistics [NIS] 1998). The annual population growth rate is 2.5%. The 2000 Cambodia Demographic and Health Survey (CDHS) found that women constitute approximately 52% of the population, and 25.7% of all households are headed by women (NIS 2001a).

Life expectancy at birth is 56 years (55 years for males and 57 years for females). The crude birth rate is 29 per 1000 population and 25 and 29 per 1000 in the urban and rural areas, respectively (National Institute of Public Health [NIPH] 1999). The adult mortality rate for females and males 15 to 19 years old was 1.95 deaths and 2.49 deaths per 1000 population, respectively. In the age group 20 to 24 years the adult mortality for females and males was 2.63 deaths per 1000 population and 4.75 deaths per 1000 population, respectively (NIS 2001a).

Cambodia has a large dependent population of children and adolescents, and 42.8% of the population is younger than 15 years old (NIS 1998), and 32.8% are aged 10 to 24 years (Table 1). Based on current trends, it is projected that 30.6% of the population will be between the ages of 10 and 24 years by 2021.

Cambodia's Human Development Index ranking is 121 out of 162 countries, the second lowest in South-East Asia (United Nations Development Programme [UNDP] 2001). In 1998, the gross domestic product (GDP) per capita was estimated at US$ 238 (NIS 2001a). The average per capita consumption per day is 1800 riel (4000 = US$1). In 1999, 40% to 45% of the Cambodian people were living below the poverty line (using head-count indices). There is no indication that the situation is improving (Ministry of Planning 2001).

Table 1. Age distribution of the Cambodian population in 1998

Age/Years	Male	Female	Total
10-14	7.4 %	7.1%	14.5%
15-19	5.8 %	6.0%	11.8%
20-24	3.1 %	3.4%	6.5%
Total	16.3%	16.5%	32.8%

Source: NIS. 1998. General Population Census of Cambodia 1998. Ministry of Planning.

2.1.1 Marriage

Legally, a female can marry at the age of 18 and a male can marry at 20. A KAP study on fertility and contraception in Cambodia (Chhun et al. 1995) showed that the mean age for marriage was 20 years and median age of rural and urban women was 19 and 20 years, respectively. The median age at marriage for respondents with no schooling or incomplete primary education was 19 years. It was 20 years for respondents with primary or some higher education. A similar trend was found in the CDHS 2000. Women who attended high school or higher, married on average one year later than their less-educated counterparts. The CDHS 2000 found some variation in age of first marriage between regions, ranging from 19.1 years in Prey Veng Province to 20.7 years in Phnom Penh (NIS 2001a).

A survey among garment factory[1] workers aged 15 to 25 years in Phnom Penh (Forder 1999) showed the mean age of marriage as 19 years old. Among vulnerable female youth (out-of-school and from very poor backgrounds) aged 12 to 25 years in Battambang Province, 18% of 15 to 19 year olds and 26% of 20 to 25 year old females were married; whereas only 9% of all male respondents were married and they were between the ages of 20 and 25 years (Friends 1999a). Interestingly, the national census (2000) found that the mean age for marriage for males was 24.2 years and for females it was 22.5 years (NIS 1998), approximately two years later than that showed by other studies.

Marriage is arranged for many Cambodian women; however, this practice is becoming less common, especially in provincial centres and

[1] *National AIDS Authority (NAA) estimates that there are more than 170 000 young women, mostly from rural areas, have sought work in the garment factories in Phnom Penh, Kandal, Kampong Cham and Sihanoukville (NAA 2001).*

Phnom Penh. Studies in rural areas indicate that arranged marriage remains a common practice. In Kampot Province, a survey among adolescents found that 89% of respondents said that marriages were still arranged by parents. The process usually starts when a boy meets a girl he wants to marry, he tells his parents and then his parents meet the girl's parents. If both parties agree, they will be married. A female has very little say about the arranged marriages unless she really does not like the male. However, 40% of respondents in Kampot Province said they could choose their own partner, but males have more say than females. Among the unmarried female respondents, 85% said that they were afraid their parents would choose someone they do not like (Memisa/Cambodia Health Committee [CHC] 2000).

2.1.2 Fertility

According to the CDHS 2000 (NIS 2001a), the total fertility rate (TFR) is 5.30 (4.42 urban and 5.47 rural). The NIPH (1999) found the TFR was 4.11 in the general population and the age-specific fertility rates for 15 to 19 year olds and 20 to 24 year olds was 45 and 196 per 1000 women, respectively. The average age of women having their first child was approximately 21.8 years, and urban women start childbearing nearly one year later than rural women (median of 22.3 years and 21.6 years, respectively), and will give birth to 1.2 children by age 25 years. On average, women in Phnom Penh have their first birth 1.4 years later than women in isolated provinces and almost a year later than women in other rural provinces. The NIPH found that as education increases so does the age of first birth. Despite the fertility rate being higher in rural areas, the age pattern of childbearing is essentially the same in rural and urban areas (NIPH 1999). A survey with out-of-school adolescents aged 12 to 25 years in Kampot Province found that the average number of pregnancies of ever-pregnant female respondents was 1.4 pregnancies and most pregnancies occurred in the first year after the marriage (Memisa/CHC 2000).

According to the CDHS 2000, women continue to have more than four children on average even though the modern contraceptive prevalence rate (CPR) has more than doubled among married women, from 6.9% in 1995 to 18.5% in 2000. In addition, women from rural areas and uneducated women contributed the most to the observed increase in CPR. Contraceptive use was found to be lowest among females less than 20 years old (see section 5.3.1).

The fertility desires of women decreased steadily with age. Among adolescents aged 15 to 19 years, only 5% wanted no more children. Of married women aged 15 to 19 years, 38.5% said they wanted to have another child later, but they would delay having the child for two or more years, 25.9% were undecided, and 21.1% felt that they would like another child within two years. For women aged 20 to 24 years, the majority of women (36.6%) wanted another child but they said they would delay having the child for two or more years, 28.7% were undecided, and 14% said they would like to have another child within two years (NIS 2001a).

2.1.3 Education

Generally, the level of education in Cambodia is low. The Cambodian constitution states that children have the right to nine years of basic education and that education should be free to all. However, parents have to pay for their children's books and private tuition fees, making education inaccessible to many poor families. Compulsory education starts at six years old; however, only 23% of the six-year-old population enters school (NIS 1998). The gross enrollment ratio[2] was 83.9% at the primary level, dwindling to 16.1% at the lower secondary level and declining to 6% at the upper secondary levels (NIS 1998).

The grade level does not reflect the official age of the students in that grade, with children as old as 14 years entering Grade one (Longfils 2000; Vanchon 2003). The Ministry of Education, Youth and Sport (MoEYS 2000b) found that children were on average in grades far below the grades they should be in. The average grade attended for those aged 12 to 13 years was 3.6, for 14 to 15 years it was 5.3, which means that they had not completed primary school. The reasons given for their slow progress through schooling are the very high retention rates as well as non-availability of higher grades in many rural schools. For adolescents aged 14 to 15 years, 4% had never enrolled in school.

The national census (NIS 1998) found that 64% of the population aged seven to 14 years attended school. Attendance dropped to 40% and to 8% in age groups 15 to 19 and 20 to 24 years, respectively. Less than a 4% difference can be seen between the attendance rates of males and females aged seven to 14 years, but it increases to about 20%

[2] *The gross enrolment ratio is the proportion of children enrolled at a particular educational level to the population of relevant ages.*

difference in the 15 to 19 year age group. For both age groups, attendance at school is higher in urban areas than it is in rural areas (Table 2). Nationally, only 45 % of the enrolled students ever reach Grade 5 (MoEYS 2000a) and the large drop-out rate in the lower grades account for the high rate of illiteracy in the population (NIS 1998).

Due to poverty, shortage of labour in the family and lack of physical access to schools, certain segments of the population perceive that education is not imperative (MoEYS 1998a). The lower enrollment rates of females do not relate to families enrolling their female children to school. Instead, the families remove girls from school after only a few years of primary school; this is especially true in rural areas (Beaufils 2000). At the secondary level and above, there are more males than females attending school, and nearly half (45.3 %) of all female students attending Grade 9 (last year of lower secondary school) will drop out of school after completing that year (NIS 1998). Educating boys is considered as more important than girls because boys are seen as the head of the household and responsible for future income generation for the family (MoEYS 1998b; Memisa / CHC 2000). A study on girls' education found that security is a concern for parents when sending their daughters to school, and 62% of caretakers said they worried about girls' security when sending them to school. It was higher for urban respondents than rural respondents (MoEYS 1998b). The parents, however, did not consider the school location a major problem. The main concern was about the risk of abduction, even when the students live close to the school. Loss of traditional values was noted by 38% of respondents and among urban respondents, it was 57% (new and modern values are more prevalent in urban areas).

Literacy rates

The overall literacy level is 62.8%, with higher literacy levels in urban (75.5%) compared to rural (60.3%) areas. More than half the literate population has not

Table 2. Percentage of population aged seven and over attending school/educational institution by sex, age and residence

Age group	Total			Urban			Rural		
	Both Sexes	Male	Female	Both Sexes	Urban Male	Female	Both Sexes	Rural Male	Female
7+	26.0	30.3	22.1	30.4	34.4	26.8	25.1	29.5	21.2
7-14	64.3	66.3	62.3	75.3	76.8	73.7	62.4	64.5	60.3
15-19	40.6	51.4	30.0	54.6	64.8	45.0	37.6	48.7	26.8
20-24	8.3	11.6	5.3	16.1	22.4	10.1	6.7	9.2	4.4
25+	1.4	1.7	1.1	2.3	2.9	1.7	1.2	1.5	1.0

Source: NIS. 1998. General Population Census 1998. MoP: Phnom Penh.

Table 3. Age and functional literacy rate for young people aged 15 to 24 years in Cambodia

Age group	Illiterate			Semi-literate			Literate		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
15-19	7.7	9.1	7.1	13.0	13.1	12.9	16.3	16.5	16.1
20-24	7.5	8.7	7.0	9.2	8.7	9.6	10.7	8.9	13.0

Source: MoEYS. 2000. Report on the Assessment of the Functional Literacy Levels of the Adult Population in Cambodia. Department of Non-Formal Education: Phnom Penh.

completed primary school (80% of males and 88% of females). A comparison between males and females found that in urban areas 82.1% of males and 69.3% of females were literate, and in the rural areas it was 68.8% and 52.7%, respectively (NIS 1998). For young people aged 15 to 24 years, 76.3% were literate (males 81.8% and females 71.1%). The Department of Non-formal Education conducted a Literacy Test Assessment, Taxonomy and Question Weightage to determine the functional literacy levels of the adult population aged 15 years and over in Cambodia (MoEYS 2000b). The assessment found that 37.1% of individuals aged 15 years and over were literate and 62.9% were illiterate and semi-literate, and in the age groups 15 to19 years and 20 to 24 years it was 7.7% and 15.2%, respectively (Table 3). These results reveal quite different information to the national census data (NIS 1998). A study conducted by Friends (1999c) with street children[3] and vulnerable urban youth (aged 12 to 25 years) found that 23% of girls aged 12 to 14 years, 30% aged 15 to 19 years and 33% aged 20 to 25 year had no education. Among boys aged 12 to 14 years, 15 to 19 years and 20 to 25 years, 95%, 70% and 88%, respectively, had received some form of education. However, in terms of vocational training, the rate is lower, 37% of boys 15 to 19 years and 30% aged 20 to 25 years had received some vocational training.

2.1.4 Employment

The 1999 Cambodia Socio-economic Survey (NIS 2001b) found that 14.9% of adolescents aged 10 to 14 years and 42.5% aged 15 to 17 years are working[4]. The majority of adolescents lives in the rural areas and works in the agricultural sector. The proportion of female adolescents in the labour force is higher than males, reflecting their lower rates

[3] *For the purpose of this review street children are defined as children up to 18 years of age who spend most of their life on the street irrespective of whether they return to a family setting on a regular or irregular basis.*

[4] *NIS and ILO define work as "an economic activity that a person performs for pay, profit or family gain" (NIS-ILO 2001:3). Girls who were involved in household chores were considered to be working.*

of participation in formal education. In the 15 to 19 year age group, 63.9% of girls, compared with 43.8% of boys are in the labour force. However, at ages 20 to 24 years, they are approximately equal (MoP 1997). Women and girls enter the labour market earlier and are more likely to be less skilled and qualified than men or boys.

A study among vulnerable female adolescents in Battambang Province (out-of-school and from poor backgrounds) aged 12 to 14 years, 15 to 19 years, and 20 to 25 years found that 4%, 10% and 35%, respectively, had employment. For males in the same study, only 2% of males aged 15 to 19 years were working, versus 65% aged 20 to 25 years (Friends 1999a). A study among street children and vulnerable youth in Phnom Penh found that girls start working at an early age (16% of girls 12 to 14 years old said they had an income-generating occupation). For boys, the employment rate was lower, 25% of 15 to 19 year olds and 58% of 20 to 25 year olds had a job at the time of the survey (Friends 1999c). The Adolescent Reproductive Health Initiative (ARHI) in Cambodia lessons learnt research project (European Union [EU]/United Nations Population Fund [UNFPA] 2002) found that employment opportunities for young people appear to be limited to family and seasonal income generation activities, and in rural areas this was mainly farming and animal husbandry. The outcome of their labour is food to eat rather than money in their pocket. However, many adolescents in rural areas, such as Battambang and Prey Veng Provinces, describe opportunities to migrate to Phnom Penh and across the Thai-Cambodian Border into Thailand to sell their labour. The study also identified sex work and drug dealing as a means of earning money.

3. KAP of sexuality and reproduction

3.1 Knowledge about sexuality and reproduction

Women often lack awareness about physiology and sexuality, resulting in difficulties identifying, discussing and addressing sexual and reproductive health problems. Studies have revealed women's lack of knowledge about the body, human reproduction and how contraception works (Chhun et al. 1995; White 1996; Chap and Escoffier 1996; Memisa/CHC 2000). A study by Sadan and Snow in Cambodia (1999) with married women aged 15 to 44 years who had experience with modern birth spacing methods found that local beliefs situate a woman's most fertile period from a few days before menstruation to approximately one week after the blood flow ceases, in direct contrast with modern reproductive physiology. Little is known about the male's knowledge of the male and female body and human reproduction other than the small KAP studies analysed in this review.

The Reproductive Health Association of Cambodia (RHAC) conducted a baseline study among school-going adolescents from Grade 8 to 13 (aged 12 to 21 years) in three schools in Phnom Penh. Most (74%) females and 72% of males did not know when pregnancy could occur during the menstrual cycle (RHAC 1999). Among vulnerable adolescents (out-of-school and with poor backgrounds) in Battambang Province, only 4% of females aged 12 to 14 years had accurate information about the body and how they could become pregnant, whereas 28% of females aged 15 to 25 years knew how they could become pregnant.

A KAP study conducted by Memisa/CHC (2000) in Kampot Province with 520 adolescents found that only 16% of respondents knew when the fertile period of the menstrual cycle occurred and 50% said they 'do not know'. The majority of male respondents did not know anything about menstruation (31% of male respondents knew there was a menstrual cycle). Almost all female respondents had heard about the menstrual cycle. Despite having heard about menstruation, the majority of females gave incorrect answers about the fertile period in the menstrual cycle and said they thought it occurs right after bleeding, whereas males thought that it occurs during the bleeding phase (this is consistent with Sadana and Snow's (1999) findings among married women with experiences using modern

contraceptives). Only a few respondents (31% of females and 8.7% of males) could correctly state when the woman could get pregnant during the menstrual cycle. When asked if it was possible for females to become pregnant after their first sexual encounter, 47% of respondents said yes, 44% said no, and 8% said they 'do not know'. There was a difference between males and females, and 39% of females and 50% of males said it was not possible to become pregnant during their first sexual encounter.

A study by Friends (1999b) among freelance sex workers aged 13 to 25 years found that these young women had a very poor understanding of their bodies, and only 30% had any knowledge of the menstrual cycle. A CARE study among garment factory workers aged 15 to 25 years in Phnom Penh (Sprechmann 1999) found that the overall knowledge of fecundity was poor, and only 18% of respondents (male and female) could correctly identify the fertile period of the menstrual cycle.

3.1.1 Source of information

The 2000 Memisa/CHC KAP study in Kampot Province found that many female respondents were afraid the first time they menstruated because they thought they would die soon. Most girls are very shy in rural areas and they do not talk about reproductive health issues and their mothers do not discuss menstruation with adolescent females before it occurs. A qualitative study in Phnom Penh among garment workers (Sprechmann 1999) found that many young women did not know about menstruation before they began menstruating themselves. They reported being afraid that the bleeding was due to a leech biting them. The RHAC (1999) baseline study among 1197 students aged 12 to 21 years in three schools in Phnom Penh found that issues relating to sexuality and reproduction are not freely discussed among adolescents (Table 4).

Menstruation is not discussed among adolescents themselves or between adolescents and their parents. The most commonly discussed topics were HIV/AIDS and the use of condoms, which the authors attributed to the effects of various information, education and communication (IEC) campaigns in Phnom Penh that addressed HIV/AIDS and safe sex practices. The study found that females receive their sexuality and reproduction information from their mothers and sisters, whereas males learn about these issues from the media (females also do but to a lesser degree). A 1999 baseline study by Cambodia Health Education Media Service

(CHEMS) and Health Unlimited (HU) found that young people 12 to 24 years (53% urban and 34% rural) in Battambang, Kampot and Kratie Provinces and in Phnom Penh learned about sex from the television, radio, magazines, and movies (some mentioned in coffee shops) as well as from family and friends and nongovernment organizations (NGOs), and few mentioned their siblings. Street children said that they turned to friends for help and support because they do not have a family.

The Friends (1999b) KAP study with freelance sex workers found that females turned to their mothers and families for information about their bodies. Likewise, mothers and families are the main providers of information about sexuality for the 12 to 14 years and 20 to 25 year age groups. Adolescents aged 15 to 19 years generally asked their friends for information regarding sexuality. A KAP study (Friends 1999a) with out-of-school adolescents in Battambang Province found that boys turn to their families (mother and father) for information about the body. However, when it comes to discussing sex, male adolescents turned to their male friends and their families played a relatively small role. Older boys tended to be shy or indifferent, especially when it came to discussing topics such as the female anatomy and birth spacing. They were interested in learning about reproductive and sexual health at meetings (conducted by Friends) and from videos and television programmes.

Among street children and vulnerable youth in Phnom Penh, older females said that they receive their information from their family, but younger females turned to female friends (Friends, 1999c). For males, the family is the main source of information about the body, in particular their father, whereas, male friends are the main source of information about sexuality. Males tend to talk about sexual intercourse among their peers, especially the older males (aged 20 to 25 years). In terms of discussions about sexuality, the family played a minor role for male adolescents in this social group.

A study in Kampong Thom among teachers and students in three secondary schools and one college found that teachers see themselves as the ideal channel for teaching about sex and love. However, 20% of the female students interviewed doubted that this was the ideal means of delivering education about sexual and reproductive health. Parents were the respondents' least preferred choice of educationist, and 30% of students were undecided (Stulz and Lao 2001). The students' main areas

of interest were male-female relationships and pregnancy (56%), HIV/AIDS issues, especially social issues. Sexually transmitted infections (STI) were of minimal interest to male and female students in Kampong Thom.

CHEMS/HU (1999) conducted a study in the rural and urban areas where they deliver regular radio health messages and found that the rural sample preferred radio and the urban sample preferred television for health information. The majority of adolescents, especially males, said they went to their parents for advice on health issues (including reproductive health). Adolescents without parents go to a neighbour, sibling, teacher or another family member. Interestingly, no respondents said they went to health services, a doctor or health worker for advice and education; health services were places to go when they had a serious illness. Adolescents said they talk with friends about personal problems. A higher number of women than men didn't talk to anyone. Memisa/CHC (2000) found that in Kampot Province most young people learn about sexuality from friends, the media, parents, adults and elderly people.

The ARHI in Cambodia lessons learnt research (EU/UNFPA 2002) found that young people, as young as seven years, wanted answers to questions that related to male and female genitalia, conception and childbirth. The young people said they would ask peer educators (PEs) and community-based educators (CBEs) these questions because they found it difficult to ask and receive answers on sensitive issues from their parents and teachers. Videos, radio, story books and pictures are popular sources of information for young people age 10 to 25 years. They felt that reproductive health and sexuality education should be conducted by teachers and clinical staff who are the same sex as the students. There was interest in sex-related issues from respondents as young as 10 years old, with considerable interest among males about brothels and pornographic material. By ages 11 to 13 years, young people have started to worry about the physical changes in their body and have started to openly seek information from others. Girls said that when their body changes and they enter puberty, people perceive them differently. Instead of being seen as a child, they are seen as a sexual being. Female street children, in particular, identified this issue as making them more vulnerable to rape and sexual coercion.

Memisa/CHC (2000) found that a considerable percentage of unmarried out-of-school youth in Kampot Province mentioned that they had never heard about sexual relations. The radio

(26%) and PEs (25%) were the main sources of information. Male friends and relatives were the main sources of information for male adolescents, while parents were the main source of information for married females. Communication tended to be stronger among persons of the same sex. While females received information from their husbands and boyfriends, they were not sources of information for their husbands or boyfriends. Single youth, especially females, said their parents were the most important source of information. Mothers were more frequently consulted than fathers. Health staff and PEs also played a significant role. However, males, particularly those not married, addressed their questions to male friends. Married

Table 4. Adolescents who discussed the following topics in the last six months

Description	All	Males	Females
Body changes in puberty			
Yes	22.4	22.3	22.8
No	57.4	60.5	53.6
Other	20.2	17.2	23.7
Sexual urges and needs			
Yes	7.2	0.9	12.6
No	84.2	90.0	79.3
Other	8.5	9.1	8.2
How to avoid pregnancy			
Yes	10.0	12.8	6.6
No	81.6	78.9	84.9
Other	8.4	8.3	8.6
Relationships with the other sex			
Yes	16.4	20.8	10.9
No	75.4	70.6	81.5
Other	8.2	8.6	7.6
Whether or not to have sex with someone			
Yes	7.8	13.1	1.6
No	84.9	80.5	90.0
Other	7.3	6.4	8.4
Unwanted pregnancy or abortion			
Yes	7.6	8.3	6.0
No	84.4	82.6	86.5
Other	8.0	8.5	7.5
STI and HIV/AIDS			
Yes	33.1	40.6	24.2
No	59.7	55.0	65.2
Other	7.2	4.4	10.6
How to use condoms			
Yes	25.3	36.9	11.7
No	66.2	56.3	78.1
Other	8.4	6.9	10.2
Where to get condoms			
Yes	14.6	21.6	6.6
No	74.5	66.9	83.4
Other	10.9	11.6	10.0

Source: RHAC. 1999. Adolescent reproductive health survey, a baseline study. School going adolescents in Phnom Penh: Phnom Penh.

females discussed their problems with a spouse and single females consulted a female friend. Very few respondents, especially males, said they would not discuss their questions with anyone.

The 2002 EU/UNFPA study found that as a child enters adolescence it becomes harder for them to ask adults questions because of their shyness and because adults think that questions about sexuality and reproduction "go against the culture". In Kampot Province, adolescents said they were afraid, shamed and shy, scared and frightened to talk with their parents about sexuality (Memisa/CHC 2000).

3.2 Sexual activity

3.2.1 Societal attitudes

Gender roles and relationships are deeply rooted in Cambodian culture. Expectations of young women and men are radically different. Appropriate and ideal behaviour for young women is to be shy, unassertive, submissive and to be a virgin at the time of her marriage. A young male is permitted to engage in sexual activity prior to marriage, including buying sex (Tarr 1996a; Maclean 1999; Beaufils 2000). It is a common practice among young men (married and unmarried) to visit brothels together and have sex with commercial sex workers (CSWs) (NAA 2001). A woman who has sex with a man other than her husband is considered a 'bad woman' in Cambodian society (Beaufils 2000). Virginity at the time of marriage is not an issue for young men. It is widely accepted, but not universally condoned, that young men have irrepressible sexual needs and it is in their nature to seek out multiple partners. Beliefs include the following: sexual intercourse with a virgin will bring vitality to the man; there is no risk of contamination, even without a condom; and masturbation can damage your health and even your brain (ibid). Recent research in Phnom Penh suggests that the traditional belief that young people, in particular females, are not sexually active until marriage may no longer be valid (Wilkinson and Fletcher 2002; Population Services International [PSI] 2002).

Many young people are having sex by their mid-teens. By this time it is nearly impossible for them to ask an adult for information about sexuality and reproductive health issues. To admit to having sex would be too shameful, "so they are left to navigate the minefield of sexual and human relationships very much alone" (EU/UNFPA 2002). Many adolescents and youth who are sexually active hide their relationships from their family and friends because

they are concerned about perceptions of their morality and reputation (Tarr 1995, 1996a). A study in Kampong Thom Province with 529 secondary and college students aged 15 to 21 years and their teachers, found that teachers felt that female adolescents should not have premarital sex, but half the teachers interviewed felt that male adolescents could have premarital sex (Stulz and Lao 2001). Half the teachers felt that females accept sex because they look for gifts or money, an idea that was rejected by the female students. In schools in Kampong Thom Province, girls who become pregnant and the responsible male are suspended.

Adolescents who leave their home to go study in urban centers are in a more vulnerable situation because they are away from their families and have weak social networks in their new environment (Stulz and Lao 2001). This is also true for adolescents migrating from rural areas to work in factories in Phnom Penh, in particular, garment factories. This situation often necessitates that five to 10 adolescents live together in one house to save on housing expenses (Forder 1999; Sprechmann 1999). Sexual awakening, loneliness, distance from family, absence of parents' authority, opportunities to have many friends combined with the feeling of freedom can lead to risky sexual behaviour (NAA 2001). Single young migrant workers are more likely to have casual sex and a low rate of condom use (United Nations Children's Fund [UNICEF] 2000).

3.2.2 Adolescents' attitudes to sexual activity

The EU/UNFPA (2002) ARHI lessons learned research found that adolescents considered it natural for young people to have "sweethearts" and experiment with sex. Females said that if they were to experiment with sex they would be putting their reputation at risk as well as placing themselves in a vulnerable position. Young males, however, saw few disadvantages in having sweethearts. The Memisa/CHC study with out-of-school adolescents in Kampot Province found that more males than female respondents agreed that premarital sex was acceptable; males were equally as supportive of females having premarital sex. Among those males who had sexual partners (excluding their spouses), their average number of partners was 2.8.

The study in Kampot Province found that 94% of males said that Cambodian males have sex before getting married. But when respondents were asked about males in their village, 65% said that males have sex before getting married. However, when respondents were asked

about females in their village having sex prior to marriage, 58% said they had sex prior to marriage and 84% said that it was important to fall in love before they started a sexual relationship. The mean age for first sexual encounter for males and females in this study was 18 years. Respondents said that young people get married earlier to prevent themselves from having premarital sex or having sex with different partners

Young garment workers said that males and females should abstain from sexual intercourse until they are married. However, what the respondents said and what they did was quite different. A higher percentage of males thought that sex before marriage was acceptable for males (27%) compared to females (6%). Half the male respondents said that males have their first sexual encounter with commercial sex workers (CSWs), a third said with a girlfriend and only 9% said males wait until marriage to have sex. Young women had quite different opinions about males' behaviour. Most said that males have their first sexual experience with their wives or girlfriends, and only 15% said with CSWs. Eighty per cent of females said that females have their first sexual experience with their husband and 9% said with sweethearts or boyfriends (Sprechmann 1999). The HU project evaluation found that the majority of respondents said that adolescents should start having sex when they get married; however, 44% of females said that it would be appropriate to have sex with boyfriends from age 18 years onwards, and 45% of male respondents (older group) agreed with this statement (Sainsbury 2001).

3.2.3 Sexual practices

The 2000 CDHS found that the median age at first intercourse for women aged 15 to 25 years is 20 years. It is the same as the median age of marriage for women 15 to 25 years old. The National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) 2001 sexually transmitted infections (STI) surveillance survey (NCHADS 2002) found the mean age of brothel-based sex workers was 21.6 years. The mean age at first sexual encounter was 17.7 years, and 3.6% were less than 15 years old, 81.5% were 15 to 19 years and 13.5% were 20 to 24 years old. The mean age at first sexual encounter for women who attended reproductive health services was 20.9 years.

Tarr's 1996 study in Phnom Penh showed that more than half the females interviewed had their first sexual encounter before 18 years and some were as young as 13 years. A 1999

baseline study conducted by RHAC with school-going adolescents in Phnom Penh found the mean age of first sexual encounter was 19 years. Research conducted in Phnom Penh with freelance CSWs (non-brothel based) showed that on average these women first engaged in sexual intercourse when they were 17 years old. The earliest age stated was 13 years old and the oldest age was 24 years. The same age (17 years) was found among male respondents (Friends 1999b).

Save the Children (SCF) conducted a study in Phnom Penh, Battambang and Kratie Provinces among adolescents aged 11 to 20 years and found that 16 to 18 years was the usual age for males and females to have their first sexual encounter. In rural and urban areas more than 40% of young people thought that their peers of both sexes had their first sexual experience between ages 16 and 18 years, and 10% of the 11 to 20 year old adolescents had already had sex (Ly et al. 1997). Males who reported having had sexual intercourse had done so outside marriage. Only one in three girls who reported sexual activity had done so outside marriage. A KAP survey in Kampot Province found the mean age for males' and females' first sexual encounter is 18 years (CHC / Memisa, 2001).

Friends (1999c) research in Phnom Penh among street children[5] and vulnerable youth found that sexual activity among males and females commenced on average at 16 years of age. In Battambang, vulnerable out-of-school adolescents said that their first sexual encounter occurred at 17 years (Friends 1999a). A study conducted in the garment factories in Phnom Penh found that the female garment workers were 18 years old and males 19 years old when they had their sexual debut (Sprechmann 1999). A 2002 study conducted by Family Health International of 807 men who have sex with men (MSM) ages 19 to 42 years old in Phnom Penh found that the mean age of the first sexual encounter was 17.7 years. Half the MSM had their first sexual partner between ages 16 and 18 years old, with 17.3% reporting they were below the age of 16 years, and 32.2% said they were older than 18 years.

Sexual patterns

The 2000 CDHS found that 9.7% of adolescents aged 15 to 19 years and 41.5% aged 20 to 24 years were sexually

[5] *There are estimated to be more than 10,000 street children in Phnom Penh (Guillou, 2000). The main reason for becoming street children is poverty and family violence (United Nations, 2000).*

active in the four weeks prior to the survey (NIS 2001a). The 1999 RHAC study with 1197 school-going students (12 to 21 years old) in three schools in Phnom Penh found that only 45 students had engaged in sexual intercourse. Among those who were sexually active, 25 students had one partner, seven students had two to three partners, four students had between four and 10 partners, and four students had more than 10 partners.

CHC/Memisa (2001) survey with out-of-school adolescents in Kampot Province found that 3.8% of married respondents said they had a sexual relationship with someone before they were married. Of the 424 single adolescents surveyed, 23% said they had had a sweetheart/boyfriend/fiancé, but most had not engaged in sexual relations yet. However, a RHAC survey found that 10% of sexually active adolescent males had more than 10 partners and more than a third had only one sexual partner (RHAC 1999).

Friends (1999b) research with freelance CSWs showed that 68% had more than three partners in the previous week. Among vulnerable male adolescents (out-of-school and from poor backgrounds) aged 15 to 19 years and 20 to 25 years, 12% and 22%, respectively, said they had more than three partners in the three weeks prior to the survey (Friends 1999a).

A CARE baseline survey with garment factory workers showed that despite the garment workers' attitudes to premarital sex, in reality 2% said that their first sexual intercourse was with a boyfriend (Sprechmann 1999). Only 2% of single garment workers said they had had a sexual experience. One quarter of the single respondents said that they had ever had or currently had a boyfriend, but most of these women said they had not had a sexual relationship with these males. Among single women who had sexual intercourse, all of them said they had had sex with a boyfriend, and about half the respondents in this group used a condom. The single garment workers who were sexually active had sex with more than one sexual partner, indicating that this small group of garment workers were different from their peers. Almost all the male garment workers said they would not marry a female who had previously had a sexual relationship. However, at least 60% of the male respondents said they had at least one sexual experience themselves. Among those males who were sexually active, on average, they had had a total of 16 sexual partners since their sexual debut, and 10 partners in the year preceding the study. Their sexual encounters had been with a girlfriend/sweetheart (42%),

CSW (42%), and only 15% said with their wife. Married female garment workers on average had only one sexual partner.

Type of sex

Among the out-of-school vulnerable males aged 15 to 19 years and 20 to 25 years, 24% and 22%, respectively, said vaginal sex was the most common form of intercourse they engaged in. Some respondents also had oral sex (Friends 1999a). Young freelance CSWs predominately engaged in heterosexual sex (93%) and the majority had vaginal intercourse. Other respondents said they also had anal intercourse (2%) and oral intercourse (7%) and 36% of the respondents had intercourse during menstruation (Friends 1999b). A MSM study found that approximately half the males (age not specified) reported that their first sexual partner was male. Engaging in vaginal penetrative sex with a female partner during the six months prior was reported by 61.2% of participants. Eighty per cent of respondents reported penetrative anal sex with male partners in the six months prior to the study, and 42.6% reported having penetrative sex with female and male partners in the previous six months (FHI 2002).

4. Teenage pregnancy

4.1 Risks

Children are more likely to die in early childhood if they are born to mothers who are too young or too old, if they are born after too short a birth interval, or if they are of too high a birth order. The National Health Survey (NHS) classified 18 years as too young to bear children. Children born to mothers younger than 18 years were 1.5 times more likely to die than children born to mothers without any risk factor (NIPH 1999). The level of teenage fertility is higher in rural areas (10%) than it is in urban areas (8%). The level of teenage fertility in Phnom Penh was the lowest (5%), with accessible provinces having higher levels of teenage childbearing (11%). Teenage fertility was also associated with years of schooling and literacy. The highest levels of teenage fertility were found in females who were illiterate and had no schooling (12%) (ibid).

The KAP study on fertility and contraception found that among women

aged 15 to 19 years, 39.4% of married women had one child and 34.5% of married women in this age group were pregnant (Chhun et al. 1995). A NIPH survey was conducted three years later and used different survey methods in different locations and under different research conditions. It was found that 9% of women aged 15 to 19 years had begun childbearing, 6% had already given birth, and 3% were pregnant with their first child. Only 1% of the females who had already begun childbearing were 15 years. At 17 years it was 6% and among 19 year olds it was 26% (NIPH 1999).

Among vulnerable adolescents aged 15 to 19 years, 6% had been pregnant. Some of these adolescents "lost" their child (cause unknown) and 1% kept their baby. In the 20 to 25 year age group, 26% stated they had already been pregnant. For street children, the teenage pregnancy rate was much higher (Friends 1999a). A 1999 Friends study in Phnom Penh of street children and vulnerable youth found that 93% of adolescents aged 15 to 19 years and 86% of youth aged 20 to 25 years had been pregnant. Among 15 to 19 year old females, about one third had "lost" their baby, while nearly all the pregnant 20 to 25 year old females had kept their babies. Among garment factory workers in Phnom Penh aged 15 to 25 years, 41% of respondents said they had a friend who had a child at a very young age (Sprechmann 1999). The Neavea Thmey Centre in Toul Kok Phnom Penh is where vulnerable young girls seek support and care. Of the 277 females accessing the centre between 1998 and 2001, 12 teenage girls (4.3%) were pregnant (World Vision 2001).

Among garment factory workers, 40% of respondents said that pregnancy and childbirth at a young age were more risky than at an older age, because women can die. Other reasons given for not having a pregnancy at a young age included: the need for a higher income to properly care for the child; the lack of time for child care; and the high costs and increased expenses associated with raising a child. Respondents also said that having a child at a young age would deter the mother from continuing with her education. Young men were more concerned about the economic costs of having a child at a young age, whereas, young women expressed more fears about the health of mother and infant (Sprechmann 1999).

4.2 Maternity care

The CDHS 2000 found that the majority of births in Cambodia occurred at home and in the care of traditional birth attendants (TBAs) (66.3%). Births to

young mothers and first-time mothers were more likely to be assisted by trained health professionals. Women were more likely to deliver their first baby in a health facility, compared to subsequent births. In the five years preceding the CDHS, 12.9% of females younger than 20 years old who had a live birth, delivered in a health facility. Among females less than 20 years old, 34.5% were assisted in birth by trained health personnel compared to women aged 20 to 34 (33.1%) and 35 to 49 years (26.2%). Friends found that among freelance CSWs (13 to 25 years old) who had been pregnant in the past, only 14% of the respondents had seen a doctor during their pregnancy. In 2002, approximately 13% of all women who delivered in the National Maternal and Child Health Centre (NMCHC) in Phnom Penh (6656 women) were aged 15 to 20 years. The socio-demographics of the female adolescents who delivered their infants in the NMCHC were not recorded (NMCHC 2003).

4.3 Maternal and infant mortality

The maternal mortality ratio in Cambodia from 1994 to 2000 was 437 per 100 000 live births, or four deaths per 1000 live births, which is high relative to developed countries. The main direct causes of maternal mortality were haemorrhage, obstructed labour, hypertension and sepsis (Ministry of Health 2002b). However, for each age group, maternal deaths were a rare event (NIS 2001a). A study, Deaths Among Women of Reproductive Age, was conducted in Kampot, Siem Reap, Pursat and Stung Treng Provinces between October 1998 and September 1999 (Reproductive and Child Health Alliance [RACHA] 2000). It found that 236 deaths had occurred among women aged 15 to 49 years and 21% of the deceased women were aged 15 to 24 years. The main causes of death were infectious diseases, pregnancy complications, tumour/cancer, injury and convulsions. Of the 48 maternal deaths reported during the study, it was found that the direct obstetric causes were due to haemorrhage, sepsis, and eclampsia. The indirect obstetric causes were due to infection (tuberculosis and malaria), injuries and other/unknown. These data were not disaggregated by age.

The CDHS 2000 found the infant mortality rate (IMR) in Cambodia was 95 per 1000 live births. One in every 10 babies born in Cambodia does not survive to his or her first birthday. The IMR is higher in rural areas (96 per 1000 live births) compared with urban areas (72 per 1000 live births). For adolescents aged less than 20 years, the IMR for infants born to them was 101

per 1000 live births, which is second only to women aged 40 to 49 years (117.3 per 1000 live births). The neonatal mortality rate for adolescents aged less than 20 years was the highest of all age groups at 45.2 per 1000 live births. The under-five mortality rate for females aged less than 20 years is 126.3 per 1000 live births, second only to women aged 40 to 49 years (155.6 per 1000 live births).

4.4 Nutrition

Women's nutritional status is an indicator of general health and a predictor of pregnancy outcome for both mother and child. The CDHS 2000 considers a woman at nutritional risk if her height ranges from 140 to 150 centimetres. The mean height of women in Cambodia is 153 centimeters, with 6% of women less than 145 centimetres. Rural women are shorter than their urban counterparts.

The body mass index (BMI) was calculated for women aged 15 to 49 years during the CDHS 2000. One in five women fall below BMI 18.5, indicating that chronic energy deficiency is relatively high in Cambodia. Women 15 to 19 years had the lowest mean BMI at 19.9, followed by women aged 20 to 24 years with a mean BMI of 20.4. Women aged 15 to 19 years and rural women were more likely than other women to suffer chronic energy deficiency.

The 2000 CDHS found that more than half of women aged 15 to 24 years were anaemic (haemoglobin less than 12 g/dl), with the majority of women classified as mildly anaemic (10.0-11.9 g/dl). A study in Kampong Chhnang and Prey Veng Provinces found that the mean haemoglobin g/dl for pregnant women less than 30 years was 10.6 g/dl and for non-pregnant women it was 11.8 g/dl (Chhin et al. 1998). Among pregnant women aged less than 30 years, 58% had a haemoglobin less that 11.0 g/dl. For non-pregnant women less than 30 years, 50.8% had a haemoglobin less than 12.0 g/dl. The main factors affecting anaemia among pregnant women were age, age at first pregnancy and the pregnancy trimester. Younger women were more likely to have anaemia compared to women aged 30 years and over. Women who had their first pregnancy at a very young age were two times more likely to have anaemia than older women.

A 2000 study by GTZ in two districts in Kampot Province in 1999 and 2000, found that among adolescents aged 12 to 14 years old, 82.6 % in Trapiang Reang Province and 91.3% in Dang Tung Province were anaemic

(<12.g.Hb/100ml) (Longfils 2000). In 2000, after a 12 month "Iron Therapy School Programme" (one tablet of iron-folic acid per week for 20 weeks), as part of the GTZ Integrated Food Security Programme in Kampot Province, anaemia among adolescents was 44.2% in Dang Tung and 54.3% in Trapiang Reang Provinces.

A study in Kampong Chhnang and Prey Veng Provinces found that among non-pregnant women aged less than 30 years, 50% of women were anaemic (hemoglobin <12.0 g/dlh), and for pregnant women in the same age group 58% were anaemic (haemoglobin <11.0g/dl) (Chhin et al. 1998). The mean haemoglobin g/dl for pregnant and non-pregnant women less than 30 years old was 10.6 g/dl for pregnant women and 11.8g/dl for non-pregnant women. The same study found that younger women were 44% more likely to have anaemia than women aged 30 years or older. This study did not specifically look at adolescents, although adolescent females were included in this category.

5. KAP of sexual and reproductive health and related determinants

5.1 Knowledge

5.1.1 Contraceptives

Knowledge of one or two modern contraceptive methods is widespread, particularly in urban centres. The main contraceptive methods cited by respondents in almost all studies analysed were birth-spacing methods such as the daily pill, injections[1] (Depo-provera) and the IUD. These birth-spacing methods are available at most pharmacies and private clinics, but less so in rural areas. However, very few adolescents know the contraceptive methods' function, use, efficacy and complications.

A 1999 study by Sadana and Snow on married women (15 to 44 years old) who had personal experience with modern contraceptives, found that women thought that hormone methods (pill and injection) generated heat in the body and altered the balance of bodily humours,

[6] *When discussing birth spacing methods Depo-Provera is commonly referred to as the injection not by its generic name.*

resulting in drying the womb, other body parts and the skin as well as thickening the menstrual blood. The IUD and condom were thought to generate heat and dryness directly in the womb. The main source of information about birth-spacing methods, including condoms, was the media, followed by health staff, and, to a lesser degree, family members, teachers and friends (Sprechmann 1999; CHEMS/HU 1999; CHC/Memisa 2001).

The KAP survey on fertility and contraception in Cambodia (Chhun et al. 1995) found that among females aged 15 to 19 years, 64.2% knew of any method of contraception and 64.2% knew any modern method. For women aged 20 to 24 years old, 78.3% knew of any method and 77% knew any modern method of contraception. Of all the modern contraceptive methods used in Cambodia, women knew that the Ministry of Health recommended the daily pill, injection and IUD. The 2000 CDHS found that among 15 to 19 year old married females, 89.7% knew at least one contraceptive method and 88.9% knew at least one modern contraceptive method. It was slightly higher for females aged 20 to 24 years, and 94.8% knew at least one contraceptive method and 94.4% knew at least one modern contraceptive method (NIS 2001a).

The 1999 CHEMS/HU KAP study in Phnom Penh, Battambang, Kratie and Kampot Provinces with adolescents aged 12 to 24 years found that the daily pill was the most well known contraceptive, followed by IUDs, then injections and condoms. Knowledge of all contraceptive methods was higher in urban areas. Surprisingly, more than a quarter of all rural respondents (26%) did not know any contraceptive method and there was no knowledge of the vasectomy in rural areas. A study with adolescents in Battambang and Kratie Provinces and Phnom Penh found that respondents could name at least two birth spacing methods. However, they did not know about the methods' function, use, efficacy and complications. The injection was the main method cited, followed by the daily pill and IUD, and to a lesser degree condoms were mentioned (Ly et al. 1997). The 1999 RHAC study with school-going adolescents found that their knowledge of birth-spacing methods was fairly high. Of the 1197 students surveyed in three Phnom Penh schools, only 18.5% had never heard of any birth-spacing method. A 2001 CHC/Memisa study of adolescents in Kampot Province found that the daily pill and injection were the best known contraceptives, closely followed by IUD and condoms. Females knew more contraceptive methods than males.

A study with vulnerable youth in Battambang Province found that males and females had a good knowledge of the various contraceptive methods, particularly female street children (Friends 1999a). Females had good knowledge of contraceptive methods, especially the daily pill, condoms and injections, and they felt that it is important to use a contraceptive method in order to choose when to have a child (ibid). Friends found that street children and vulnerable youth in Phnom Penh had good general knowledge of contraceptives; however, younger respondents were less informed. Older females knew about IUD, condoms, injections and the daily pill. Half the adolescents aged 15 to 19 years and 83% of 20 to 25 year old respondents said they used contraceptives, and condoms were tried by nearly all the females in each age group. However, researchers found that among this group, the price of condoms and the places where condoms are sold were not widely known. Half the females interviewed have no knowledge where to obtain information about birth-spacing. Among males in the same social group, condom was the most well known contraceptive method. Eighty-one per cent of males aged 12 to 14 years, 75% aged 15 to 19 years, and 100% aged 20 to 25 years knew of condoms. The daily pill and the injection were also known contraceptives among the two older groups.

Among freelance commercial sex workers, 45% of the female respondents knew about contraceptives, 94% knew about condoms, 42% knew about the daily pill, and 18% knew about the IUD. Only 9% knew where to receive information about birth spacing (Friends 1999b).

In a study conducted by CARE (Sprechmann 1999) among garment factory workers in Phnom Penh, 71% of the respondents could spontaneously name at least one birth-spacing method, and on average respondents named two methods. A larger percentage of workers with higher literacy skills knew about modern methods compared to those with no or poor literacy skills. However, one in every four workers did not know how to prevent pregnancy. Nearly half the garment workers knew of injections (referring to Depo-Provera) and the IUD, another 44% had heard of the daily pill and 39% said that the condom could prevent pregnancy. Other methods, such as sterilization, traditional and natural methods of contraception were mentioned by less than 5% of respondents. The difference between male and female knowledge of specific contraceptives was significant. Males could name more contraceptive

methods (modern and traditional) than females. This is surprising, considering males had poor knowledge of fecundity. Respondents said the main source of supply of contraceptives was public clinics (75%), again reflecting the NRHP's focus on education of public health staff and supply of contraceptive methods to public health facilities. Private clinics were also named by respondents as another source of supply of contraceptives (55%) and then the market/store (29%) and pharmacy (21%). Interestingly, 18.6% of respondents said that contraceptives could be obtained from friends. Male garment workers knew more sources of supply of modern contraceptives than female workers. Older respondents knew more sources of supply than younger respondents.

Condoms

For the past decade, condoms have been heavily promoted as a method to prevent HIV/AIDS and not as a contraceptive method. In most studies analysed during the review, knowledge of condoms as a contraceptive method was low (CHEMS/HU 1999; Sprechmann 1999).

A 2001 UNICEF survey found that 86% of students aged 14 to 17 knew what a condom was, and of this group only 3% had used a condom and 81% said they could buy a condom themselves. Among adolescents aged 11 to 20 years in Phnom Penh, Battambang and Kratie Provinces, 68% of all respondents reported knowing about condoms (Ly et al. 1997). When adolescents were asked if they knew how to wear a condom, 27.5% said no, 19% said yes, and 31% said do not know. In terms of accessing condoms, 44% of respondents said they did not know where to access condoms. The respondents said that the main venues to purchase condoms were the pharmacy (27%), market (20%), brothel/night-club/hotel (15%), and 11% said they could be accessed in a health centre or hospital.

In Kampot Province among out-of-school adolescents, 98% had heard about condoms and among these respondents, 57% said they were available in their village, 39% said they were not available in their village and 2.5% answered "do not know". Importantly, 57% of females mentioned that they were available in their village. When asked where the youth usually get condoms, the private sector (market, pharmacy and shop) was the most cited response. Interestingly, the CHC staff who distributed condoms during village education sessions were mentioned by only 11% of respondents (CHC/

Memisa 2001).

Among garment workers in Phnom Penh aged 15 to 25 years, only 39% named the condom as a contraceptive method, and a much larger percentage knew that a condom could prevent HIV infection. Among males and literate respondents, more than 90% in each group heard about condoms. For females, 84% knew about condoms and more than 40% knew where to purchase condoms (Spechmann 1999).

5.1.2 HIV/AIDS

Generally, HIV/AIDS awareness is high. More than 90% of respondents in all studies had heard about it (Ly et al. 1997; RHAC 1999; Friends 1999a; Friends 1999b; Friends 1999c; Sprechmann 1999; CHEMS/HU 1999; Memisa/CHC 2000; Sainsbury 2001; CARE 2002). However, there is poor knowledge and many inaccuracies associated with the causes, transmission, and signs and symptoms. The main sources of information about HIV/AIDS were media (television, radio), family and friends.

A SCF study of adolescents in Battambang and Kratie Provinces and Phnom Penh found that majority had heard about HIV/AIDS (92.8%). More than 90% said that it is a debilitating illness and agreed that some Cambodians had AIDS (92.3%) (Ly et al. 1997). However, 4.8% reported that AIDS is a hidden syphilis (Eisenbruch 1997), and 33.9% said it is the virus that causes tuberculosis. Only 28% of respondents could give a name to the virus that caused AIDS. Among those who gave the virus a name, the majority came from Phnom Penh, then Battambang and then Kratie Province. Nearly all respondents (96%) knew the virus was transmitted through sexual intercourse.

Younger respondents were less informed about the modes of transmission or opted to answer, "don't know". For example, 56.8% of 11 to15 years old and 32% of the 16 to 20 year old respondents believed that HIV could be transmitted by coughing and sneezing. Youth showed differences in knowledge depending on their residence (urban or rural), particularly in Kratie Province, where males and females were less informed. For example, 52.4% of Kratie respondents said that HIV could be transmitted by "touching someone with AIDS" versus 27.2 % of respondents in Phnom Penh. Fifty-two per cent of respondents from the Kratie, 31.5% from Battambang and 27% from Phnom Penh said that HIV is transmitted when touching a HIV-positive person. Mosquito bites was also

thought to be a source of transmission by about half of all respondents. Interestingly, 81% said they could not get HIV and 70% said that they could not get a STI. Only 28.5% of respondents said that HIV transmission could be prevented by not sharing needles and syringes and only 16% said "always use a condom" and 15% said "abstain from sex".

A 1999 RHAC study in three Phnom Penh schools found that 78% of respondents had heard about HIV/AIDS. Majority learnt about HIV/AIDS from the media (96.4%), health workers (61%), teachers (50.8%), family members (34.8%), and friends (30%). The main media sources were magazines, radio and television. The school-going adolescents were well-informed about HIV and the modes of transmission, citing sharing needles, sexual intercourse and vertical transmission from mother to baby. The students were also well-informed about AIDS prevention and 93.5% said to use a condom every time you have sex, 86.6% said avoid sharing needles for drug injections and 83.4% said have only one partner. In addition, 90% of the students knew there was no cure for AIDS (Table 5). Of the students surveyed, 17.2% knew of someone who is HIV positive and not sick, and 48.4% of those who had heard about HIV/AIDS knew someone who had AIDS or who has died of it.

Among the adolescent garment factory workers in Phnom Penh (Friends 1999b), 85% of respondents had heard about HIV, especially among males and workers with good literacy skills. A large percentage of the respondents had migrated to Phnom Penh from rural areas, which may account for the 15% of workers who had not heard about HIV/AIDS. The main information sources were the mass media, health workers and, to a lesser extent, friends and health staff. More males talked to their friends about HIV than females did. More literate persons accessed information from posters and leaflets. Despite the garment workers'

Table 5. Awareness of school-going adolescents on HIV/AIDS

Awareness on:	Percentage
The importance of using condom during sex	93.5%
The risks of needle sharing	86.6%
The importance of having one sexual partner at a time	83.4%
The lack of cure for AIDS	90%

Source: RHAC. 1999. Adolescent reproductive health survey, a baseline study. School going adolescents in Phnom Penh: Phnom Penh

considerable knowledge,[7] there were many misconceptions about HIV/AIDS transmission (39% gave at least one incorrect answer). Some people believed it could be transmitted by coughing, sneezing, mosquito bites, casual contact with infected people, and sharing of spoons, plates and glasses. Misinformation was more common among male respondents. Garment workers who knew about the disease said that it was a very serious disease and 84% reported there was no cure for HIV/AIDS. Most knew that HIV can be prevented (84%), especially those with higher literacy skills.

On the average, respondents mentioned 2.4 ways of preventing HIV/AIDS. Condom use was the main method mentioned (73%). Sixty per cent said being faithful to one sexual partner, 31% said avoid sharing needles and 30% said sexual abstinence. Nearly a quarter (24%) of the garment workers said to refrain from sexual intercourse with CSWs. On average, the more literate the respondent the more answers they were able to provide. The garment workers said they would approach health workers for information about HIV/AIDS; this mirrors attitudes to seeking information about STI. However, 68% of males said they would ask their friends. A higher percentage of male respondents than females said that they would talk to their parents. In general, the study found that males were more comfortable talking to a wider range of people about HIV/AIDS than female factory workers (Sprechmann 1999).

CHEMS/HU (1999) found in focus group discussions with adolescents in Kratie, Kampot and Battambang Provinces and in Phnom Penh that the most well known STI was syphilis, followed by HIV/AIDS and then gonorrhoea. In the rural areas, 32% of adolescents did not know one STI (excluding HIV/AIDS). Misinformation in the rural areas was significant and 15% of respondents said that HIV can be transmitted by kissing. Eighteen per cent said that HIV/AIDS can be contracted from CSWs, and 30% did not know that condoms could prevent the spread of HIV/AIDS.

In a survey with out-of-school adolescents in Kampot Province, the most common responses given for

[7] *CARE Cambodia has been working in garment factories in Phnom Penh for more than five years. During this time they provided regular reproductive health IEC sessions with garment factory workers, staff and management and established a system to refer to appropriate clinical services, such as RHAC clinics.*

HIV transmission were through sexual contact, receiving unsafe blood products, and sharing needles and mother-to-baby transmission (CHC/ Memisa 2001). Of those who said that HIV transmission was possible though mother-to-child transmission, more than 85% of respondents knew that it occurred during pregnancy, delivery and during breastfeeding. To prevent HIV infection, 88% of respondents said that they should "always use a condom", "have one partner – be faithful" (26.4 %), and avoid sharing needles (20%). Very few respondents gave incorrect answers to AIDS transmission.

The HU final project evaluation (Sainsbury 2001) on rural and urban young people 12 to 24 years old found that 90% of respondents knew that HIV was transmitted through sexual intercourse. Other answers were the use of unclean needles, mother-to-child transmission and blood transfusion. Eighteen per cent said that HIV could be transmitted from cutting finger nails and hair. This showed approximately the same number as the baseline KAP survey in 1999. Other incorrect answers given were, washing clothes with the clothes of people living with AIDS, using the same toilet and mosquito bites (Table 6). There was no difference in the levels of knowledge of transmission of HIV between respondents living in urban and rural areas. Protection from HIV infection could occur by using condoms (74%), not going to brothels (35%), being faithful to one partner (29%), and 26% said not having sex at all (this was a response mainly from older respondents 16 to 23 years). Testing your blood for HIV was mentioned by 15% of respondents, delaying having sex (14%) and using clean needles (12%).

Table 6. KAP on HIV/AIDS among rural and urban young people

HIV/AIDS can be transmitted through:	Percentage
Sex	90%
Unprotected sex	31%
Use of unclean needles	49%
Mother-to-child transmission	22%
Infected blood	35%
Blood transfusion	43%
Cutting finger nails and hair	18%
Washing the clothes of people with AIDS	3%
Using the toilet	6%
Mosquito bites	6%

Source: Health Unlimited, 2001.

Notably, the percentage of respondents who stated not having sex in order to prevent HIV nearly tripled from the baseline survey (1999) until 2001, and the percentage of respondents who said delaying sex more than quadrupled (44% compared to 9% in the baseline KAP). HIV/AIDS was identified as the most important disease in the project sites. It replaced malaria, identified as the main public health problem in 1999. In addition, HIV/AIDS had replaced syphilis as the most well known STI in the study sites. Nearly all the respondents had heard of HIV/AIDS, and the primary source of information was the media. They also received information from friends and community members and at school. The least popular source of information was family members (10%), especially for rural respondents while health staff, newspapers, posters, NGO staff and IEC activities were cited by a minority of respondents. Compared to the KAP study conducted two years earlier, when there was no mention of HIV-positive people living in their villages, the project evaluation found that respondents had heard of or had learnt about HIV/AIDS by observing people living with AIDS in their village.

Freelance CSWs in Phnom Penh knew about HIV and the modes of transmission (95% knew the main methods of transmission), but 10% thought they could get HIV from sharing toilets and dishes and 13% from mosquito bites (Friends 1999b). Among the same group, 90% knew they could protect themselves by using condoms when having sexual intercourse. The main sources of information were the media and friends. In this same group, 51% felt that they could become infected with HIV/AIDS because they did not systematically use condoms. Only 1% of respondents thought they could acquire their infection from their husband.

Another 1999 Friends study of out-of-school adolescents in Phnom Penh found that knowledge of HIV/AIDS is quite high among this group. Nearly 100% knew that HIV is transmitted through unprotected sexual intercourse and sharing needles. Two thirds of the respondents knew that they could protect themselves by using condoms during sexual intercourse, and 21% said that they "do not know" how to protect themselves from HIV/AIDS. Not going to CSWs was also a common response. Half of the female respondents mentioned that HIV transmission occurred through mosquito bites. Among the respondents who knew about HIV/AIDS, the main sources of information were the television, radio, leaflets, and families.

Among street children and vulnerable urban youth in Phnom Penh, 100% of the females had heard about HIV/AIDS (Friends 1999c). The modes of transmission were also well known. Sexual transmission was cited by more than 80% of respondents in each age groups, and needle transmission by more than 90%. However, misinformation is widespread and many respondents cited kissing, mosquito bites and toilets as a source of transmission. Only half the respondents aged 12 to 14 said they could protect themselves from HIV by using condoms. However, the majority of the males knew they could protect themselves from HIV by using condoms. A high percentage of the female respondents felt they were protected from HIV/AIDS.

Among females aged 12 to 14 years, 55% said they cannot get HIV/AIDS, and among 15 to 19 years old and 20 to 25 years it was 65% and 40%, respectively. The modes of transmission were not clear and much misinformation existed. Kissing, sharing dishes and toilets were cited as modes of transmission by many adolescents. A surprising number of females thought that AIDS could be cured (5% aged 12 to14 years, 10% aged 15 to 19 years, and 16% aged 20 to 25 years). The main source of information was the media. The younger group said they learned about HIV/AIDS by reading leaflets and listening to the radio. Friends and families were also considered an important source of information about HIV/AIDS.

Health education messages

The HU project evaluation identified some interesting features of the health education messages that are widely transmitted through radio and television in Cambodia (Sainsbury 2001). There were several contradictions or misinformation embedded in the HIV/AIDS education messages. First, the HIV/AIDS prevention message, "faithful one and one," held contradictions in its meaning. To be faithful did not necessarily mean making a commitment to one partner, only that a condom should be used to protect the other partner from transmission of AIDS, or that one should not have too many partners. Second, the message "Use a condom when having sex" was clear. Respondents knew that wearing a condom would protect against AIDS. It also was interpreted as meaning men should use condoms when going to brothels or when they have sex with people they don't know. However, there was no focus on wearing condoms to prevent a pregnancy or wearing condoms when having sexual

intercourse with a spouse. The focus was solely on preventing HIV/AIDS and STI. The third message was "Having a blood test can avoid transmission of HIV/AIDS." There were several problems with this message. For example, females in particular saw having a blood test as a prerequisite for a healthy marriage in which AIDS cannot be transmitted. They heard this message on the radio as well as through NGOs. Males, however, saw this message as checking to see whether they had AIDS before giving blood or just knowing their HIV status in general. It was often stated that having a blood test was the only way of knowing whether someone had AIDS or not.

The fourth message was "Men are responsible not to bring home AIDS." Female and male respondents understood this message differently. Females suggested that it meant the husband or partner would be faithful. The implications were either: a) if the husband really loved his family he would not go outside to brothels and have girlfriends; or b) he should be too afraid of getting AIDS to go outside his marriage for sex. For males, however, some felt that it meant being faithful, but the majority of males felt that it meant that if a man had sex outside he should act in a responsible way and use a condom or not have too many partners.

The next message was "Young people should delay having sex to avoid getting HIV/AIDS." This message was misinterpreted in several ways. Some participants stated that it meant young people should not have sex early because they might catch AIDS when they are young (the message the campaign aimed to deliver). Another interpretation of this message was young people should delay having sex until they are married. Some messages were well received, such as "Prevention of HIV transmission." Most participants knew methods of transmitting HIV and they knew how to protect themselves. Methods of preventing HIV were: being faithful; using a condom; using clean needles; and testing their blood. This information came from television, radio, health centre personnel, banners on the roadside, magazines and newspapers.

5.1.3 STI

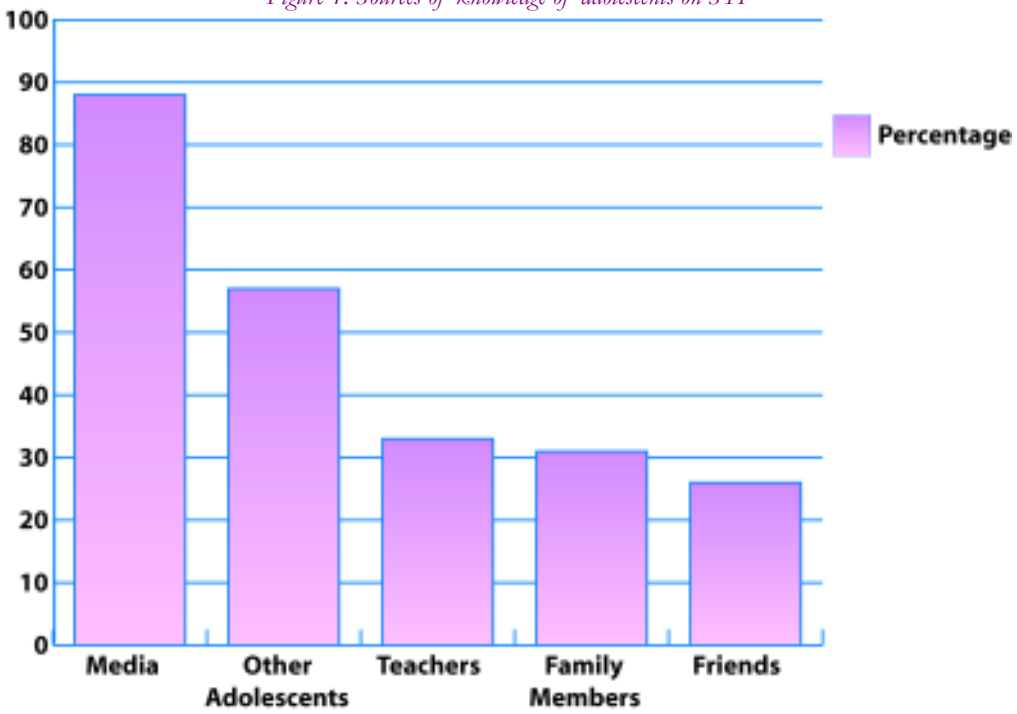
Awareness and knowledge of STI among adolescents is generally low, much lower than it is for HIV/AIDS. Many adolescents thought that STI and AIDS were the same illness. In many rural areas the generic name given to STI is swaay, which is also the name for syphilis (Eisenbruch 1997).

The SCF study in Battambang and Kratie Provinces and Phnom Penh found that only a third to a fifth of respondents knew about STI, 33% reported knowing one STI, and 11% named AIDS as an STI (Ly et al. 1997). Only 12% of respondents could name one or more symptoms of an STI. Forty-five per cent of young people aged 16 to 20 years and 25% aged 11 to 16 year could identify the symptoms of one STI. Young men had better knowledge of STI than young women did. Only 12% of respondents reported ever talking to anyone about STI, and 32% said they had ever talked to anyone about AIDS. Of those who did speak to someone about HIV/AIDS, 86% had spoken to friends and 43% had spoken to a sibling or a relative. More girls than boys reported speaking to their parents about STI and HIV/AIDS. Only 3% reported speaking to health workers and 8% to teachers about HIV/AIDS.

A KAP study with school-going students in three Phnom Penh schools (RHAC 1999) found that 51% of students had heard about STI. Of the students who knew about STI, 94.4% thought that the infection occurred through unprotected sexual intercourse. Many adolescents answered "some other way" which meant through blood or transfusions (5.9%), needles and sharing needles (0.8%). Other forms of STI transmission mentioned were sharing a latrine, mother-to-child, haircuts and make-up, no condom use, visits to the brothel and having more than one partner. Knowledge about STI came from many sources (multiple answers were possible) including the media, other adolescents, teachers, family members, and friends (Figure 1). In terms of the media, adolescents said that the radio (68.8%), television (83.7%), posters and brochures (48.6%) were the main sources. Adolescents had a moderate knowledge of the signs and symptoms of STI, for example, pain in urination (44.2%), pus from the penis (42.5%), vaginal discharge (18.5%), warts (23%), swollen groin (41.4%) and 29.6% of students responded that they "do not know". Their knowledge of how to protect themselves from contracting STI was moderate, and their responses included: always using condoms (77.2%), not having sex (45%), not having sex with CSW (52%), using condoms only with CSW (30%), having only one partner (68%), washing or douching after sex (22%), and 5% of students said that they did not know how to avoid getting STI.

Knowledge about STI among garment workers aged 15 to 25 years in Phnom Penh was considerably lower than it was for HIV/AIDS. Seventy per cent of garment workers had heard of at least

Figure 1. Sources of knowledge of adolescents on STI



Source: RHAC, 1999.

one STI. More males than females could identify STI. Garment workers who knew at least one STI could spontaneously mention two symptoms. The main source of information was the mass media, followed by friends (especially for male garment workers), and then health staff. Teachers were the least common source of information.

In 1996 Tarr found that STI knowledge was poor among teachers, who felt that only doctors should know about these matters. More males than females learned STI from posters and leaflets, which can be attributed to males having more education and literacy skills than females. The study found that 90% of respondents mentioned condoms as a way to prevent STI. This study like several other studies found that recent campaigns promoting condoms as a way to prevent HIV/AIDS could have informed a large number of the respondents about the importance of condom use. In addition, avoidance of sexual intercourse with CSWs, faithfulness to one partner, and abstinence were mentioned by at least one third of respondents as a means of preventing STI.

Majority of the garment workers knew that STI can not be prevented by medicines and drugs, but one quarter said washing and douching would work. Those who knew about STI felt that they could approach health staff (88.6%), their mothers (26%), friends (26%), their fathers (12%), and siblings (15%) for information. In summary, about one quarter of workers would seek information from their mothers. A larger proportion of workers who were younger than 20 years would talk to their fathers, and the older group of garment workers would talk with friends about STI and related issues (Sprechmann 1999).

In rural Kampot Province, 80% of out-of-school adolescents had heard about STI and syphilis and gonorrhea were the most well known; warts was mentioned by 6.5% of respondents. A considerable percentage of the respondents who had heard about STI gave incorrect answers about the methods of transmission. About half thought that they were transmitted through sharing clothes and toilets or by deep kissing. Interestingly, these incorrect answers came from the same group of respondents who were familiar with syphilis and gonorrhea. The majority (76%) of respondents did not know the signs of STI, and males knew less than females. The main method cited to protect themselves from STI was condoms. However, a majority did not know how to prevent STI and there were many incorrect answers given, such as: use of medicines (6%); do not share clothes (4%); and wash and take a shower after sexual contact (3%). The main source of information for the rural adolescents was: village PEs and CHC staff (30%); radio (30%); male relatives (14%); television (11%); school teacher (9%); and health staff (6%).

The Friends study among of freelance CSWs aged 13 to 24 years found that 53% of respondents knew what STI were, and 94% knew that STI were transmitted from having unprotected sexual intercourse (1999b). A study among out-of-school adolescents in Battambang found high STI awareness (Friends 1999a). For example, 81% of young people aged 12 to 14 years, 70% aged 15 to 19 years, and 87% aged 20 to 24 years had heard about STI. The majority of respondents (95%-100%) knew how STI were transmitted. Among male respondents, the older males had more knowledge about STI than younger males. The majority of female adolescents had a good understanding of the modes of transmitting STI. Of the female respondents, 12% of the 15 to 19 year olds and 9% of the 20 to 24 year old females had had STI.

5.2 Attitudes

5.2.1 Contraceptives

There are many misconceptions about contraceptives in the general population. No in-depth research has been conducted on adolescents about their attitudes towards and acceptance of contraceptive methods. In 1999, CHEMS/HU in Phnom Penh, Battambang, Kratie and Kampot Provinces found that female adolescents were afraid that contraception would make them infertile, and taking contraceptives would put their health at risk because of the side-effects, such as abdominal pain and making the periods (blood) thin. Adolescents in Kampot Province said that only married couples should talk about birth-spacing and single young women should not. Despite this attitude, most single and married respondents have heard about birth-spacing and could name more than one contraceptive method. Of the 520 adolescents interviewed, 67% said that it is good to use contraceptives and 56% said that it is a sin (tvee barp) to practise birth-spacing. The researchers conducted in-depth interviews with key informants to explore this response and found that abortion was a sin and to use abortion as a birth-spacing method was sinful. They concluded that adolescents did not consider using contraceptive methods as sinful, but abortion was.

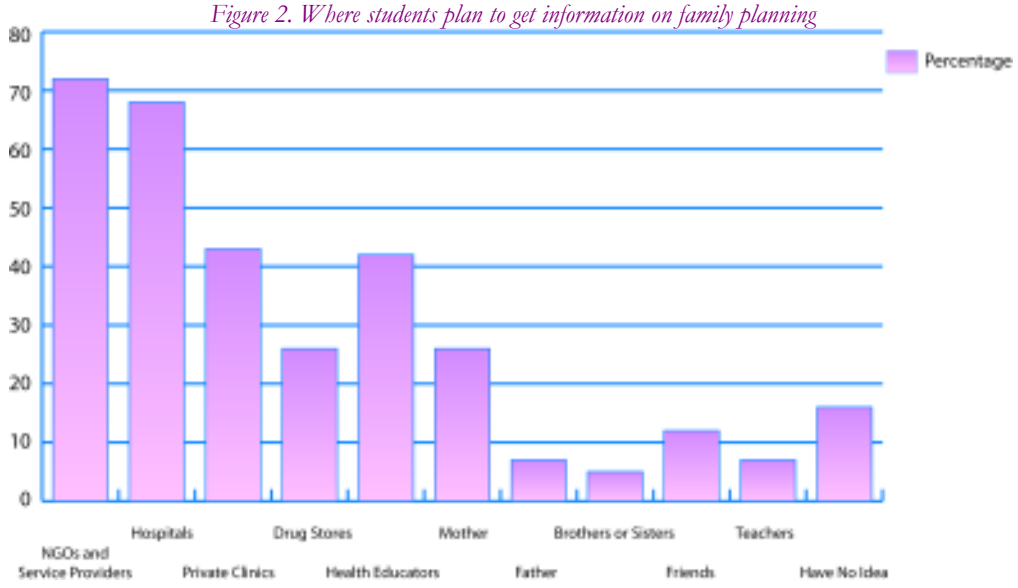
The study also found that 71% of adolescents said the woman makes the decision to talk about contraceptive use and 68% said the woman decides whether to use a contraceptive or not. The man has more influence over deciding on the number of children to have. A study with out-of-school adolescents in Kampot Province found that approximately one third (31.4 %) of married respondents discussed contraception with their spouse, and among married respondents only 15.7% had ever used a birth-spacing method (CHC/Memisa 2001). A study among freelance CSWs aged 13 to 24 years found that 53% of women thought it was important to use contraceptives to avoid becoming pregnant and 38% said a pregnancy would hinder their business. Nearly all the respondents (98%) said it was important to learn about birth-spacing (Friends 1999b).

A KAP study among school-going adolescents in Phnom Penh explored students' attitudes towards their peers discussing STI and family planning. Interestingly, 9.3% of students said they would think these students were "bad", 14.4% said they would think these students must have a problem, 35% said that it is normal for people to discuss such issues, and 41.3% of students said

they thought that it is very good to discuss STI and family planning. The students said that they would seek out information about family planning from NGOs and family planning service providers, hospitals, private clinics, drug stores, health educators, and their mothers. Few adolescents said they would talk to other family members, friends and teachers. More than 16% of respondents said they do not know where to access information about family planning (Figure 2).

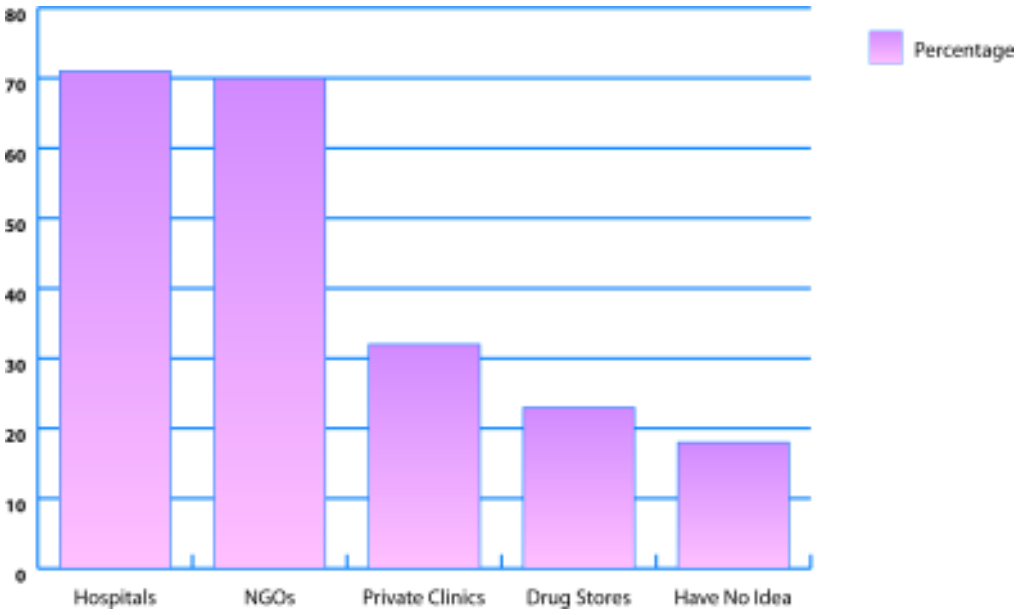
Similar trends were expressed in terms of accessing birth spacing services; 71% said they would go to a hospital, 70% said NGOs, 32% said private clinics, and drug stores were mentioned by 23% of respondents. Eighteen per cent of respondents did not know where to go to obtain a family planning method. Of the students who had had sexual intercourse (45 out of 1197 students), 58% said that it was easy to access contraceptive methods, 9% said it was difficult and 33% said they "do not know". The main difficulties expressed regarding access to family planning methods were: contraceptives were too expensive; young people were too embarrassed to ask for them; and neighbours may think they are bad if they were seen going into a pharmacy. In terms of accessing condoms, 98% of males and 84% of female respondents said that it was easy to get condoms in Phnom Penh (RHAC 1999).

Figure 2. Where students plan to get information on family planning



Source: RHAC, 1999.

Figure 3. Where students plan to access birth spacing services



Source: RHAC, 1999.

Garment factory workers in Phnom Penh had fairly good knowledge of modern contraceptive outlets, but 43% of respondents felt that it was difficult to obtain modern contraceptives (Sprechmann 1999). The difficulties identified were: too ashamed to go to any contraceptive provider (50%) and fear of the providers' disapproval of young people's search for modern contraceptives (16%). Several barriers to accessing contraceptives were identified: disapproval by elders; contraceptives were too expensive (nearly 50% gave this response); and too difficult to find (43%). Expense and difficulty finding contraceptive outlets were mentioned by the 20 to 25 year olds in particular, reflecting their personal experience in trying to access modern contraceptive methods. Adolescents with lower education levels felt that the main barriers were the cost and difficulty finding them. A large percentage said they would talk to their mothers, relatives and spouses about modern contraceptives, and less said they would speak with their friends.

Condom use

As noted above, condom is perceived

by the Cambodian population as a method of preventing HIV/AIDS, and not as a method to prevent a pregnancy (Chhun et al. 1995). This widespread perception came from health promotion messages that commenced in the mid-1990s, the beginning of the HIV/AIDS epidemic in Cambodia. During the initial health promotion campaigns, condoms were promoted as 'hygiene bags' (sroum anamai), resulting in the condom being seen as a protective method which should be used when having 'unhygienic' sexual intercourse with CSWs, and not when having a sexual relationship with a regular partner or spouse (Tarr 1996a).

Only 39% of the garment factory workers in Phnom Penh named condom as a contraceptive method, a much larger percentage naming condom as a method to prevent HIV infection (Sprechmann 1999). The HU project evaluation found that among older respondents (aged 16 years and over), the majority of adolescents (80%) said they would use a condom when having sexual intercourse to protect themselves against HIV/AIDS (Sainsbury 2001). Using condom to prevent pregnancy was also mentioned by females, and males to a lesser extent. The main reasons given for not using a condom during sexual intercourse were: (1) faithfulness of both partners (majority of responses came from females); (2) prior knowledge that the partner does not have HIV/AIDS; and 3) condoms should only be used with CSWs (this answer was given only by male respondents). Females gave other reasons for not using condoms: not having sex before they were married, and they would have a blood test before they commenced a sexual relationship to ensure their partner was not HIV positive. Not surprisingly, married respondents said that they do not use condoms because they were faithful.

Among adolescents in Battambang, Kratie and Phnom Penh 63.5% said that condoms should always be used for sexual intercourse (Ly et al. 1997). Eighteen per cent of females and 35% of males said that condoms should always be used when having sex with a CSW. The disparity between attitudes of males and females in terms of condom use has been highlighted in a research conducted by Tarr (1995, 1996b). Surprisingly, 15% of respondents did not know when condoms should be used, and in Kratie Province 31.2% of respondents less than 15 years old did not know when condoms should be used. The study found that the message of "faithfulness", especially among females, has been promoted as a HIV avoidance strategy. This is problematic,

as a woman who is faithful to one partner can be exposed to HIV by a sexual partner who has sex with other people and is not faithful.

In terms of initiating condoms use, a SCF study with adolescents in rural and urban areas found that 40% of respondents said women initiate condom use, 21.3% said that it was the male who initiates condom use, and 33.2% said "don't know" (Ly et al. 1997). However, female respondents were much more likely to see condom initiation as a female responsibility (51%) versus a male responsibility (15.2%). Males were unclear who had the responsibility of initiating condom use

A study conducted with school-going adolescents in Phnom Penh (RHAC 1999) found that the majority (63%) of female respondents disagreed with the statement, "A girl who carries a condom in her bag is a responsible girl." Whereas, more than half the male students (55.3%) agreed with this statement. Half the female students and 65% of males thought that males were acting responsibly if they carried condoms. Buying condoms was an embarrassing thing to do, and more so for female students (57.6%) than male students (48%). A study conducted in Kampong Thom Province in three secondary schools and one college found that 60% of teachers supported the idea of distributing condoms to unmarried students (male and female), and they saw no adverse outcomes of this practice (Stulz and Lao 2001).

5.2.2 HIV/AIDS

Risk

Several studies attempted to assess adolescents' perceived risk of acquiring or transmitting HIV/AIDS. A study in Battambang, Kratie and Phnom Penh with young people aged 11 to 20 years found that when the young people were asked to assess who was at risk of contracting HIV, 47.6% said "men who visit CSWs", nearly a third (27.5%) mentioned CSWs, and 18.5% said they "don't know" (Ly et al. 1997). These responses mirror the responses given for risks of acquiring STI. Respondents identified risk groups/categories instead of individuals' risk behaviour. More than 80% of respondents said they could not contract HIV. More rural adolescents (Kratie and Battambang) said they could contract HIV. The respondents did not consider using a condom or limiting sexual partners as important avoidance strategies. Instead, they placed emphasis on "not sharing needles" (5%), hygiene (23.2%), and staying away from people with AIDS

(12.9%).

The HU project evaluation (Sainsbury 2001) conducted in rural and urban areas with young people 12 to 24 years found overwhelmingly that respondents perceived the persons most at risk of transmitting HIV to others were CSWs (82%), followed by the clients of CSWs (51%), entertainment women (47%) and soldiers (28%). The majority of respondents inferred that women are the primary transmitters of HIV. Rather than women being seen as a recipient of HIV (victim) they were seen as the "vector". Adolescent males were twice as likely as females to mention a female "risk group", such as CSWs or entertainment girls. Female respondents, on the other hand, tended to be non-gendered in their responses and had no obvious biases towards a particular group. Police officers, soldiers and people who had many partners were also considered transmitters of HIV/AIDS. Females felt that people who did not wear condoms were likely sources of HIV transmission. Clients of CSWs were regarded as a high-risk group. In the Friends (1999c) study with vulnerable urban adolescents and street children, CSWs were also cited as the main source of AIDS in Cambodia. A 1999 CHEMS/HU study in Battambang, Kratie and Kampot Provinces and Phnom Penh showed that 68% of respondents felt that people can contract HIV from having sexual intercourse with CSWs and 30% said with beer girls (indirect sex workers). Only 18% said that a client of a CSW could contract HIV. CHC/Memisa found that in Kampot Province, 71% of respondents thought that they were not at risk of contracting AIDS.

Younger adolescents feel more protected and less at risk from contracting HIV/AIDS than older adolescents do. A 1999 Friends study in Battambang Province of out-of-school females (ages 12 to 25 years) found that the majority (74%) of younger females felt very protected from HIV/AIDS, whereas the older they became, the less secure they felt. By 20 to 24 years, only 43% of adolescents felt protected from HIV/AIDS. Younger females felt that their protection was due to lack of sexual activity, faithfulness and the use of condoms. But this perception decreased with age.

Among street children and vulnerable urban youth, about half of the male respondents thought they could contract HIV, and almost half of these respondents said there was no cure for AIDS. Among garment workers in Phnom Penh, nearly 90% of males and 86% of females said they were worried

about getting HIV/AIDS (Sprechmann 1999). In Battambang, Kratie, Kampot and Phnom Penh more single adolescents thought they were at risk than married adolescents. A single difference occurred between married and unmarried males, as more single males thought that they were more at risk than did married males. Females also mentioned that they could become infected from their husband (CHEMS/HU 1999). The 2001 CHC/Memisa study in Kampot Province found that women who were married did not allow their husbands to go outside the village because they were afraid that their husbands would visit prostitutes and acquire an STI or HIV and give the disease to them. Nearly all the respondents (98%) said they were afraid to marry someone with AIDS.

Attitudes towards people living with HIV/AIDS

There is a significant level of fear among adolescents, especially in the rural areas, towards people living with HIV/AIDS. The 1999 CHEMS/HU study in three provinces and Phnom Penh found that 50% of adolescents were afraid of people with HIV/AIDS. Adolescents' attitudes towards people with HIV/AIDS were more negative than their feelings about sick people in general. Almost 50% of the respondents said they felt sorry for them and wanted to help them, and 50% said they were afraid of people living with HIV/AIDS. Adolescents in rural areas showed more fear and hate towards HIV-positive people than youth in urban areas did. However, rural people were more likely to help HIV-positive people. In Phnom Penh, Battambang and Kratie Provinces, two thirds of young people aged 11 to 20 years said they would stop contact with someone if they knew he or she had HIV/AIDS (Ly et al. 1997). More than half the respondents, many of whom were under 15 years, and those from Kratie believed that HIV-positive people should not be allowed to study in school with other students. More than half the respondents said that HIV-positive people should not be allowed to live with their families. This finding was fairly consistent with the overall low level of knowledge and awareness of HIV/AIDS and inaccurate information relating to the modes of transmitting HIV.

By contrast, a study conducted in Phnom Penh with school-going students found that 93% said they would live normally with a friend or relative with AIDS and 26% said they would keep the person in a separate room. Only two students (of 1197 students) would expel the person from the house (RHAC 1999). Adolescents see HIV/

AIDS as a serious problem and are concerned about the future of Cambodians, especially young people. They expressed concern that many young people will die if no effective measures are taken to stop the AIDS epidemic. The majority of adolescents surveyed felt that adolescents should be told about HIV/AIDS so that they can protect themselves from becoming infected. A study in Kampot Province found that among out-of-school adolescents who had heard about AIDS, 62.5% said that they would visit a friend with AIDS more frequently than before, and only 16% said they cease visiting their friend once they knew they had AIDS.

Sainsbury found during the CHEMS project evaluation that 70% of respondents were sympathetic towards people with HIV/AIDS and expressed a desire to help them. Two thirds of these respondents were female (2001). Nearly a third of people said that people with HIV/AIDS were the same as those who did not have the disease. One quarter of respondents said they were afraid of people with HIV/AIDS, 10% said that they hate them, 8% said they avoided them, and 2% said that they would chase them away or want to kill them. Although many respondents pitied people with HIV/AIDS, over 50% had negative responses to these people, and used expressions like, hate, anger, blame and fear of transmission.

Approximately 30% to 40% who said they pitied people with HIV/AIDS or wanted to support them were also likely to have negative feeling towards them. More than half knew someone who had HIV/AIDS, and 86% knew someone in their village with AIDS. When asked if they would touch and care for someone with HIV/AIDS, 64% said that they would, 34% said they would not care for them because they were afraid and were angry towards the person living with AIDS, and 2% said they "do not know" if they would care for these people. Attitudes, such as being afraid, were related to fear of transmission; that is, AIDS could be transmitted if they were close to an AIDS patient. Their knowledge of HIV symptoms was good (thin, weakness, pale, blisters and lumps on the body, spots on the body and tongue). Regardless of adolescents' knowledge of HIV, participants still had a fear of people with AIDS. The authors concluded that respondents' fear of a person living with AIDS was related to their fear of the disease's symptoms.

Many studies noted adolescents' increased contact with people who had HIV or were ill with AIDS over the past five years. From 1998 to 1999,

surveillance sentinel data showed that the number of people who knew someone sick with AIDS increased from 2.5 to 3.0 in the sentinel groups (NCHADS 2000). Nearly one fifth of garment factory workers knew of someone who had AIDS. Among male respondents, 32% knew someone who was HIV-positive. Thus, HIV/AIDS was part of garment workers' immediate reality (Sprechmann 1999). The 1999 RHAC study with school-going students in Phnom Penh found that 80% of students felt that it was not possible to know if someone were HIV positive. Only half the respondents recognized the signs and symptoms of AIDS. Likewise, they did not have a good understanding of the progression and manifestation of the disease. Thirty-five per cent said that it took several years, 31% said it took one to two years and 25% said "do not know." More than half (60%) of the adolescents in Battambang and Kratie Provinces and Phnom Penh said that HIV-positive people look unhealthy, and 65.5% said that people with HIV do not realize that they are infected (Ly et al. 1997).

5.2.3 STI

The 2002 EU/UNFPA lessons learnt research found there was a tendency for young people and parents to blame certain sections of the population for the spread of STI, namely single women and CSWs. More than a third of adolescents surveyed in three provinces and Phnom Penh thought that men who visit CSWs have STI (Ly et al. 1997). Twenty per cent said CSWs had STI and 37% were not sure who had STI. Eleven per cent said that those who did not protect themselves were at risk. More than two thirds of respondents (69.9%) denied being at risk because "never having sexual intercourse", and 42.7% said it was because they were "too young". The researchers thought that too young may be a code for lack of sexual experience, possessing inherent immunity because of their youth, or associating the disease with old people.

In Kratie Province, the perceived risk of STI was different. More than a third (34.8%) of respondents said they could get an STI. Adolescents who were sexually active (four out of 11 male respondents and nine out of 17 females) said that they are worried about getting STI after their first sexual encounter. All respondents said they had spoken with someone about their concerns.

A study conducted among vulnerable males aged 12 to 25 years found that almost half the respondents would talk with their regular partner if they had a STI (Friends 1999a). The other half said they would not talk to anyone about

their infection. More than half the respondents (all age groups) said they would go to a hospital and get treatment. The next place they would seek treatment was the pharmacy, followed by private doctors. Many males said they would go to a traditional healer (kruu khmer).

Adolescents in Kampot Province said that if a friend had an STI they would advise the friend to go to a public health facility to get modern treatment (59.5%) (CHC/Memisa 2001). However, a third, especially males, said they would advise their friend to use traditional medicines. A study among male street children and vulnerable urban youth aged 12 to 25 years, found that more than half of the male respondents said they would talk to their usual partner if they had a STI. Some respondents said they would not talk to anyone.

5.3 Practices

5.3.1 Contraception

The 2000 CDHS found that the unmet need for family planning among married women aged 15 to 19 years was higher for birth-spacing than for limiting the family size. Meantime, the met needs were very low for both. For married women aged 20 to 24 years the unmet need for spacing was also higher than for limiting family size (NIS 2001:106). Among adolescents aged 15 to19 years who had ever used a contraceptive method, 1.7% had used any method and 1.3% had used a modern method. For women 20 to 24 years the rate was higher; 13.3% had ever used a contraceptive method and 11.5% had used a modern contraceptive method. The rate of contraceptive use was higher among currently married women aged

Table 7. Met and unmet needs of married women

	Unmet Needs	Met Needs
15-19 year old married women		
Birth-spacing	34.2%	7.7%
Limiting family size	2.9%	1.3%
20-24 year old married women		
Birth–spacing	28.8%	12.4%
Limiting family size	7.4%	3.2%

Source: CDHS, 2000.

Table 8. Young people's contraceptive use

	Unmarried adolescents 15-24 years old	Married adolescents 15-24 years old
Have used any form of contraceptive	11%	24.9%
Have used any modern method	8.6%	18.4%

Source: CDHS, 2000.

15 to 24 years. The injection (Depo-provera), the daily pill and IUDs were the most commonly used contraceptives for women aged 15 to 24 years and for married the rates were significantly higher (ibid).

NIPH (1999) found that among young people aged 15 to 24 years, 11% of single women used some form of contraception. Among married women in the same age group, 24.9% used contraception (Table 8). The daily pill and the Depo-provera injection were the two most commonly used contraceptive methods for all women.

Data from the past five years show an increase in the use of modern contraceptive methods. A KAP study on fertility and contraception (Chhun et al. 1995), the 1998 National Health Survey and the 2000 CDHS show an increase in contraceptive methods used between 1995 and 1998 and 1998 and 2000. Most of the increase was in the use of modern contraceptives. However, the use of contraceptives for youth ages 15 to 24 years was the lowest among all women and currently married women. The most popular contraceptive used by women of all age groups was injectables.

Contraceptive use among unmarried adolescents is low. The 1999 RHAC baseline study with school-going adolescents in Phnom Penh found that students who had engaged in sexual intercourse (45 students) did not use any form of contraceptive. See Table 9 for the result of the study.

Table 9. Reasons adolescents do not use contraceptives (among 45 students who engaged in sexual intercourse)

Reasons	Number of adolescents
They did not expect to have sex and were not prepared	9
There was no need to take a contraceptive method because it was not possible to get pregnant the first time they had sexual intercourse	5
They were afraid their partner would think that they were not a nice person if they suggested using a method	3
Too expensive	2
Not romantic to discuss or use a method	2
Too shy to talk about contraceptive use	2

Source: RHAC, 1999

Other reasons given by respondents were: they thought it was the safe time of the month (used the rhythm method); they wanted a pregnancy; it is bad for their health; they could not find a contraceptive method; and they were too shy to purchase a contraceptive method.

Among sexually active students, 60% said that the first time they had intercourse they used a contraceptive method because they wanted to protect themselves from a pregnancy. The main method used was a condom (79%). Two students said they used the monthly pill and the IUD. The daily pill, injectable, diaphragm, Norplant, withdrawal method and one unspecified method were used by the remaining students. Among the 45 sexually active students, 30% (13 students) had discussed family planning with their partners before having intercourse, 58% (25 students) did not discuss family planning and 12% did not know; if they did discuss family planning they did not remember the discussion. The study found that the school-going adolescents' lack of knowledge and awareness of pregnancy-avoidance methods puts young people at risk of unwanted pregnancies.

The study of 12 to 25 year olds in Kampot Province found that only 15.7% had ever used a birth-spacing method. The daily pill was the most common method used, followed by injections, and then condoms. The calendar method was used by a few married respondents. The main reason married adolescents gave for never using birth-spacing was because they wanted another child (75.4%) and they feared the side-effects (CHC/Memisa 2001).

Contraceptive use among a vulnerable group of sexually active males and females in Battambang Province was higher than other groups. Of the males aged 15 to 19 years, 6% said they had used contraception, and 48% of males aged 20 to 24 years said they had (Friends 1999a). Female street children used contraceptives the most. Half the sexually active females aged 15 to 19 years claimed to use contraceptives, and 83% of those in the 20 to 25 year age group said they used some method of contraception. Among the most sexually active male street children aged 15 to 19 years, over two thirds of respondents claimed to have used some form of contraceptive method. However, among 20 to 25 year old males, 71% said they used a condom on an occasion (Friends 1999c).

A 1999 Friends study with out-of-school female youth in Battambang Province found that although their knowledge of

contraceptives was good (especially of the daily pill, condoms and injectables), contraception was not widely used. Only 1% of females 15 to 19 years, and 4% of females aged 20 to 25 year olds were using any form of contraception. Less than 10% of respondents used a contraceptive method during their first sexual encounter. About one quarter of the female respondents had tried condoms. But most of them said they had not used a condom in the three months prior to the study.

Condoms

In 1999, the Ministry of Health introduced a 100% condom use policy in brothels accompanied by an aggressive condom social marketing campaign conducted by PSI and the availability of free condoms was widespread in the public sector. The 100% condom use policy appears to have had some impact on condom use by CSWs (brothel based) and their clients. However, condom use among indirect CSWs and with couples who do not exchange money for sex, including married couples, is low.

The 2000 NCHADS behavioural surveillance survey found that 13% of the Cambodian male population paid for sex with a female sex worker between 1999 and 2000. Among the men who had sex with a CSW in the 12 months prior to the survey, 18.1% were married and 25.2% were single. In terms of men using condoms during commercial sex in the 12 months prior to the study, 57.3% of married men and 78.6% single men in rural areas, and 72.7% of married men and 81.7% of single men in urban areas said they always used condoms when having sex with CSWs. These data were not disaggregated by age. The Health Unlimited project evaluation found that 86% of male respondents aged 16 years and over said they did not visit CSWs, and 14% said they went to brothels and had sex with CSWs. All the respondents said they used condoms when having sexual intercourse with CSWs to protect themselves from contracting HIV/AIDS (Sainsbury 2001).

A study in Kampot Province found that the majority of unmarried adolescents said they were not using a contraceptive method. Of the sexually active males, approximately one quarter (27%) said they used condoms. However, researchers noted that in all the study villages, condoms were not available and the respondents had poor knowledge of the retail price of condoms. CHEMS/HU found in

Battambang, Kratie and Kampot Provinces that condoms were not sold in villages or communes. However, in Phnom Penh condoms were more widely available, even in small drugs stalls. One study of adolescents found that 5.2% were currently married and 5.2% reported having sex without being married. None of the sexually active females respondents used a condom when they had their first sexual encounter, whereas, seven out of the 11 sexually active male respondents said they used a condom (Ly et al. 1997).

Friends (1999) found that among vulnerable male adolescents in Battambang Province many respondents said they used condoms; however, when questioned about the retail price of condoms, they were unable to provide an answer. Most males said it was important to use condoms. Older males were most likely to believe this and 96% of those aged 20 to 24 said it was important. The main reason given for using condoms was to "control the time when having a baby." However, the study concluded that older boys were not interested in the subjects of condom use or birth-spacing.

Among brothel-based CSWs (average age 21.6 years) the average number of clients per CSW per day is four, or 24 clients per week. Condom use depends on the type of client or partner the women see. In the day prior to conducting survey (NCHADS 2002), 98% of women had used condoms, and in the week prior to the survey, 82.3% said they used a condom with every sexual encounter, and 17.7% of women said almost every time. Many of the CSWs were in relationships with a boyfriend/sweetheart in the year prior to the survey (46.8%). Half the CSWs said they used a condom with their sweetheart in the year prior to the study, 37.5% said they used a condom every time and 12% said almost every time.

A CARE survey found that condom use among sexually active male factory workers was 33%. Twenty-eight per cent said they sometimes used condoms and 39% said they never did (Sprechmann 1999). All males reported using condoms with CSWs, and 21% said they used condoms for casual sex or when having intercourse with 'other' partners. Only 4% said they used a condom with every sexual encounter. The CARE project with garment factory workers provided regular HIV/AIDS/STI education to garment workers in Phnom Penh for more than four years. Garment workers' knowledge of condoms to prevent HIV and STI transmission has increased, but recent data suggest that young people's skills and determination to negotiate safe sex

with every sexual encounter remains weak (CARE 2002).

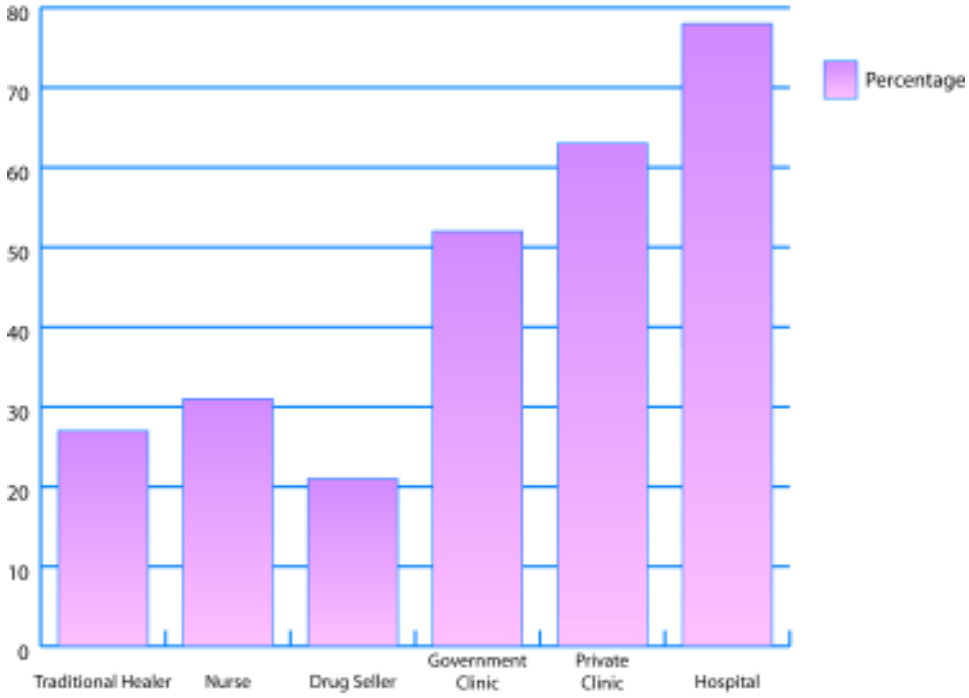
5.3.2 Treatment of HIV/AIDS/ STI

Several studies conducted in Cambodia have shown that STI treatment, including for adolescents, comes from a variety of providers outside the formal health system, such as pharmacies and traditional healers (Ryan and Gorbach 1997; Eisenbruch 1997). Garment workers in Phnom Penh said they go to public and private services to seek treatment. However, one third said that treatment was available from traditional healers, 22% reported that treatment was available from a store, and 18% said a pharmacy. Research conducted by the NIPH in 1999 found that the widespread use of pharmacies and stores in Cambodia has resulted in a very high cost of treatment, and these treatments were often inadequate and harmful.

A study with street children and vulnerable urban adolescents showed that more than 80% of respondents aged 12 to 15 years said they would go to the pharmacy to get treatment. More than 80% cited hospitals and the traditional healers as places they would go (Friends 1999c). A 1999 CHEMS/ HU study found that males who get STI in rural areas went to traditional healers for treatment. A Friends survey of vulnerable female adolescents found that they sought treatment from the pharmacy and hospital. A few respondents said they would go to the private doctor or their family for treatment. The 2000 Memisa/CHC survey in Kampot Province found that 36% of respondents said they went to the health centre when they had syphilis. However, health service data indicated that young people did not go to the health centre for treatment of syphilis. The study found that 45% of respondents said they went to the traditional healer.

A RHAC (1999) study found that more than one third of students surveyed in three Phnom Penh schools had heard about STI and 31 students had previously had an STI. Of the students that had had an STI, 65% sought treatment for their STI and 35% did not. There was no significant difference between females and males in terms of treatment seeking behaviour towards STI. Of those who had received treatment for their STI, a majority went to a hospital (Figure 4).

Figure 4. Where adolescents get treatment for STI



Source: RHAC, 1999.

On average, the adolescents visited more than one health provider before they found the treatment that was effective; 10 adolescents collectively reported treatment from 52 service providers. Those that did not get treated said that they did not know where to go, the clinic was too far away, they did not have any money to pay for treatment, they were afraid and embarrassed, and they thought there was no need for treatment. Among the students (31 respondents) who had previously had an STI, 63% said they had worn a condom the next time they had sex to prevent themselves from contracting HIVAIDS and STIS. Those who did not wear a condom during their next sexual encounter cited the following reasons: did not know how to use a condom, did not expect to have sex and were unprepared, condoms are bad for their health, had no condoms available, too embarrassed to buy condoms or ask for them, too shy to talk about them, afraid that their partner would think that they are not clean, not romantic to talk about condoms, partner did not have a disease.

A survey in Kampot Province of out-of-school adolescents found that among adolescents (married and unmarried), a third were sexually active. Two adolescents reported having ever had an STI. Both adolescents went to a traditional healer for treatment and both said they informed their partner that they had an STI. A study with out-of-school female adolescents in Battambang Province found that about 10% had had an STI (Friends 1999a). Among males in the same social group, there were a large number of respondents that had had an STI (percentage unknown). Of this group, about 20% of respondents said that they continued to have sex when they had a STI. Among freelance CSWs aged 13 to 24 years, 24% said they had previously had an STI. However, the NGO that conducted the research considers this figure low (Friends 1999b).

6. Mental health and physical safety

6.1 Relationships

A 2001 UNICEF survey with school-going children and adolescents aged 9 to 17 years (508 respondents) revealed that 72% of respondents had a very good relationship with their parents (Table 10). However, the respondents said that when they did something wrong their parents scolded them (48%), talked to them and advised them (60%), beat them (44%). Surprisingly, 28% of respondents said there were individuals in their home that hit each other. Among this group of respondents, 2% said they hit each other very often, 22% quite often, 47% said sometimes. The respondents felt that they have difficulty talking with their teachers because they yell at them (30%), they don't treat them well (7%), they don't listen to them (8%), they are unfair (52%), they beat them (48%). The survey found that only 14 % of respondents felt that their opinions and those of their friends mattered to people in their community.

Table 10. Relationship of adolescents with their parents

	Very Good	Good	Average	Bad
Parents	72%			
Mother		21%		
Father	24%	52%	7%	4%

Source: UNICEF, 2001.

6.2 Happiness and sadness

The 2001 UNICEF survey found that 13% of respondents said they felt happy most of the time. Respondents said their happiness came from being with their family (52%), being with friends (38%), playing (16%) and getting good grades at school (44%). When the students were asked what makes them sad, their responses were: being scolded (34%); doing badly at school (42%); being punished (33%); and hearing arguments at home (21%). One quarter of the students said they kept their problems to themselves.

6.3 Domestic violence

Violence in the family is not uncommon in Cambodia. It is reportedly high due in part to the psychological effects of the genocide that took place between 1975 and 1979. Children witnessed inhumane atrocities, including sex crimes and, in extreme cases, some children were forced to butcher their parents and friends. Twenty years later, these infants are now adolescents and adults, who are living with the legacy of their brutal past (United Nations 2000). Studies in Cambodia have shown that when wives are abused, the children/adolescents are often beaten as well (Zimmermann 1994; Nelson and Zimmerman 1996).

There is no statistical data on the prevalence of domestic violence among the Cambodian population in general and adolescents in particular. Zimmerman found that in every village visited during their study, there were cases and reports of domestic violence (1994). The violence ranged from slaps, punching, choking, and kicks to being hit with metal pipes, guns, bayonets and grenades.

Several other small studies have highlighted violence as a problem in families. In a survey in Kampot Province, adolescents defined domestic violence as: fighting in the family; quarrels with a partner and children; one family member beating or swearing at another family member; and a person who was angry and wanted to divorce the other person (Memisa/CHC 2000). More than half the respondents said that it is not possible to intervene in domestic violence situations. A 1999 CHEMS/HU study with adolescents in Phnom Penh, Battambang, Kampot and Kratie Provinces found that 16% said that violence was a problem in their family. The examples of violence given by the respondents were: the husband beats his wife and children; husbands get drunk and maltreat their wives and children; fighting; forcing people to have sex; throwing and destroying household assets, like utensils and materials; and

mothers beating and forcing their children to marry.

The EU/UNFPA lessons learnt research revealed that many adolescents and youth voiced their concerns about domestic violence. Adolescents said that abuse within families was a significant 'push factor' for young people leaving their families and becoming homeless or placing themselves in vulnerable housing arrangements in Phnom Penh. One of the main concerns expressed was that parents were too strict, particularly with their daughters, and restricted their freedoms, which was a source of conflict. Another study on domestic violence found that 67.5 %of respondents believed that they should hit their children as a disciplinary measure (Nelson and Zimmerman 1996).

6.4 Physical and sexual violence

Research conducted by Gender and Development for Cambodia of 580 adolescents/young people aged 13 to 28 years in Phnom Penh found that 11.9% of respondents claimed that youth gangs had threatened them and 8.3% claimed a youth gang had assaulted them (2003). Nearly two thirds had witnessed an assault or robbery perpetrated by a youth gang. The study found that 73.4% of respondents had witnessed an assault where the person "deserved it". The authors concluded that there was a alarming level of familiarity and acceptance of violence as a legitimate means of resolving conflict.

Among university and school students, 60% and 68% respectively, worried about young gangs, suggesting that youth gangs are a major fear and concern of young people in secondary schools and university in Phnom Penh. A 2001 UNICEF survey found that 14% of students felt very safe during the day and only 4% felt very safe at night. Among the respondents, 27% had experienced a robbery, 56% an assault, 37% had been involved in fighting, and 25% had been threatened.

6.4.1 Rape and sexual abuse

Domestic law prohibits sexual abuse, but this means little for the victims of rape and indecent assault (sexual assault). Of the female sexual abuse cases investigated by LICADHO that took place between January 1999 and March 2000, 7% of the suspected perpetrators were males under 16 years. Males between 19 and 25 years made up the majority of the accused people (32.9%). The average age of the accused was 25.7 years old. Nearly 90% of rape victims were below the age of 19 years,

and 40% were between 11 and 15 years. Of the total cases investigated by LICARDHO in 1999, 20% were rape cases. In 2000 the figure rose to 26%.

Survivors of rape often face discriminatory attitudes from a society that considers them "fallen women" (srey khoic). There are many myths associated with rape, such as "women provoke rape". Social scorn and family shame resulting from the loss of virginity are powerful factors that result in some victims feeling their only option is to turn to prostitution to earn a living. Some parents encourage their daughters into prostitution if they are no longer virgins. In other cases, the victim is forced to marry the man who raped her, in a bid to preserve her family's reputation. These women and children are often blamed for being victims and are left traumatized and ashamed, reluctant to come forward and lay complaints against rapists.

Rapes are often not reported to authorities or family for months, or never because of their fear of damaging a family's honour. In addition, indecent assault is often not reported by parents because their daughter's virginity has not been lost. Indecent assault is even more hidden than rape, and more difficult to intervene. LICADHO found when females had been abused and raped, shame was placed on the victim. There could be continual harassment from the perpetrator or his family, and severe physical deterioration and psychological problems often result. Many victims do not report rape, and therefore do not receive medical care or screening for STI. LICADHO found that among the 108 sexual abuse cases), 54.6 % involved threats of violence to the victim and her family, and 7% involved a weapon. Of the 108 victims, 38.3% were aged 11 to 15 years, the highest proportion of all victims. Among this group, the average age was 12 years, meaning that the average victim had not yet reached sexual maturity (ibid).

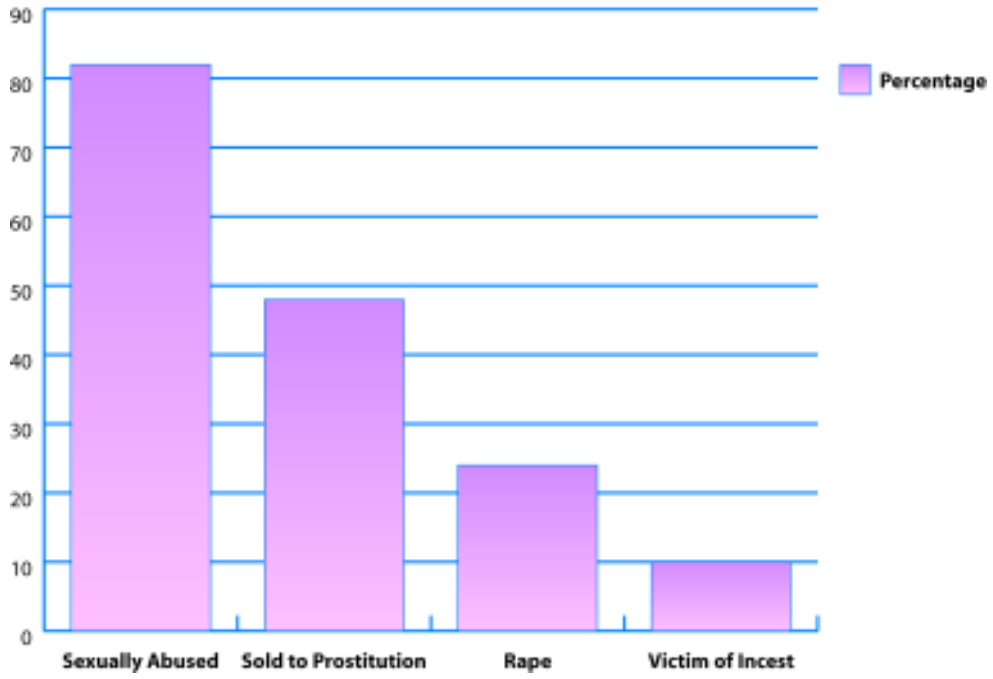
Rape and sexual abuse are widespread among vulnerable groups of adolescents such as street workers, prostitutes and homeless individuals. Victims are often poorly treated by the police and judicial officers or authorities, who often do not believe their stories, do not conduct adequate investigations, and who may accept bribes from the perpetrators (Friends 2002; Healthcare Centre for Children (HCC) 2003). HCC conducted a media review of Cambodian newspaper reports between May 2001 and August 2002 and found that 630 children and adolescents (ages three to 16 years old) were raped (HCC 2003). On 27 May 2003, the Cambodia Daily newspaper reported that ADHOC, a

Cambodian human rights organization received 297 complaints of rape by the end of 2001, and 25% of the complaints came from females 18 years and younger. In the World Vision Neavea Thmey Centre in Phnom Penh, the number of female adolescents rape victims who sought refuge increased from 21 in 1999 to 27 in 2001. In 2000, it was 44 (World Vision 2001).

In a study of male school students in Phnom Penh, more than one third (34%) knew someone who has participated in bauk (gang rape) (Gender and Development for Cambodia 2003). For out-of-school male adolescents and male university students the rate was higher, 49.6% and 60% respectively. In the same study, interviews with gang members indicated widespread involvement in bauk for economic and male bonding reasons. A 2002 study by Wilkinson and Fletcher found that bauk was "commonplace" among university students. However, the Gender and Development for Cambodia study found that only 13% of male and female respondents recognized bauk as being rape or being wrong. The most common response given by males (33.4%) and females (40.7%) was that bauk was dangerous because of possible transmission of STI, not because it denied a woman's right to safety or control of her own body.

A study of freelance CSWs found that 82% of female respondents had been sexually abused, almost half were sold by their families into prostitution, and some had been raped and became victims of incest (Figure 5). Whereas the younger (12 to 14 years) and older males (20 to 25 years) did not want to talk about the sexual abuse. There were no reported cases of incest in any age group of males. Among 20-25 year old street children and vulnerable youth in Phnom Penh, 20% reported being raped, 17% had experienced incest and 22% said they were sold into prostitution by their families (Friends 1999c). Among males, sexual abuse was quite common, 41% of males aged 15 to 19 years reported being raped, and 18% reported incest.

Figure 5. Sexual history of female freelance commercial sex workers



Source: Friends, 1999.

Rape in marriage

Because of the low status of women in Cambodia and their subservience to their husbands, there is a widespread perception among women that a husband can have sex with his wife whenever he wants. Zimmerman found that 22 out of 37 married women agreed with this assessment. It was difficult for women to speak about sex with their husbands or to use the word rape in marriage. Women generally felt ashamed to use the word rape in public, so in dealings with police and the court the subject of rape often did not come up (Zimmerman 1994). Rape was often not considered to occur in marriage, even by the judiciary, as Zimmerman found in her interviews with judges in Cambodia. According to one judge, when it comes to allegations of rape by women, custom dictates that "rape occurs only outside the marriage relationship".

Family planning is rarely possible in relationships that include forced intercourse. If women are subject to rape or the threat of rape, they are

unable to negotiate the use of contraceptives, in particular condoms, which places women at risk for unwanted pregnancies and the transmission of STI (Zimmerman 1994). The Zimmerman study found that women whose husbands visited CSWs reported contracting STI and sought treatment for the infections. In many relationships, battered women said they could not negotiate the use of condoms, even when they knew the husband had extramarital relationships, for fear of being beaten. Zimmerman found that a "good wife should not ask her husband to use condoms, as they were seen to look down on the husband or show lack of trust in their marriage."

6.4.2 Pornography and violence

Pornographic materials, such as videos and magazines, influence the sexual practices of young Cambodians, and are readily available at the markets and on the Internet (Tarr 1996a). A study conducted in Phnom Penh, Siem Reap, Kampong Cham and Kampong Som Provinces with in- and out-of-school adolescents found that about half of 11 to 17 year olds had viewed pornography (Child Welfare Group 2003). Higher rate of males (62%) than females (39%) had viewed pornography. Males were nearly three times as likely to purchase pornography as females (21% as opposed to 8%).

Out-of-school minors (younger than 18 years) were more likely to have viewed pornography than the respondents who attended school. Street children said they regularly watched pornography in coffee shops in the evening (some show pornographic films and videos throughout the day) because "there is nothing to do" (ibid). Minors said they view pornography in coffee shops (60%), at home (23%), and also at hotels and guest-houses. Coffee shop owners knew that it was illegal. They did not charge the viewers, only a small fee for the coffee. Videos and magazines were the most common media used for viewing pornography. Some mentioned they viewed pornography at private computer schools using CD-ROM. Majority of the minors watched pornographic films at home, and shared and exchanged them with friends because it was cheaper than going to a coffee shop. In general, the research found that pornography is widely available in Cambodia and is frequently of a violent nature.

6.4.3 Sexual exploitation

The social and economic situation of Cambodia has created a large supply of young, under-educated and naïve adolescents seeking employment outside

their community. They look for work in areas such as garment factories, the entertainment industry and prostitution, often to assist their families financially. There is a high demand for sexual services in Cambodia, especially for virgin females, because the client can avoid the risk of HIV infection (United Nations 2000) and because of the myths associated with virgins. A 2003 study by HCC in Svay Pak Commune near Phnom Penh found that female virgins were sold to clients, brothel owners, or traffickers for between US$200 and US$1000, depending on their age and beauty. Thousands of impoverished young girls in rural areas are being sold into prostitution, often because their families are deceived by false promises of job opportunities for their daughters. The girls and young women are virtually enslaved by the brothel owners, confined to tiny rooms, and forced to have sex with many customers to pay off their debt to the brothel owner (Physicians for Human Rights 1997; HCC 2003). The psychological impact on these young women is immense, and includes: sexual trauma and victimization; shame; loss of trust; feelings of betrayal, self-blame; disruption of normal development; separation from their family; grief and depression; fear; and constant physical captivity (World Vision 1996; Physicians for Human Rights 1997).

6.4.4 Prostitution

According to the Ministry of Women's and Veterans Affairs and the International Organization for Migration (IOM), there are more than 80 000 CSWs in Cambodia at any one time. Adolescents aged 12 to 17 years constitute 31% of this group, and 40% to 60% of CSWs have been forced into prostitution (MoWVA 2002). In Phnom Penh, there are many venues for commercial sex, such as karaoke bars, restaurants, night-clubs, hotels, rented houses, and public parks. There are 544 brothels in Phnom Penh that are served by approximately 17 000 CSWs (usually aged between 13 and 25 years) (HCC 2003).

Svay Pak Commune is a town known for commercial sex, particularly sex with children. There are 997 young Vietnamese females (age 12 to 20 years) who have been trafficked or entered prostitution by other means. Svay Pak town is a very unsafe environment for the young sex workers. At the venues where commercial sex is provided, men wearing handguns, grenades and AK-47s guard the CSWs. Young Vietnamese women are taken to brothels in Svay Pak after they have lost their virginity, most often to serve wealthy clients. Once they have lost their virginity, their commercial value decreases. In these brothels, they

are told to work off their inflated debts to secure their freedom. Many of the adolescents working in Svay Pak are orphans or were physically and sexually abused by their parents. These children have serious mental health problems, to the extent that many of the adolescents consider their captors to be their family (HCC 2003).

A study of vulnerable youth in Battambang Province found that about one third (34%) of female respondents had exchanged money for sex. Among males, 25% said they had exchanged sex for money (Friends 1999a). Males aged 12 to 14 years and 20 to 25 years did not report participating in male prostitution. A study with street children and vulnerable youth in Phnom Penh found that 40% of females aged 20 to 25 years had received money in exchange for sex. Among males in the same social groups, 32% of respondents aged 15 to 19 years and 61% aged 20 to 25 years received money for sexual favours (Friends 1999c).

Street sex work at night in Phnom Penh, especially in public parks, is a dangerous activity. HCC works with young CSWs and reported that 100 to 130 young females are brought by bodyguards and mamasan (manager) to parks near the Independence Monument and Samdach Hun Sen Park to makeshift brothels. The children and adolescents are divided into small groups and sent to seek out clients. Many of these children/ adolescents (many are taking drugs supplied by traffickers and brothel owners) are deceived and never receive the money they earned from prostitution. The drugs issued to these young people serves several purposes: to give them energy to work long hours; to make the adolescents more compliant to the customers' requests; to make them dependent on the drugs; and to ensure the young CSWs stay in the industry, reliant on drug supplies from brothel owners in turn for sexual services.

6.4.5 Trafficking for sexual exploitation

Cambodia is a transit country (from Viet Nam, Thailand, China and the Lao People's Democratic Republic. It is a source country for human trafficking for sexual exploitation. The IOM estimates that between 10 000 and 15 000 women and children are trafficked to Cambodia each year and 35% are children (less than 18 years old). About 400 Cambodian children, who may have been trafficked, are returned from Thailand each month (MoWVA 2002). A 1995 LICADHO survey in Battambang Province found that 65% of child sex workers released by the police after being detained during

raids on brothels had been trafficked against their will (Seaman 1995).

Towns that border Cambodia and Thailand, such as Poipet, have a thriving trade in produce and human beings. Young women are trafficked to commercial centres to work in casinos, brothels, rest houses, and karaoke bars. There is commercial sex in casinos, brothels, beer gardens, hotels, restaurants, and private establishments. There are hundreds (exact number unknown) of sex workers (direct and indirect) in these border towns, many of whom have been trafficked or deceived into working in prostitution. Cambodian border customs officers estimate that 20 to 30 young Vietnamese women (aged 12 to 22 years) enter Cambodia at Bavet District, Svay Rieng Province each day. Many other adolescents cross the Cambodian-Vietnamese border illegally each day (they pay off the officials) for other economic reasons, such as selling food, and then are lured into prostitution on arrival.

Most young people who cross into Cambodia are from poor backgrounds and live in rural areas along the Mekong Delta and southeastern provinces of Viet Nam (HCC 2003). A 2003 study in Svay Pak Commune found that 52% of young women entered prostitution voluntarily to provide financial support for the family, 30% were deceived, and 18% were sold into prostitution by their family (HCC). There is widespread sexual abuse among young sex workers in Kien Svay District, Kandal Province, many of whom have been trafficked for sexual exploitation. HCC reports that STI, such as syphilis and gonorrhea, are common among these young sex workers.

6.4.6 Sex tourism

Sex tourism is a thriving business in Cambodia. Many young girls who are trafficked from Thailand and Viet Nam are as young as 13 years old. These young females are sold to sex tourists (also to Cambodian men) at a high price or forced to pose for obscene pictures (pornography). Some sex tourists have been detained and convicted by Cambodian and international authorities, such as the Australian Federal Police. But this is a small percentage of the sex tourists that operate in Cambodia (HCC 2003). Once the perpetrators are captured by the Cambodian police, the authorities and judiciary do not pursue many of the accused or the cases are settled out of court (as with rape and indecent assault).

6.5 Illicit drugs

Youth take risks, especially when it comes to drugs and sexual activity. Drugs taken include glue, alcohol, yama (amphetamine), and amphetamine type substances (ATS). Peer pressure encourages risky behaviour. The use of drugs and alcohol are linked to casual sex and the non-use of condoms. Illicit drugs have become a menace in Cambodia in the past five years. Until the mid 1990s, most drug abuse was related to cannabis. A small group of well-to-do Cambodians and foreigners also abused methamphetamines and other ATS in discos, bars and night-clubs, mostly in Phnom Penh. There were also small groups of heroin and opium users, mostly in the capital. In the late 1990s, there was an increase in the use of ATS by students, CSWs, labourers, and alarmingly, younger school students (United Nations Drug Control Programme [UNDCP] 2001).

There are few systematic studies of drug use in Cambodia. However, media reports and studies conducted by Friends of street children in Phnom Penh indicate that drug use is on the increase among children and adolescents (UNDCP 2001). A 2003 study by Gender and Development for Cambodia in Phnom Penh found that yama or methamphetamines poses the worst risks to young people. There is a lack of understanding of the potential risks involved in using yama. The study found that some respondents felt that yama use was acceptable, depending on the colour of the yama. Among school and university students, 54.3% and 37.5%, respectively, said that yama use was occurring at their education institution. The concern is that ingesting yama orally may lead some young people to engage in high-risk behaviour, such as unsafe sex practices. This study also found that ketamine (referred to as 'k') and guncha (cannabis) are regularly used by gang members. There was some reference on the use of sky (ecstasy). Increasingly, inhalants are being used by a growing number of street children and adolescents, especially in urban centres (UNDCP 2001).

A study of young people aged nine to 21 years (19% female) in Phnom Penh found that drug use among Cambodian youth is widespread, with a significant amount of glue and amphetamine use (Friends 1999d). The study also found that heroin, cannabis and ecstasy are prevalent. Vulnerable youths' drug-use patterns are changing due to their mobility. The percentage of street children using substances rose from 37.3% in 1999 to 51.9% in 2001 (Friends 1999c). In 2001, the main substance used by street children in Phnom Penh

was glue (47.7%). In 2000, more than 13% (13.2 %) used ATS and by 2001 nearly 20% used ATS in 2001. During the same time-frame, there was also an increase in the number of street children injecting substances (Friends 2002). These studies show an overall increase in drug use among some vulnerable children and adolescents, particularly of ATS and injectable drugs.

One study of street children and adolescents who lived on the streets, in squatter areas and in street children centers in Phnom Penh found that street children knew the most about glue (Friends 1999c). Informants who were more protected, such as those living in accommodations or with their parents, were more familiar with alcohol and cigarettes. Among the same group of informants, almost half said they used glue, some used cigarettes and others consumed alcohol (Table 11). The children/adolescents who use glue live on the streets (60.5%) and in street children centres (46.1%). Interestingly, among those who still use substances, 65% use one substance, 31% use two of the substances and 4% use three of the substances mentioned. The majority of interviewees who use two or more substances live either on the streets or in street children accommodation. Most children/adolescents (98%) consumed substances with someone else. The study found that friends introduced them to the substance, and that peer pressure and imitation were significant reasons for commencing substance use. The other reasons given were escapism and street survival (Table 12). The survey also found that most parents of street children had used a substance themselves (95%).

Table 11. Common substances abused by adolescents

Substance	Percentage
Glue	47.5%
Cigarettes	37.5%
Alcohol	15%

Source: Friends, 1999.

Table 12. Reasons for substance abuse

Reason	Percentage
Peer	50%
pressure	20.5%
Escapism	22.8%

Source: Friends, 1999.

The CARE study of garment factory workers in Phnom Penh found that 4% and 13% had ever consumed alcohol and tobacco, respectively (Sprechmann 1999). Among young men, 37% had ever smoked and 44% had taken alcohol at least one time in their life. The average age of commencing smoking and trying alcohol was 19 years. Though the respondents did not drink often, 78% of those who had consumed alcohol had been drinking in the month prior to the survey.

The links between drug use and HIV

in Cambodia are as yet not explored, including the relationship between drug-induced intoxication and high-risk sexual behaviour. To date, no reported HIV infection in Cambodia occurred as a consequence of drug use (NAA 2001).

7. Unmarried pregnancy and induced abortion

7.1 Unmarried pregnancy

While many traditional values are changing, it is still true that an unwanted pregnancy results in a permanent taint on the family and a burden for the young unmarried female. Adolescents who become pregnant are sometimes cast out by their family because they are too ashamed to protect and care for the pregnant teenager. Under these circumstances, adolescents often choose to have an abortion, but those who do not, continue their pregnancy alone and without support (Bei Chamnorn 2003).

One study with adolescents in rural and urban areas revealed interesting responses by adolescents towards unmarried mothers. For example, the adolescents felt pity, compassion and anger towards the unmarried mother, and many expressed their disapproval because the female (not the male) was stubborn and disobeyed her parents and had ignored traditional Cambodian cultural mores (CHEMS/HU 1999). A 1999 RHAC study of students in Phnom Penh found that students who were sexually active said that if they or their partner became pregnant, then they would raise the child (31%), place the child in adoption (11%), or seek an abortion (20%). Many (38%) respondents did not know what they would do.

7.2 Induced abortion

Many adolescents wishing to hide their pregnancy seek an abortion. Due to fear and a lack of support, adolescents will usually seek care from an unskilled abortion provider that can result in chronic reproductive health complications or even death. Lind van Wijngaaden found that adolescent females who chose to have an abortion were often blamed for the rest of their lives for being a "bad woman" because they spoiled their virginity and lost their value in the 'marriage market' (2001).

In Cambodia, liberal abortion laws were ratified in 1997, and the guidelines, known as PRAKAS, were instituted in 2002. From 2004 to 2006 the Ministry of Health plans to train health

practitioners in safe abortion practices and register them. Safe Abortion Clinical Protocols are being developed and a training curriculum will be developed. A Safe Abortion Technical Working Group has been formed and will meet and discuss the implementation of the abortion protocols and guidelines.

According to the 1997 law, abortions can only be conducted by medical doctors, medical practitioners, or midwives authorized by the Ministry of Health. They can only be carried out in a hospital, health centre, health clinic, or maternity ward. Abortions can legally be conducted before the twelfth week of pregnancy, unless one of a number of specific conditions are met, which permit later abortions (Article 8).

Low CPR in Cambodia has resulted in an increased demand for induced abortions. Because of the sensitive nature of this issue, it is difficult to obtain accurate data on abortions, particularly for female adolescents. A KAP survey on contraception and fertility found that 29% of currently married women aged 15 to 19 years and 24.9% of women aged 20 to 24 years knew of someone who had had an abortion (Chhun et al. 1995:7). Of currently married women aged 15 to 19 years and 20 to 24 years, 0.3% and 1.7%, respectively, reported having had at least one abortion in their lives.

The CDHS 2000 estimated that 5% of all women in Cambodia have had an abortion. There were no reports of abortions among females aged 15 to 19 years. The CDHS concluded that because of the silence and social stigma associated with unmarried women having sexual intercourse, the prevalence of induced abortion among females aged 15 to 19 years and unmarried females is underestimated. For females aged 20 to 24 years, 98.4% had never had an abortion. For females aged 15 to 34 years who had had an abortion in the past five years, 47.2% of the abortions took place in a private health facility, 26.9% in a public health facility and 18.9% in the respondent's home, and the remainder took place in other locations (Table 13). The CDHS found that among females aged 15 to 34 years, the last abortion performed during the five years prior to the study, 82.5% were performed by a doctor/midwife/other health worker, 9% by a traditional birth attendant/traditional healer, 1.3% by a relative, and the remainder by no one (6.4%).

Table 13. Where abortions take place among females aged 15 to 34 years

Place	Percentage
Private health facility	47.2%
Public health facility	26.9%
Home	18.9%
Other locations	7%

Source: CDHS 2000.

A CHC/Memisa study in Kampot Province with out-of-school adolescents found that among couples that had ever had a pregnancy, 19.6% said they had an unwanted pregnancy (2001). A 2000 survey in Kampot Province with adolescents (in and out of school) showed that induced abortions occurred in villages and 75% of respondents said that it was dangerous. Nearly all the respondents (92%) said that abortion was a sin because it "kills someone", and because the unborn baby dies before it has had an opportunity to be reborn or reincarnated.

Fear of danger and death from unsafe abortions is of particular concern to young women in Cambodia (EU/UNFPA 2002). One evaluation found that 78% of adolescents in Phnom Penh, Battambang, Kratie and Kampot Provinces had no idea what happens to women when they have an abortion (CHEMS/HU 1999). Only 1% of respondents said that it involved a baby being pulled from the uterus. Most adolescents did not know anyone who had had an abortion, and those who did know someone were urban respondents.

A 1999 Friends study with freelance CSWs aged 13 to 25 years found that 28% of adolescents had had an abortion. The main methods for inducing an abortion were "modern" practices (43% used curettage) and 14% of respondents said they used traditional methods. Interestingly, 20% said they had complications during or after their abortion. A Friends (1999c) study among vulnerable female adolescents in Battambang Province found that induced abortion was well known among the respondents. Five per cent of the vulnerable female respondents aged 15 to 19 years and 13% aged 20 to 25 years had had an abortion, and 3% of females 15 to 19 years had more than one abortion. Of the young people who had had an abortion, 3% of the 15 to 19 year old and 9% of the 20 to 25 year old young people had had a complication from the abortion (Table 14).

Table 14. Abortion and complication rates among vulnerable female young people

Age	Abortion rate	Abortion >1 time	With complications
15-19	5%	3%	3%
20-25	13%		9%

Source: Friends, 1999.

Generally, vulnerable adolescents do not discuss abortion, and if they do it is with female friends. The males in the study were aware of abortion techniques, and curettage was the most well known method. A third of the males aged 20 to 25 years knew of the traditional methods of inducing an abortion. Among street children and vulnerable youth in Phnom Penh, females knew about abortion, younger respondents were more familiar with traditional methods, and older respondents knew more about modern methods of inducing an abortion (Friends 1999c). Half the females interviewed felt there were no problems associated with having an abortion. The main reasons respondents gave for not having an abortion were post-abortion health problems and individual and family shame. Whereas the reasons they gave for resorting to an abortion were related to limiting the size of families. Most females interviewed who had previously had an abortion said they had complications post-abortion (100% for 15 to 19 year olds and 71% for 20 to 25 year olds). The Cambodia Women's Development Agency surveyed 100 ethnic Khmer CSWs in the Toul Kork, Trolok Baik area in Phnom Penh and Chom Chouv District, and found that about 30% had undergone an abortion (1995). There is no data on the age of the sex workers surveyed, but the average age of CSWs in Phnom Penh is about 20 years. In Stoung Saen city in Kampong Thom Province, 54% to 60% of direct sex workers had had an abortion. All of the first abortions among this group were induced after a separation from the child's father (GTZ/Kampong Thom Provincial Health Department Project Data 2001).

Lester's 2002 study of private and public abortion practitioners found that the main methods used for first trimester abortions were: manual vacuum aspiration (MVA) (44%); dilatation and curettage (41%); electric vacuum aspiration (EVA) (7%); massage (7%); Cytotec (1%); and Oxytocin (3%). For second trimester abortions, the findings were: MVA (7%); dilatation and curettage (12%); insert an object (1%); massage (1%); oxytocin (1%); Covac (9%); and caesarian section (3%). The main methods used for third trimester abortions were Covac and a combination of Covac and massage.

7.3 Attitudes of abortion service providers

Very little is known about the attitudes of abortion providers, particularly their attitudes towards unmarried women seeking abortion services. Lester found that many abortion providers were reluctant to provide services to single females, and often providers did not accept that unmarried females were in need of reproductive health services (2002). The ARHI in Cambodia lessons learnt research found that safer abortion procedures were more likely to occur at private and NGO clinics. Traditional birth attendants were the most likely abortion provider due to cost and confidentiality factors. This was particularly true for young women in rural areas (EU/UNFPA 2002).

8. Reproductive system anomaly and disease

8.1 HIV/AIDS

HIV was first detected in Cambodia in 1991 during serological screening of donated blood. The first cases of AIDS were diagnosed in 1993 and 1994. Since then the country has witnessed a rapid increase in the incidence of HIV/AIDS, making it the fastest growing HIV/AIDS epidemic in Asia. The number of reported cases of AIDS is rising sharply. The NCHADS sentinel surveillance has shown that HIV infection is declining in all surveillance groups, excluding beer promotion girls (often female adolescents), with the incidence in the general population remaining stable. However, the people who were infected with the HIV virus in the early 1990s are now dying, and the number of new infections has dropped, especially among the younger people (NCHADS 2000).

The main forms of transmission for HIV in Cambodia are sexual intercourse, blood transfusion, reuse of needles for injections, and mother-to-child transmission. HIV transmission is enhanced because of the widespread practice of men having extramarital and premarital sex, often with women whom they pay for sex (MoP 2001). Men are spreading HIV from sex workers to their noncommercial sex partners, including wives, who may pass the virus into their unborn babies. Sex with CSWs is common among several mobile groups, including the military, police, and motor-taxi drivers. Surveillance data indicate that rates are also high among other groups, including adolescents and youth.

However, adolescents and young people are not among the sentinel population groups routinely surveyed. NCHADS uses CSWs and police as a proxy for incidence of HIV among adolescents. This is, however, not a true incidence of HIV among adolescents because this group is not representative of male and female adolescents in the general population (NCHADS 2002).

The 2000 CDHS 2000 noted that the HIV prevalence rate was 2.8% (3.45% among males) among the adult population aged 15 to 49. It was 3.9 in 1997, and appears to be declining. There are 30 000 children younger than 15 years who have been orphaned by HIV/AIDS (KHANA 2000). Cambodia has the highest prevalence of HIV among youth aged 15 to 24 years in Asia. Cambodians below the age of 24 years make up nearly half of the new HIV infections (NCHADS 2002).

The HIV seroprevalence rate among direct CSWs (brothel-based) is 31.1%, and among females less than 20 years (22.7%), and 20 to 29 years (33.3%) (NCHADS 2000). The seroprevalence among direct CSWs less than 20 years old (in 19 provinces) declined from 40.8% in 1998 to 22.7% in 2000. For indirect CSWs (women who provide sexual services in bars, hotels, street, dancing restaurants and karaoke and massage venues) the HIV seroprevalence rate is 16.1% and for women less than 20 years and 20 to 29 years it is 10 % and 18.2 %, respectively (NCHADS 2000)(Table 15). For policemen less than 30 years the seroprevalence rate is 3.1%. The trend of seroprevalence among policemen aged less than 30 years in urban areas declined from 6.3% in 1997 to 3.52% in 2000.

Street children are at risk of HIV/AIDS and STI because they sell sex to earn money, are mobile, are often separated from their families, drink alcohol, and use drugs. Male street children have both male and female sexual partners, and this increases their risk of contracting and transmitting HIV and

Table 15. HIV seroprevalence rate

Direct CSWs	31.1%
Women less than 20 years old	22.7%
Women 20 to 29 years old	33.3%
Indirect CSWs	16.1%
Women less than 20 years old	10%
Women 20 to 29 years old	18.2%

STI. Street children are also more at risk for physical abuse, including rape (United Nations 2000). Street children are not among the NCHADS surveillance groups; therefore, the seroprevalence rate of this vulnerable group of adolescents is unknown.

8.2 STI

There is no STI prevalence data available in Cambodia. There is some small STI surveillance studies and programme-based information available, especially among CSWs. A STI prevalence study conducted by NCHADS in 2001 with women who attended reproductive health clinics found that the STI prevalence rate for this group was low. The majority of the women who attend reproductive health clinics complained of reproductive tract infection (RTI) symptoms and half of the women were symptomatic with vaginal discharge and a third complained of vaginal itching. These results are in line with the high prevalence of candidiasis that was detected by gram stain among the study population. Over one third of women were found to have vaginal discharge and one fifth had cervical erosion on examination. Other signs of RTI were uncommon. Three quarters of women said that they used vaginal douches and 10% used vaginal antiseptic tablets (Salnophomin).

The same STI prevalence study found that 14% of CSWs had gonorrhea and 12% had a chlamydial infection. There were very low rates of genital ulcers detected and no cases of primary syphilis were seen. Moreover, no evidence of asymptomatic chancroid or syphilis was detected using highly sensitive mPCR (multiplex polymerase chain reaction) assay on vaginal swabs from 395 brothel-based CSWs. Low rates of genital ulcers are especially significant because of the strong association between these STI and HIV transmission. The majority of the STI that were detected were asymptomatic and lacked obvious clinical signs (NCHAD 2001).

A study in Battambang Province with vulnerable young males found that 6% of 15 to 19 year olds and 4% of 20 to 25 year olds said they had had a STI (Friends 1999a). A 2002 study by FHI with MSM found that 21.1% of men aged 18 to 42 years had had STI symptom in the 12 months prior to the study. In the same group, 14.4% and 5.5% had HIV and syphilis, respectively. Overall, 26.5% of the respondents tested positive for at least one STI, including HIV. Other diagnosed STI were urethral Neisseria gonorrhoea (4.8%); anal Neisseria gonorrhoea (0.3%); urethral chlamydial infection (7.2%); and anal chlamydial infection (1.0%).

9. Need for education and service

9.1 Need for education

Adolescents should receive education about male and female anatomy, physiology, sexuality, reproduction and health related issues, including negotiating safe sex practices as soon as possible. In addition, health education in primary and secondary schools should utilize a variety of teaching methods, gender-specific and culturally sensitive approaches, as well as adapt modes of delivering health education to the diverse group of adolescent and youth who attend schools in Cambodia. This large enterprise should be given the utmost priority among national and international policy-makers, including the relevant ministries, funding agencies, local NGOs, and communities. If this generation's health knowledge is not increased and their behaviour changed, then they will continue to cope with serious reproductive health consequences, including the HIV/AIDS epidemic.

The 2002 EU/UNFPA lessons learnt research found that adolescent reproductive health initiatives tend to focus on and feel more comfortable working with older young people (from 16 years upward). This reflects the reluctance of society in general to think of younger people as sexual human beings. Discussing sexuality and reproductive health with adolescents 10 years and older is a sensitive subject. Nevertheless, unless adolescent reproductive health programmes discuss and engage with adolescents' sexual and reproductive health needs during their emotional, sexual and physical development, many young people will come into contact with educational and health services long after they have begun sexual activity, when it is too late.

The education experience of young females is qualitatively different than it is for young males (Tarr 1996a). Researchers noted that female students in primary, secondary and post-secondary school were shy, non-assertive and deferred to their male counterparts (Ledgerwood 1990; Tarr 1996a). This is partly due to the hierarchical dimensions of gender in Cambodian society and also to a lack of female teachers at all levels, especially at secondary and post-secondary levels. This situation makes it difficult for female students to talk openly with teachers about subjects such as sexuality and reproductive health in the classroom (Tarr 1996a; EU/UNFPA 2002). In

addition, the culture of silence around sexuality and reproduction makes it difficult for unmarried females to talk about these issues in group discussions versus their male counterparts who are much more willing to do so (ibid).

Tarr's study found that more communication between male and females occurs in private classes, such as computer and language classes, away from the view of older Cambodians. Discussions of sex has been problematic for both parents and teachers, and teachers have been reluctant to provide females with sex education out of fear that this will encourage them to have sex (Tarr 1996a). Another concern is the low number of female adolescents attending upper-secondary and post-secondary school. This trend means that health education has to begin in primary school, and/or be delivered in a variety of non-formal education settings that use alternative modes of delivering education to adolescents with low levels of literacy.

9.1.1 School-based sexual and reproductive health education

Health education commences in the fifth grade in primary schools and is reviewed and updated by the School Health Department in the Ministry of Education, Youth and Sport in collaboration with UNESCO and UNICEF. The School Health curriculum was reviewed in 2003. There is no school health policy that addresses reproductive health, including sexuality, reproduction and HIV/AIDS/STI. The Ministry of Education, Youth and Sport is in the process of drafting a policy on HIV/AIDS education for primary and secondary school students. There is a ministry Inter-Departmental Committee on HIV/AIDS that developed the Strategic Plan on HIV/AIDS in Education 2000-2005 (MoEYS 2002a). Ministry of Education, Youth and Sport (Teacher Training Department), UNESCO and UNICEF are currently developing a dedicated module on HIV/AIDS education specifically for primary level students.

Students are introduced to the anatomy and physiology of the male and female reproductive system in fifth grade. From grade nine to grade 12, students learn about reproduction and sexuality, which are integrated into the main education curriculum. From grade five to grade 12, students learn about HIV/AIDS (prevention, modes of transmission, attitudes, and caring for people living with HIV/AIDS). The information is integrated into the general curriculum, such as social studies and Khmer language. There is no life-

skills curriculum in primary and secondary schools. The main sexual and reproductive health subjects taught in secondary schools in Cambodia is HIV/AIDS education, which is supported by UNESCO and UNICEF.

A national pilot project "Strengthening HIV/AIDS/STI Prevention Education for Secondary Schools in Cambodia" was implemented by the Ministry of Education, Youth and Sport in 1999 and 2000 (MoEYS 2002b). During this pilot project, all grade nine and grade 12 students received information about HIV/AIDS/STI. There were several outcomes:

- A new curriculum, student books and teacher guides on HIV/AIDS/STI prevention education were developed and used nationwide for all students in these two grades.
- Sixty teacher trainers from six regions and 1300 teachers from secondary schools received training on HIV/AIDS/STI prevention.
- More than 55 000 grade nine and 22 000 grade 12 students received HIV/AIDS/STI instructions.
- The capacity to evaluate projects was enhanced by staff members of the School Health Department.
- Experience from the pilot project was documented and shared with stakeholders, especially administrators and teachers in Cambodia.

Overall, the pilot project evaluation was favourable. Students' knowledge of HIV/AIDS increased, particularly for female students. There was a positive response from the majority of parents and teachers. Sixty-three per cent of teachers and 81% of trainers wanted to teach this programme again. There were limitations with this project: sex is a "taboo" subject to discuss in schools; teachers and students are shy; teachers have limited knowledge of HIV/AIDS; there is a scarcity of HIV/AIDS trainers (ibid). In Kampong Thom Province, Stulz and Lao identified several problems with the pilot project: few workbooks were issued during the implementation phase; sporadic activities were held by trained teachers; and few activities that developed trust and communication between students and teachers (2001).

Several NGOs deliver HIV/AIDS education in secondary schools in their project areas, such as RHAC in schools in Phnom Penh and in select provinces. The NGOs generally follow the Ministry of Education, Youth and Sport curriculum; however, there is additional

information and materials issued to students that are not in accordance with the Ministry of Education, Youth and Sport policies.

9.1.2 Community-based education

The ARHI in Cambodia is the main adolescent reproductive health initiative in Cambodia, and many projects include community education initiatives. The ARHI in Cambodia initiatives are supported by EU/UNFPA and aim to improve the reproductive health of adolescents and youth in selected rural and urban areas and among underserved vulnerable population groups including rural out-of-school youth, youth in squatter communities, factory workers, sex workers and street children. Seven European NGOs work with 23 Cambodian partner NGOs to develop and implement effective sexual reproductive health approaches and services (EU/UNFPA 2002). The ARHI in Cambodia was initiated after the International Conference on Population and Development (ICPD) was held in Cairo in 1994 in response to the growing reproductive health needs of Cambodia's young people. These initiatives have been operating in Cambodia for four years and many will continue with the support of EU/UNFPA. Several projects deliver community education, either as stand-alone activities or in conjunction with reproductive health service delivery. For example, CARE Deutschland works with the Cambodian Health Education Development, Women's Development Association and Cooperation for Sustainable Cambodian Society to provide reproductive and sexual education for young people working in garment factories in Phnom Penh. PEs provide IEC activities and there are on-site or mobile clinical services and referral.

The literature review identified several barriers to providing community-based reproductive and sexual health education to adolescents in Cambodia. Conservative family values combined with poverty often lead village elders to criticize young people who want to take part in community initiatives that do not entail any payment or material incentive for their attendance (EU/UNFPA 2002). Young people contribute significantly with family income generating activities. Spending time with an NGO activity means less income for families. There are more opportunity costs for rural young people than there are for urban youth.

The safety of young women wishing to participate in activities is of particular concern. The fear of rape, assault and

the loss of honour for young women is a problem cited by NGOs that deliver outreach reproductive health education to adolescents, especially in rural areas (ibid). Programmes in rural areas have found that they cannot afford nor is it logistically possible for NGOs to chaperone or arrange transport so that young people can go from their village to the activity. Sometimes the outreach activities are far from the village, and this creates many concerns for the parents. Young people who migrate for work, especially in rural areas such as in Battambang and Prey Veng Provinces, are difficult to reach with community education programmes. This subgroup of adolescents is vulnerable and at significant risk for HIV/AIDS/STI.

Peer community education involved the participation of young people in the design of PE and CBE interventions that varied between each agency (EU/UNFPA 2002). Some agencies developed participatory processes throughout their training programme, using KAP surveys with their target groups as the starting point. The same agencies developed a largely inclusive and evolving monitoring and evaluation process that took into account young people's ideas and innovations. However, most did not provide an avenue for participants to provide a way for PEs and CBEs to give feedback on what was working and what was not. The EU/UNFPA lessons learnt research found that there were limitations to the PE and CBE approach. A lack of adequate supervision and follow-up allowed PEs and CBEs to spread misinformation. Few boundaries were placed around the knowledge and interventions that PEs and CBEs were imparting, which created a situation in which young people regarded themselves as para-professionals rather than as conduits for information, advice and referrals. Also, PEs and CBEs failed to review and revise the discussions and inputs from adolescents that resulted in the initial information learnt by PEs and CBEs continuing throughout the life of the project and then becoming 'fact'. Secondly, the model of community education is based on the medical model. The end users of the information are the vulnerable youth. This situation created several technical inaccuracies and poorly understood information (ibid).

9.2 Need for reproductive health service

The Ministry of Health provides reproductive health services for the general population under the management of the NRHP. There are

not any services or programmes specifically for adolescents. There are NGO-supported reproductive and sexual health services specifically for CSWs in Phnom Penh and in some provinces, such as Kampong Som, Koh Kong, Kampong Thom and Banteay Meanchey Provinces.

The literature review identified two adolescent-friendly services: Friends in Phnom Penh and select provinces, and RHAC in Phnom Penh and four provinces. Both services are partners in the AHI in Cambodia initiative. Adolescent-friendly health services are designed to be responsive to the needs of young people. For example, staff treat their young clients with respect and confidentiality is ensured (WHO 2003). Friends' clinical and health education services are specifically designed for vulnerable youth, such as street children, and other adolescents. The RHAC services, a clinic and community education by Peer Group Educators, provide adolescent friendly services where they place emphasis to adolescents' needs. The package of services for adolescents includes: a special entrance and library area; IEC and behavioural change communication materials specifically produced for adolescents; a network of peer educators; links with schools and workplaces; and staff specifically trained in adolescent-friendly service delivery. RHAC is collaborating with the Ministry of Health to pilot adolescent-friendly sexual and reproductive health services in health centers in two districts (WHO 2003).

Adolescents value adolescent-friendly services, but these services are scarce and not an option for most youth, especially rural adolescents (EU/UNFPA 2002). EU/UNFPA found that urban and rural adolescents have some similar access issues, such as the cost of transport or no transport and loss of income if they take the time off work to visit a service. But these issues are intensified for young people living in rural areas. Rural young people live many kilometers from NGOs and government health clinics. There may be no health service close to their village. Privacy can also be a key issue. Leaving their village to visit a health services means that adolescents' families and neighbors will know and question them about the nature of their visit. Independent travel for females is fraught with problems, and families place restrictions on females because they worry about damage to the female's reputation.

Significant barriers face adolescents when seeking reproductive health care at government health services. Cultural

norms in Cambodia discourage access to clinical services for information about safe sex practices, and this is particularly true for young people. A study in Kampong Thom found that it was not acceptable for a married woman to discuss reproductive health issues with unmarried health staff. Young people in rural areas also do not trust local health services (see also Hoban 2002). Government health services often have no medicines available in the health facility and the quality of care is regarded poor or dangerous. Adolescents said that staff were disinterested in them, especially if they had little or no money. Confidentiality was a major concern. As a result, young people seek the cheapest and most viable option, such as the local pharmacy, drug seller, traditional healer and yieh maap (traditional birth attendant) (EU/UNFPA 2002). The Kampong Thom study also found that some private practitioners do provide 'discreet' reproductive health services for adolescents, but they are expensive and of various qualities (Stulz and Lao 2001)

Lester identified social stigma associated with premarital sex among adolescents as a concern for adolescents when seeking reproductive health care (2002). This was particularly true for rural adolescents. Confidentiality was cited as a problem in rural areas. The EU/UNFPA research found that for young people, seeking clinical services for sexual and reproductive health was a frightening prospect and they would not do so unless it was very urgent.

9.2.1 STI clinical services

The Ministry of Health approved STI syndrome management guidelines based on WHO recommendations that were developed in 1998. WHO supports the training of health care providers in STI management in nearly all the provinces. Inadequate supplies of effective antibiotics, however, limit widespread implementation of the guidelines. A more sensitive, nonlaboratory-based algorithm is being implemented for female sex workers and regular meetings are held with NGOs working with high-risk populations to coordinate efforts. CSW interventions are the priority for the limited antibiotic supplies (NCHADS 2002). The Ministry of Health clinics provide STI services in outpatient departments. Several NGOs have provided STI prevention and care services to both general and high-risk populations, including adolescent-friendly services provided by RHAC (Table 16).

Table 16. NGO involvement in provision of STI services

NGOs	Target populations
Reproductive Health Association of Cambodia	General population
Médecins Sans Frontières (MSF)	Mixed: general and high-risk populations
Reproductive and Child Health Alliance (RACHA)	General population
Pharmaciens Sans Frontières (PSF)	Mixed: general and high-risk populations
IMPACT/FHI	High-risk groups
Mèdecins du Monde	Mixed: general and high-risk populations
EU/ITM Project	Mixed: general and high-risk populations

Source: NCHADS 2002. Cambodia STI Prevalence Study 2001. Draft Final Report. Phnom Penh.

10. Policies and regulations related to adolescence

10.1 Reproductive Health Policies

The Ministry of Health does not have a specific adolescent reproductive health policy or a multisectoral policy that addresses youth and adolescents. Adolescent reproductive health falls within the context of other health policies, such as safe motherhood, birth-spacing, gender and equity, HIV/AIDS, and abortion. The focus of the National Reproductive Health Program focus is on married women's reproductive health, primarily due to the Ministry of Health's limited resources. The Ministry made a policy statement in the Health Sector Strategic Plan 2003-2007 that addressed adolescents' health:

> Priority emphasis on prevention and control of communicable and selected chronic and non-communicable diseases, on injury, the elderly, adolescents and vulnerable groups such as the poor, and on managing public health crisis (Ministry of Health 2002:8).

The Ministry asked that NGOs assist with the adolescent reproductive health sector because of their comparative advantage and capacity (EU/UNFPA 2002).

10.2 School health education policies

The Ministry of Education, Youth and Sport has no policy on sexual and reproductive health. A policy will be developed specifically for HIV/AIDS and STI education in primary and secondary schools (grades 5 through 12). The School Health Department is

reluctant, as are teachers and parents, to incorporate other sexual and reproductive health subjects into the general curriculum, especially at the primary school level.

Ministry of Education, Youth and Sport does not have a department responsible for adolescents. There is cooperation among ministries and departments on specific issues and activities, but this is limited and on an informal basis. There is not an intersectoral working group for adolescent affairs or adolescent reproductive health.

10.3 Women and female children's policy

The Ministry of Women's and Veteran's Affairs does not have a policy on adolescent and youth reproductive and sexual health. In conjunction with NAA, the Ministry of Women's and Veteran's Affairs is developing a national Policy on Women, the Girl Child and STI/HIV/AIDS (MoWVA 2002). This policy was revised in July 2002, and has been redrafted in the context of the NAA's National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS 2001-2005, and the Proposed Law on the Prevention and Control of HIV/AIDS.[8]

The Ministry of Women's and Veteran's Affairs supports HIV/AIDS policies and programmes that incorporate gender relations to involve both women and men in appropriate ways. The Ministry of Women's and Veteran's Affairs recognizes that there is a gender-based pandemic and that the spread of HIV/AIDS among women and girls can be slowed, but only if positive changes are brought about in men's sexual behaviour. Gender and HIV mainstreaming efforts at the national, provincial and local levels are hampered by negative attitudes towards discussing sex, sexuality and reproductive rights. Therefore, the Ministry of Women's and Veteran's Affairs places prevention, care, support and protection of women and the girl child, plus the need to change the behaviour of men, on the agenda of policy-makers and service providers through the Policy of Women, the Girl Child and STI/HIV/AIDS. The policy will incorporate: the principles of human rights; community and family; freedom from stigmatization and discrimination; confidentiality and privacy; equality and equity; accessibility; quality of services; and appropriateness

[8] *Law drafted by the National Assembly during the 8th Session/2nd Legislature.*

of services. Ministry of Women's and Veteran's Affairs is working with the Ministry of Health and Ministry of Education, Youth and Sport to develop the policy on HIV/AIDS and STI.

10.4 Human rights and international and domestic law

The Government is a signatory to several relevant international human rights instruments that protect individuals' rights, including:

- The United Nations Convention on the Rights of the Child, Articles 34 and 35;
- The ILO Convention No. 182 concerning the Prohibition and Immediate Action for the elimination of the Worst Forms of Child Labour;
- The Convention of the Elimination of Discrimination against Women (CEDAW) Article 6;
- The Stockholm Declaration and Agenda for Action 1996;
- The Optional Protocol to the United Nations Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography; and
- The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime.

As a signatory to such international human rights instruments, the Government of Cambodia is therefore responsible for private acts of violence against women especially if it fails to take the necessary steps to prevent violations of rights or to investigate and punish acts of violence and to provide compensation to the victims.

The Government of Cambodia ratified the United Nations Convention of the Rights of the Child (CRC) in October 1992 and incorporated it into the Constitution of the Kingdom of Cambodia. This required the Government to develop a national framework for implementing the treaty standards, usually by incorporating the principles into domestic law. Eight years later there has been no application of the treaty to protect the rights of the child.

Under the CRC, a minor is an individual less than 18 years. There is no definition of minor under Cambodian Law. There is no age of consent to sexual intercourse in Cambodian Law, but most

others use the age of 18. This matter is confused by the Labour Law, which gives three ages (12, 15, and 18 years) as age of majority. The Criminal Code complicates the issue further by stating that there is a double penalty for anyone who sexually assaults a person under the age of 16 years. The human trafficking law provides another age benchmark by doubling the penalties if the victim is under age 15 years. Article 33 of the Criminal Code does not specifically recognize statutory rape (consensual sex with a minor under a specified age) (LICADHO 2001).

11. Intervention studies on sexual and reproductive health

11.1 Adolescent reproductive health initiatives in Cambodia

ARHI in Cambodia focuses on adolescent and youth reproductive health (education and clinical services) in rural and urban areas in Cambodia (2002). ARHI in Cambodia is funded and supported by the EU/UNFPA. Its programmes are outlined in Table 17.

Table 17. The projects of adolescent reproductive health initiative in Cambodia

Programme	Executing Agency	Implementing Agency	Description
1. Media Education to Improve Adolescent Sexual and Reproductive Health in Cambodia	Health Unlimited	Cambodian Health Education Media Service, Cambodian Health Education Development (in cooperation with Project Against Domestic Violence and Reproductive Health Association of Cambodia)	A media project targeting 12 to 25 year old young people. The project aims to improve adolescents' knowledge, encourage behaviour change and increase national IEC capacity. Adolescents and young people are involved in the production, delivery and evaluation of the interactive radio programmes and magazines.

Table 17. The projects of adolescent reproductive health initiative in Cambodia (Continued)

Programme	Executing Agency	Implementing Agency	Description
2. Promoting Reproductive Health Practices among Working Adolescents and Young Adults in Cambodia	CARE Deutschland	Cambodian Health Education Development, Reproductive Health Association of Cambodia, Women Development Association, Cooperation of Sustainable Cambodian Society	The project targets working youth, especially female workers in garment factories, for reproductive and sexual health information. Factory workers, who are predominately females and have migrated to Phnom Penh for employment, have special needs, which are reflected in a wide range of IEC activities and the provision of on-site or mobile clinical services and referral.
3. Adolescent Reproductive Health in Cambodia	International Planned Parenthood Federation	Reproductive Health Association of Cambodia	Reproductive health clinical services dedicated to the needs of adolescents and youth are provided in several locations in urban and rural Cambodia. Youth clubs and libraries are organized. Youth volunteers are mobilized, trained and supported in outreach and peer education.

Table 17. The projects of adolescent reproductive health initiative in Cambodia (Continued)

Programme	Executing Agency	Implementing Agency	Description
4. Reproductive Health for Marginalized Youth in Phnom Penh and Kratie Province	Save the Children Fund UK	Women's Organization for Modern Economy and Nursing, Solidarity of Urban Poor Federation, Kratie Women's Welfare Association, Local Youth and Children's Support Organization	Working with out-of-school youth in rural and urban settings, to provide counselling and information centres, and mobile facilities. Outreach activities are delivered to promote reproductive health knowledge, and to improve life skills and decision-making. Peer educators are mobilized, trained and supported, and Buddhist monks and leaders are included in reproductive health education activities.
5. Reproductive Health for Vulnerable Children and Youth in Cambodia	Pharmaciens Sans Frontières	Mith Samlanh/Friends, Opération Enfants de Battambang	The target group is vulnerable young people, including street children and young women at risk of abuse and exploitation. The range of interventions include: community reproductive health education, information and STI care. There is a youth centre in the squatter community where young people are offered education and training in alternative means of earning an income. The project supports their reintegration into their families and communities, and the public education system.

Table 17. The projects of adolescent reproductive health initiative in Cambodia (Continued)

Programme	Executing Agency	Implementing Agency	Description
6. Reducing the Vulnerability of Young Cambodians to HIV/STI through Local NGO Sector Mobilisation and Strengthening	International HIV/AIDS Alliance	Khmer HIV/AIDS NGO Alliance and nine partner NGOs	This project focuses on building up the capacity of local community-based NGOs, by mobilizing, selecting, training, monitoring and supervising their activities to develop sustainable effective responses to HIV/AIDS and STI and other sexual and reproductive health issues identified by youth. Effective programme models and tools are identified, documented and disseminated among the project partners. The project holds an annual youth camp.
7. Promotion of Reproductive Health in Kampot Province for Youth Aged 12 to 25 years	Memisa Medicus Mundi/Coraid	Cambodian Health Committee	This project works with out-of-school youth in remote rural areas. It supports youth groups and offers a range of activities. Community support for youth reproductive health issues is carried out by working through local authorities, village leaders and parents. Youth group peer leaders are selected and act as youth representatives and reproductive health educators for young people in their village.

12. Issues identified

The literature review identified several cross-cutting issues that directly impact on the reproductive health status of youth and adolescents in Cambodia, and they include:

- The life stages of youth and adolescents and the transition between childhood, youth and adolescence have not been defined in Cambodia.
- Poverty is widespread. Social and economic indicators show that in some areas of the country poverty is increasing, particularly in rural areas.
- Out-migration of youth and adolescents to urban centres and across national borders in search of employment is increasing, especially in rural areas that border Thailand and Viet Nam.
- The education level, especially the functional literacy level of youth and adolescents, is low. Poverty is the major barrier to youth and adolescents attending school, especially for females.
- Cultural norms and societal attitudes and values discourage discussions about sexuality, reproduction and reproductive health issues, even among close kin and friends.
- Cambodia has experienced decades of war and civil unrest resulting in the destruction of all government infrastructures, including health, education and religious institutions, and the dismantling of many cultural values and social mores.

12.1 HIV/AIDS and STI

12.1.1 Interventions

Policies

- The Ministry of Health has a HIV/AIDS and STI policy for the general population, but there is no specific HIV/AIDS and STI policy for youth and adolescents. The Ministry of Education, Youth and Sport is currently drafting a HIV/AIDS/STI policy. The Ministry of Women's and Veteran's Affairs has a draft HIV/AIDS/STI policy for women and girls.

Education

- The Ministry of Education, Youth and Sport's School Health Department is responsible for HIV/AIDS/STI education for primary and secondary students. HIV/AIDS is being taught in late primary and secondary schools through the general curricula in the absence of a HIV/AIDS/STI policy. HIV/AIDS/STI education is the main reproductive health subject taught in primary and secondary schools in Cambodia.

- Community-based HIV/AIDS/STI education with out-of-school adolescents occurs in locations where ARHI in Cambodia partners (EU/UNFPA 2002) deliver programme activities. The ARHI in Cambodia partner NGOs utilize the services of PEs and CBEs who are volunteers, or are paid a small stipend. These initiatives are mainly in Phnom Penh and provincial centres, and there are few initiatives in rural areas. Other ARHI in Cambodia partners deliver community-based education to vulnerable and mobile populations, such as street children, vulnerable youth, and garment factory workers. There is a gross lack of community-based HIV/AIDS/STI education for out-of-school, vulnerable and mobile youth and adolescents who live in rural areas away from Phnom Penh and provincial centres.

Information, education and communication

- IEC campaigns that address HIV/AIDS have been operating in Cambodia for more than a decade. There is a high level of awareness of HIV/AIDS, but a low level of knowledge and considerable misinformation about the aetiology, modes of transmission, and signs and symptoms of HIV/AIDS. Little is known about youth and adolescents' knowledge and local understanding of STI. The literature review found that many adolescents considered that HIV/AIDS is a STI. Knowledge of STI is low, in particular, their aetiology, transmission and signs and symptoms of different STI.

- There has been no in-depth research into youth and adolescents' local understanding of HIV/AIDS and STI and their relationship to the germ theory. This is a significant oversight by the Ministry of Health and international health experts. This information would have informed HIV/AIDS health

promotion and education initiatives from the outset.

- Youth and adolescents' stigmatization of and discriminatory attitudes towards populations classified as "at risk", such as CSWs, and people who are living with HIV/AIDS, is alarming. These attitudes demonstrate a low level of knowledge and misinformation about the cause and mode of transmission of HIV/AIDS.

- IEC campaigns have targeted high risk groups and not high risk behaviour, which has further stigmatised and marginalised vulnerable populations, such as CSWs (direct and indirect), factory workers and other mobile populations such as police and the military. IEC campaigns have portrayed CSWs (usually young women) as vectors and not as vulnerable victims and the clients of CSWs remain invisible and not accountable for the spread of HIV and STI.

Services

- The adolescent-friendly reproductive health services in Phnom Penh and select provincial centres deliver HIV/AIDS/STI education and training, along with screening and treatment of RTIs. There are no government health services that specifically focus on HIV/AIDS/STI prevention and treatment of STI for youth and adolescents. There are a few reproductive health services for CSWs in Phnom Penh and provincial centres, but adolescents who are not CSWs do not frequent these clinical services.

Management

- Adolescent-friendly clinical services and education initiatives are designed and delivered by ARHI in Cambodia partners (EU/UNFPA 2002). Community education initiatives involve adolescents as PEs and CBEs to deliver education health messages to their target groups. There are no HIV/AIDS/STI activities (education or clinical services) designed, delivered and managed by adolescents.

Coordination between stakeholders

- There is no national-level, multisectoral group that coordinate adolescent reproductive health initiatives among the key stakeholders.

- There is a quarterly ARHI in Cambodia coordination meeting, facilitated by UNFPA, to discuss the progress, problems and concerns and future ARHI initiatives, which includes HIV/AIDS and STI education and clinical services.

- There is no coordination between the relevant government ministries, such as Ministry of Health, Ministry of Education, Youth and Sport and Ministry of Women's and Veteran's Affairs and other stakeholders, to develop HIV/AIDS/STI education policies and programmes for school-going, out-of-school, and vulnerable youth and adolescents in Cambodia.

- Ministry of Education, Youth and Sport (School Health Department) is working with UNICEF, UNESCO and UNAIDS to develop a HIV/AIDS/STI policy for primary and secondary schools, but to date they have not involved the Ministry of Health.

- Ministry of Women's and Veteran's Affairs is collaborating with UNAIDS and other stakeholders to develop a HIV/AIDS/STI policy for women and girls, but have not involved the NRHP (Ministry of Health) in the development of the draft policy.

12.2 Unwanted pregnancies and unsafe abortions

12.2.1 Interventions

Policies and protocols

- There is a liberal Abortion Law in Cambodia with PRAKAS (guidelines) for its implementation. Protocols for abortion providers are currently being developed by the NRHP to ensure they provide safe abortion care in registered health facilities.

- The Ministry of Health has a National Birth Spacing Policy and Programme that is widely promoted throughout Cambodia. The main birth spacing methods (Depo-provera, daily pill and IUD) are promoted in the public and private sector among married women, but to date the programme has not focused on youth and adolescents' contraceptive needs.

Education

- Adolescents have minimal exposure to sexuality and reproduction education while they are in school and out-of-school, this is particularly true for vulnerable populations.

- Education about birth spacing methods is not targeted at unmarried youth and adolescents. Adolescents' sexual debut occurs before they are exposed to birth spacing IEC, which places female adolescents at risk of unwanted pregnancies.

Information, education and communication

- There is limited IEC available and accessible to youth and adolescents, especially those living in rural areas and mobile populations, about safe abortion services, the cost of the services and quality of care by abortion providers.

Services

- Reproductive health services funded by USAID do not provide abortion services, IEC activities that address abortion issues, or refer clients to abortion services.

- There are questions surrounding the quality of care provided by private abortion practitioners (and government health staff working privately), this includes traditional healers and birth attendants.

- There are significant barriers to rural adolescents seeking safe abortion services, mainly due to poor access, the need to travel to Phnom Penh and provincial centres to seek care, the high cost of the service, and the silence and na¿vity surrounding the subject of abortion.

- There is no public or private support or counselling services available for pregnant teenagers to assist them in choosing between having a safe abortion and continuing with their pregnancy.

Coordination between stakeholders

- There is no coordination and collaboration between the Ministry of Health and private abortion providers to ensure compliance with the Abortion Law and PRAKAS and the maintenance of quality abortion services.

12.3. Malnutrition and anaemia

12.3.1 Interventions

Policies and protocols

- The Ministry of Health has nutrition polices for the general population, but it does not have a

specific policy that addresses nutrition among youth and adolescents. Safe Motherhood policies and strategies address the nutrition needs of reproductive age women, which include adolescents.

Education

- There is no public health focus on nutrition education among adolescents, other than through the basic curricula at primary and secondary school level. If female adolescents do not complete primary school (the majority of rural female adolescents do not) then nutrition education is not discussed again until adolescents attend antenatal care during pregnancy.

Services

- There are no specific public health services that address prevention and treatment of nutritional problems, such as malnutrition and anaemia among adolescents, especially females.

- Pregnant women should receive iron and folic acid supplementation during antenatal care. Antenatal care attendance in Cambodia is low, which means that many pregnant women do not receive iron supplementation during pregnancy, resulting in anaemia at the time they give birth.

12. 4 Violence and sexual abuse

12.4.1 Interventions

Policies and regulations

- The Royal Government of Cambodia is a signatory to several relevant international instruments that protect individuals, especially women and children, from sexual violence and exploitation:

    - UN Convention on the Rights of the Child (CRC), Articles 34 and 35;

    - ILO Convention No. 182 concerning the Prohibition and Immediate Action for the elimination of the Worst Forms of Child Labour;

    - Convention of the Elimination of Discrimination against Women (CEDAW) Article 6;

    - Stockholm Declaration and Agenda for Action, 1996;

- Optional Protocol to the UN Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography; and

- Protocol to Prevent, Suppress and Punish Trafficking of Persons, especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime.

Being a signatory to the human rights instruments requires the Government to develop a national framework in which to implement the treaties' standards, usually by incorporating the principles of the treaties, such as the CRC into domestic law. More than 10 years later there has been no application of the CRC, for example, to protect the rights of the child.

- The Constitution of the Kingdom of Cambodia (1993) Articles 46, 48 and relevant laws, for example, the Law on the Suppression of the Kidnapping, Trafficking/Sales and Exploitation of Human Persons (1996), Articles 4 and 8, are in place to protect the human rights of women and children. The laws are not enforced by national and local authorities and the judiciary and they are being ignored by a large percentage of the Cambodian male population.

Education, information and communication

- There is limited population-based IEC material that raises awareness of children's rights, violence and sexual abuse and human trafficking for sexual exploitation. The information available is disseminated through radio, television, workshops and dramas, rallies and marches, production and dissemination of awareness raising materials such as posters, magazines, newsletters and calendars.

- There is no information about sexual and physical violence, abuse of power, sexual and reproductive rights, social and moral responsibilities and negotiation skills in the primary and secondary school curriculum.

Services

- There are limited counselling and support services and emergency rescue programmes for male and female youth and adolescents who are victims of sexual violence and

individuals who have been trafficked to work in the sex industry. The services that exist are grossly under-resourced.

- There are a few crisis and rehabilitation centres for victims of sexual and physical abuse or who have been trafficked to work in the sex industry. These initiatives are mainly in Phnom Penh and provincial centres and they are grossly under-resourced and struggle to meet the demand for their services.

- Adolescent-friendly services do not specifically target victims of physical and sexual violence and individuals who have been trafficked to work in the sex industry.

Coordination between stakeholders

- There is good coordination between the Ministry of Women's and Veteran's Affairs; Ministry of Social Affairs, Labour, Vocational Training and Youth; IOM; ECPAT; UNICEF; and local and international NGOs who work in the area of human trafficking for sexual exploitation. These agencies had developed strong professional associations and networks in Phnom Penh and in the provinces. They have well developed referral systems in Phnom Penh and in the provinces to assist victims and their families to reunite, and the victims to reintegrate into their communities.

- To date, there is no coordination between the Ministry of Health and Ministry of Women's and Veteran's Affairs and other stakeholders to address the reproductive health needs of youth and adolescents who are victims of sexual violence and human trafficking.

12.5 Poor knowledge of sexuality, reproduction and reproductive health

12.5.1 Interventions

Policies

- Basic education is free, but there are fees charged for private tuition and learning materials.

- Ministry of Education, Youth and Sport has no reproductive health policy for primary and secondary education or for the non-formal education system.

- Ministry of Health has no

reproductive health policy for youth and adolescents that include reproductive health education in schools, and community-based education initiatives.

Education

- Human reproduction, sexual development and HIV/AIDS are taught in primary and secondary schools, commencing in Grade 5. Sexuality, reproduction and reproductive health (mainly HIV/AIDS) are not addressed as stand-alone subjects, instead, they are taught as part of the general curriculum in subjects such as social studies and Khmer language.

- Reproductive health, in particular HIV/AIDS and STI, are taught by some NGOs in secondary schools in their project sites, mainly in Phnom Penh and provincial centres. This information is not always consistent with the Ministry of Education, Youth and Sport curriculum.

- Teachers have limited knowledge of sexual and reproductive health and related issues and are not seen by students as the most appropriate and reliable source of information. Teachers do not see themselves as the most appropriate source of information, especially about sensitive subjects such as sexuality and reproduction.

Information, education and communication

- Other than the ARHI in Cambodia, there are no IEC initiatives that specifically target reproductive health issues among youth and adolescents. The ARHI target in- and out-of-school and vulnerable youth and adolescents and they rely on PEs and CBEs to deliver community-based IEC activities.

- The ARHI community-based IEC activities have focused on HIV/AIDS and have not adequately addressed other reproductive health issues, such as sexual and physical violence, human trafficking for sexual exploitation, safe sex practices, negotiation skills, reproductive and sexual rights, substance abuse, social morality and personal responsibility.

- ARHI in Cambodia IEC activities tend to be in Phnom Penh and in provincial centers, and have limited contact with youth and adolescents in rural areas.

- The media (mainly the television and radio) has been a successful means of reaching youth and adolescents and providing them with health messages that address a wide range of reproductive health issues. Adolescents in rural areas who do not have access to a television and radio have limited access to these health education messages.

Services

- There are no government health services that specifically focus on youth and adolescent reproductive health issues. There is no IEC material or resources available for youth and adolescents in public health facilities that address reproductive health issues.

- Adolescents do not access public health services for IEC about reproductive health issues. Public health care providers are the last source of information that adolescents turn to when seeking information and advice about reproductive health matters.

- Adolescent-friendly services provide IEC in a variety of settings and use a multitude of media to address reproductive health issues. The clinical services and community-based education initiatives have been very successful and appreciated by adolescents who have accessed them.

Coordination between stakeholders

- There is limited collaboration and coordination between Ministry of Education, Youth and Sport and the Ministry of Health in the development of the reproductive health policy and education programmes for primary and secondary schools and the non-formal education system.

- ARHI partners in Cambodia coordinate their education activities and clinical services to ensure reproductive health messages and clinical services reach wide audiences of youth and adolescents.

12.6 Reproductive health and related practices

12.6.1 Interventions

Policies and regulations

- The 100 % condom use policy in venues that provide commercial sex

has been in place since 1999. This policy does not apply to indirect commercial sex workers.

- The national birth-spacing policy does not specifically address the contraceptive needs of youth and adolescents.

Information, education and communication

- Birth-spacing IEC messages focus on married women.
- Unmarried adolescents, especially those living in rural areas, have limited access to reproductive and sexual health IEC and practitioners.
- The sensitivities surrounding the subject of sexuality and reproduction in schools and community settings means that adolescents, especially females, are too shy to engage in discussions about reproductive health issues for fear of being labelled sexually active.
- HIV/AIDS and STI awareness campaigns have promoted condom use between males and CSWs, and not between couples in non-fee paying sexual relationships, this includes sex between married couples.
- Community-based education activities face difficulties accessing rural adolescents, especially females, because of the indirect project costs placed on adolescents, namely the need to assist with the family's livelihood.

Services

- There are no adolescent-friendly clinical services outside provincial centres that provide treatment for RTIs.
- Private practitioners, including traditional healers and drug sellers, provide treatment for STI. Adolescents prefer to access private practitioners instead of government health staff because of the privacy, cost and accessibility of their services.
- There are many barriers to adolescents seeking treatment for STI in public health facilities, for example, health staffs' attitude towards adolescent with reproductive health problems, the stigma and shame associated with having an STI, and the high cost of transport and treatment.

Coordination between stakeholders

- Collaboration and coordination between the ARHI in Cambodia and the NRHP and NCHADS initiatives is limited.
- ARHI in Cambodia has quarterly meetings with partner NGOs, and the NRHP is represented at these meetings.

13. Recommendations

13.1 Policies and guidelines

- The Ministry of Health should develop operational policies and guidelines that address reproductive health education in schools, and with out-of-school, vulnerable and mobile youth and adolescents.
- The Ministry of Health should provide technical support and institutional guidance to international and local NGOs who provide IEC and clinical services that address reproductive health issues to youth and adolescents, to ensure that operational policies and guidelines are followed.
- The Ministry of Health should collaborate with Ministry of Education, Youth and Sport and other related ministries and stakeholders to develop reproductive health policies and guidelines that address adolescent reproductive health in the primary and secondary curriculum and for non-formal education activities.

13.2 Education

- The Ministry of Health should collaborate with the Ministry of Education, Youth and Sport and relevant local and international NGOs to pilot education initiatives for out-of-school adolescents, including vulnerable and mobile populations, using appropriate teaching methods and adaptable models of delivering community-based health education. The education initiatives should aim to increase the functional literacy and numeracy skills of the adolescent learners and address priority public health problems, including reproductive and sexual health, violence and sexual abuse and illicit drugs use.
- The Ministry of Health and the Ministry of Education, Youth and

Sport should introduce adolescent sexual and reproductive health and related issues into the medical, nursing and midwifery curriculum.

- NRHP should include adolescents, especially unmarried adolescents, as a target group of the National Birth-Spacing Programme.

13.3 Information, education and communication

- The Ministry of Health should develop specific adolescent reproductive and sexual health IEC activities that engage a wider audience of adolescents, particularly in rural adolescents. The IEC activities should address reproductive and sexual health issues and include:
  - physical and sexual development and maturity;
  - prevention of an unwanted pregnancy;
  - anaemia and malnutrition;
  - birth-spacing;
  - safe abortion;
  - STI (aetiology, transmission, signs and symptoms and treatment);
  - care and support of people living with HIV/AIDS;
  - safe sex practices;
  - illicit drug use;
  - physical and sexual violence;
  - human trafficking and sexual exploitation of women and children;
  - negotiation skills;
  - reproductive and sexual rights and responsibilities; and
  - promotion of reproductive health services.

13.4 Services

- Government health services should advertise and promote adolescent-friendly services and activities through IEC materials and referrals by health staff.
- NRHP should include adolescents as a target group in the National Birth-Spacing Programme.

- The Ministry of Health safe abortion protocols and training programmes should include the specific needs of adolescents in terms of counselling and support, education and clinical care.

13.5 Collaboration and coordination

- The Ministry of Health should develop a national adolescent reproductive health coordination committee to ensure that adolescent reproductive health programmes are being delivered in accordance with ministry operational polices and guidelines.

13.6 Advocacy

- The Ministry of Health together with other relevant government ministries and stakeholders should advocate for the implementation of international human rights treaties of which Cambodia is a signatory, and the application of the Cambodian laws that protect the human rights of women and children, especially the most vulnerable groups.

- The Ministry of Health together with other relevant ministries and international and local NGOs should lobby the Government to halt corruption within the government and the judiciary and ensure that the perpetrators of sexual and physical violence and exploitation of women and children are prosecuted in accordance with the law.

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