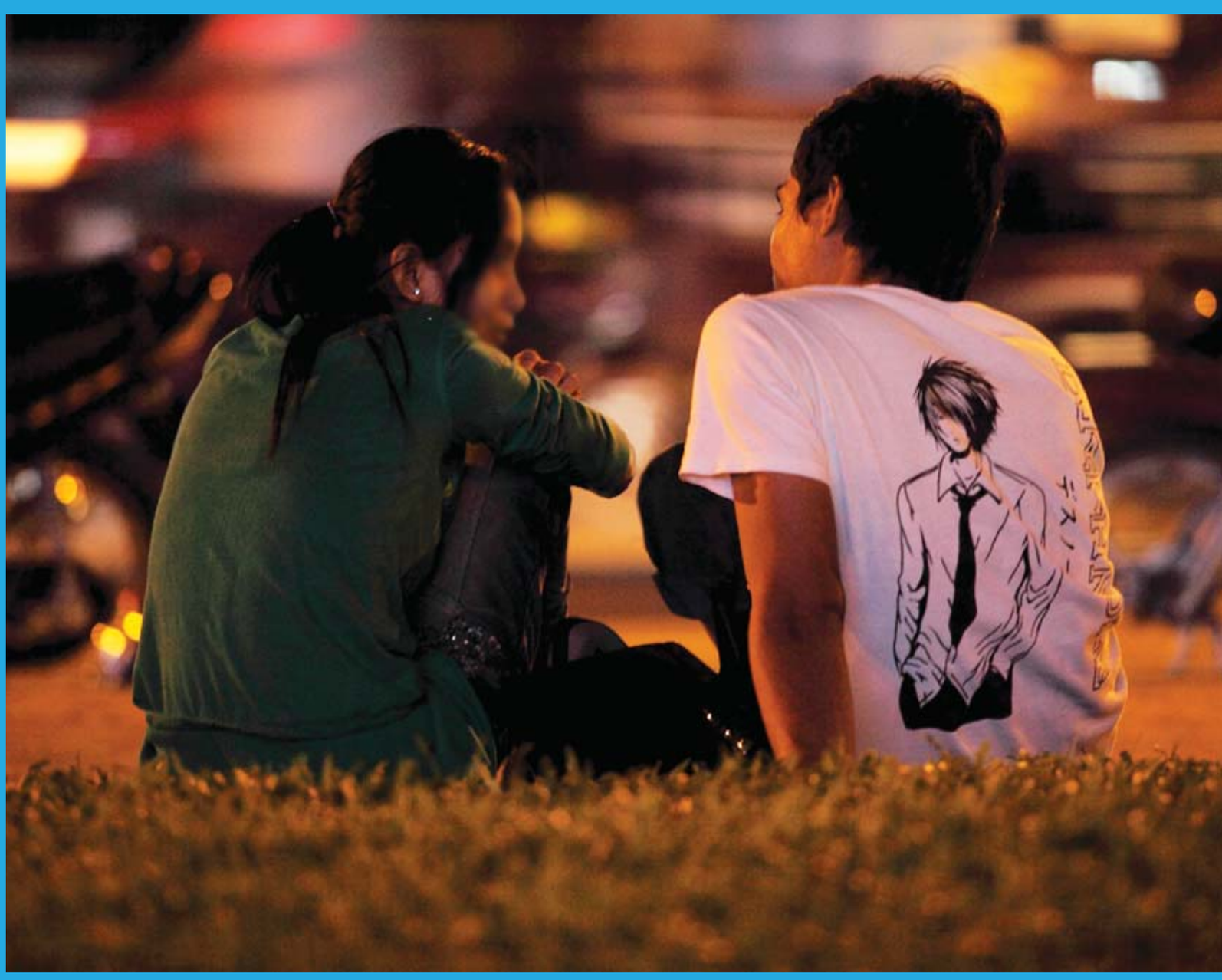
KINGDOM OF CAMBODIA

NATION RELIGION KING

MINISTRY OF EDUCATION, YOUTH AND SPORTS

MOST AT RISK YOUNG PEOPLE

SURVEY CAMBODIA 2010



MOST AT RISK YOUNG PEOPLE SURVEY CAMBODIA 2010

Photo Credit:

Front Cover and pages: 1, 3, 4, 7, 9, 14, 16, 17, 24, 58, 62, 68, 70, 117, 124 **© UNICEF/Bona Khoy/2010**
On page: 22, 23 **© UNICEF/Ulrike Gilbert/2010**
On page: 8, 69 **© UNICEF/John Vink Magnum/2007**
On page: 57,123 and inside back cover **© UNICEF/Axelrod/2010**
On page: 67, 113 **© PSI Cambodia/2010**
On page: 5, 121 **© PSI Cambodia/Bunsak But/2009**
On page: 6, 20, 21,109, 117 **©KHANA/2010**

Designed by Graphic Roots: www.graphicroots.com.kh

CONTENTS

Page

TABLES

FIGURES

LIST OF FIGURES

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ATS	Amphetamine Type Substances
BCC	Behavioral Change Communication
CDHS	Cambodian Demographic Health Survey
FGD	Focus Group Discussion
FHI	Family Health International
ICHAD	Inter-departmental Committee on HIV/AIDS and Drugs
IDI	In-depth Interview
IQR	Inter Quartile Range
KHANA	Khmer HIV/AIDS NGO Alliance
KII	Key Informant Interview
MARYP	Most at Risk Young People
MoEYS	Ministry of Education Youth and Sport
NGO	Non-Governmental Organization
PSI	Population Service International
PSU	Primary Sampling Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Diseases
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing
WHO	World Health Organization

FOREWORD

Cambodia has one of the most youthful populations in South East Asia with about 35% of a total population of 13.4 million between the ages of 10 and 24 years. A key problem faced by young people is the need for economic migration from family and community. This exposes young people to unsafe behavior related to drug use, alcohol and unsafe sexual practices that can lead to HIV infection. The at risk young people are also not benefiting from sexual and reproductive health services where they are living and working.

In this context, the Inter-departmental Committee on HIV/AIDS and Drugs of the Ministry of Education, Youth and Sports initiated research to inform a program of education especially teaching and learning methodologies for teachers and student strengthening to identify the best methods to mitigate the strong challenging issues that make it unsafe for young people in Cambodia.

Cambodia's Most at Risk Young People Survey (MARYPS) 2010 is a follow up survey of the Youth Risk Behavior Survey conducted in 2004 (although it uses different methodology). This survey is jointly supported by FHI, PSI, UNAIDS, UNESCO, UNFPA, UNICEF and WHO. The South East Asia and Pacific Technical Support Hub of KHANA (TS Hub) was responsible for the implementation of the survey with guidance from the MARYPS Steering Committee.

The survey report includes information on demographic characteristics, alcohol, drug use and sexual relationships and utilization of health services. FGD and IDI guides were desinged to explore MARYP's perceptions and preferences, the survey teams have collected quantitative data from 1,236 female and 1,253 male young people aged between 10 and 24 and qualitative data from six focus group discussions (FGD), 12 in-depth interviews (IDI) and four key informant interviews in eight provinces in Cambodia. These findings may not be representative of youth in school.

This survey was carried out under the management of Ms. PAULA GLEESON, the TS Hub Manager, with guidance from the Steering Committee of MARYP survey, Mr. TUOT SOVANNARY, Research Coordinator, Dr. SAPHONN VONTHANAK and Dr. CHHEA CHHORVANN, the Principal Investigators responsible for leading the survey team and the data analysis.

We hope that the results of this survey will provide intensive significance to national and international institutions and organizations working on policy and planning on the prevention of HIV; with most at risk young people on prevention of alcohol use, drug use and sexual engagement including using sexual reproductive health services; and especially youth out of school.

Phnom Penh 13 October 2010

Minister for Education, Youth and Sports

IM SETHY

ACKNOWLEDGEMENTS

Cambodia's Most at Risk Young People Survey (MARYPS 2010) represents continuing commitment and efforts to obtain data on our young population and their health and their risk to HIV infection and drugs. This survey was done to seek the significant issues and possible solutions to help most at risk young people (MARYP).

We gratefully acknowledge the support, guidance and encouragement for this survey extended by: HE Im Sithy, Minister for Education Youth and Sports and HE. Mak Vann, Secretary of State for Ministry of Education, Youth and Sports and Chair of the Steering Committee.

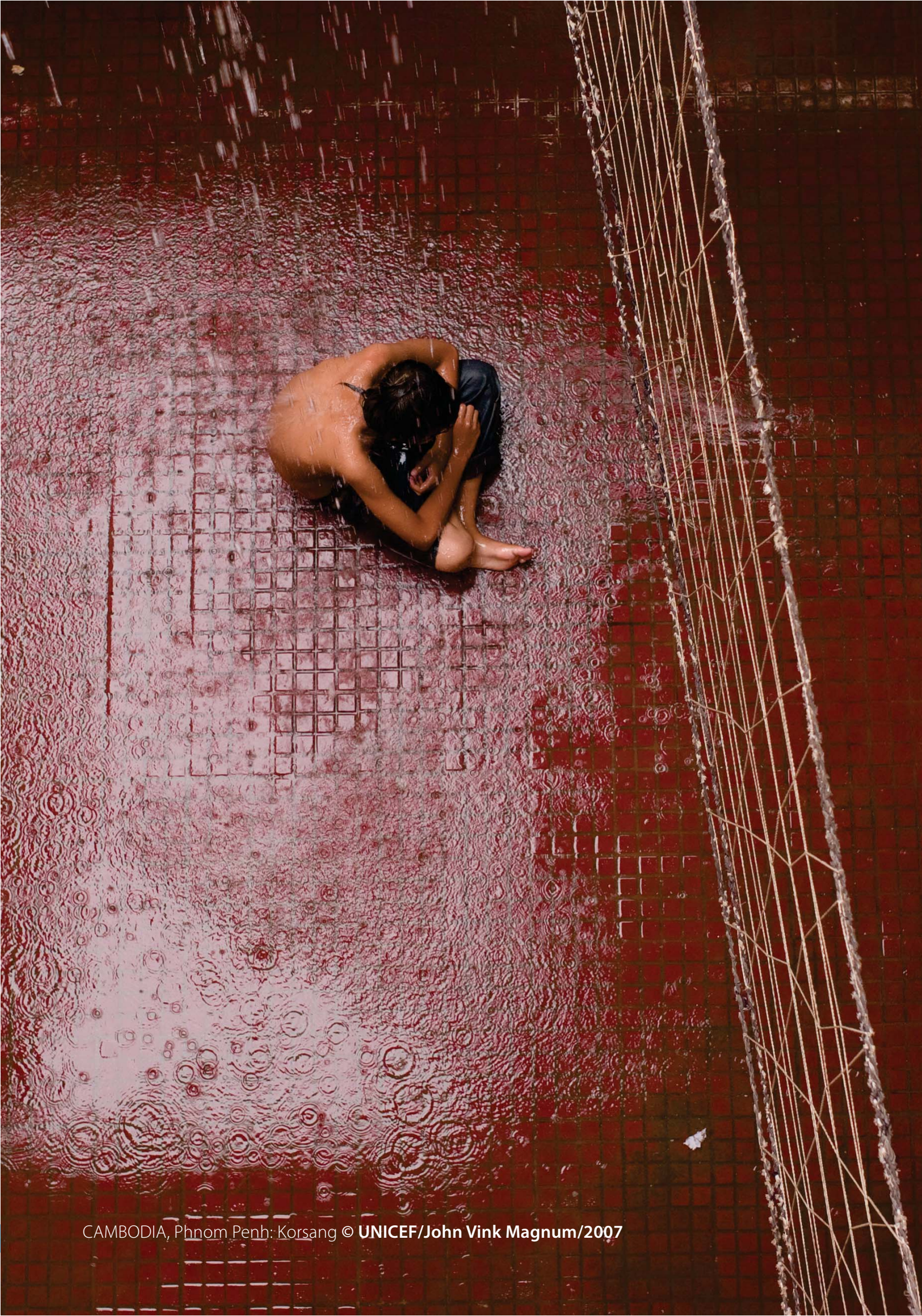
We would like to thank FHI, PSI, UNAIDS, UNESCO, UNFPA, UNICEF, WHO and The South East Asia and Pacific Technical Support Hub of KHANA (TS Hub) for providing financial and technical support for this study.

We would like to express our appreciation for all team leaders, and interviewers, local coordinators, mapping teams and the young people advisory group whose dedicated efforts ensured the quality and timeliness of the survey. We also highly acknowledge all respondents for contributing their time and for sharing their stories, enabling us to produce high-quality data for the country.

We also gratefully acknowledge all of the steering committee members including the representatives of FHI, Friends International, Korsang, Mith Samlanh, NAA, NACD, PSI, UNAIDS, UNESCO, UNFPA, UNICEF, UNODC and WHO, and their staff for their technical support and guidance throughout the survey activities.

Our special thanks go to UNICEF who, on behalf of the UN family managed the technical, administrative and financial process.

This survey could not have been implemented without the active support and the efforts of Ministry of Education Youth and Sports, many institutions, Development Partners, NGOs and Youth Advisory Group in Cambodia.



CAMBODIA, Phnom Penh: Korsang © **UNICEF/John Vink Magnum/2007**

EXECUTIVE SUMMARY

The 2010 Cambodia Most at Risk Young People Survey (MARYPS 2010) is a follow up of an earlier survey conducted in 2004 in Cambodia to obtain data on the situation, behaviors and sexual and reproductive health of most at risk young people (MARYP). The goal of the survey was to provide the policymakers and planners with reliable data on alcohol, drug and sex related behaviors and utilization of sexual and reproductive health services among MARYP. It should be noted that this survey and its findings are about MARYP, not young people in general in Cambodia. MARYP are understood as young people whose behaviors put them at greater risk of HIV infection, including multiple unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with non-sterile equipment (UNFPA 2008). The term MARYP is used throughout this report to include young:

- Male and female injecting drug users (IDUs) who use non-sterile injecting equipment
- Males who have unprotected anal sex with other males
- Females and males who are involved in sex work, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex
- Males who have unprotected sex with sex workers

Therefore, a hotspot approach was used to learn about young people between 10-24 years who may have risk behaviors and are especially vulnerable.

STUDY DESIGN

A mixed method approach was used including both qualitative and quantitative techniques. The qualitative methods, including six focus group discussions (FGD), 12 in-depth interviews (IDI) and four key informant interviews (KII), were conducted by young people to explore the determinants of HIV-related risk behaviors among MARYP, and their perceptions and preferences of sexual and reproductive health information and services. The quantitative method involved a cross-sectional study using multi-stage stratified cluster sampling to collect information from 1,236 female and 1,253 male young people aged between 10 and 24 in eight provinces. Provinces with characteristics that suggested populations had high rates of HIV-risky behavior (and therefore HIV acquisition) were selected. These characteristics included high in cidences of rape, human trafficking, migration, number of sex workers and men who have sex with men (MSM). Mapping of hot spots, or times and locations where young people are likely to gather, was carried out by a team of young people, enabling identification of potential survey participants. Face-to-face interviews conducted by young researchers using a pre-coded questionnaire, combined with FGDs and IDIs.

The survey was guided by a Steering Committee chaired by ICHA with key stakeholder representatives of those working with MARYP. A Youth Advisory Group was also convened to inform each stage of the research and its findings.

FINDINGS

In this survey the socio-economic characteristics of populations located at hotspots were similar to those reported in other studies in terms of place of residence, educational status, family structures and living circumstances (NIPH et al 2006).

Understanding what MARYP value most in life and how this drives their behavior was framed by three key influencing factors: self belief, peer belief and behavior, and family, community and societal factors. Each of these key factors is equally critical to understanding and designing programs for MARYP.

MARYP do not give high value to education. Most highly valued were happiness, popularity with peers, personal appearance and the possession of materialistic items.

Approximately 70% of female and 91% of male respondents reported drinking alcohol, which was often perceived as a way of socializing among their peers. Drinking alcohol was used for celebration as well as for coping with stress. Respondents believed that drinking alcohol makes them look fashionable or rich. Accessibility of alcohol was also cited as an influencing factor in drinking, as was the consumption of alcohol within families and their communities. Almost all respondents knew about the harmful effects of drinking alcohol, but this did not influence their drinking behavior.

Regarding drug use, 3.5% of female respondents reported 'ever using illicit drugs' while 15.2% of the male group reported so. Yama, yaba or methamphetamine-based powder (most commonly referred to as Amphetamine Type Substances - ATS) were the most popular drugs used. Injecting drug use was not common. The reasons cited for using illicit drugs were peer pressure, onerous working conditions, for pleasure or to cope with stress. Also cited were the difficulties of the family and social factors such as drug use in the family or communities. Those who reported using drugs shared drugs with their friends, with a very low percentage using drugs alone or with their sexual partner. Some MARYP displayed misconceptions about the benefits of using drugs and a lack of knowledge of the harmful effects of drug use. They were largely unaware of any drug rehabilitation or treatment programs that might be available to them with 17% of male and 33% of female respondents unable to identify where to go if they want to stop using drugs.

Over 41% of male and 23% of female study participants reported being sexually active. Age differences with first sexual partner varied according to gender with males reporting no age difference, and females' first partners being on average five years older. Among those who reported 'ever having sex', commercial sex engagement was very high among males (83% reported paying for sex with women in the past year). However consistent condom use with commercial sex workers in the past three months among males was also high (up to 89%). Social factors such as the wide availability of pornographic films and commercial sex were commonly reported by male MARYP. Heterosexuality was reported as the sexual preference for the majority of both males and females.

In general, MARYP recognized some contraceptive methods and they were also able to correctly list places from where different health services can be obtained. However, there were some examples demonstrating a lack of specific knowledge about health services or misunderstanding about how to correctly use contraception.

Rates of involvement in sweetheart relationships were high (56% and 66% in females and males respectively) with those in the older age groups (20-24 years) residing in urban areas more likely to report being in such relationships. However, condom use with sweethearts in the last three months was alarmingly low at 31% and 58% for females and males respectively. Many MARYP

believed that having sweethearts made them look fashionable or trendy. Other reasons cited for having sweethearts included: sex, companionship, money, attention or admiration from their peers.

Factors reported to be associated with high risk behaviors were; family issues, peer pressure and poverty. Social-environmental factors such as the exposure to alcohol, drugs or pornography at younger age or living in an unstable family were also reported by MARYP as reasons for their high risk behavior. A lack of either money or employment was reported as a significant cause of vulnerability for female MARYP to engage in high risk behavior.

There are strong interactions between all risk behaviors. Sexually active MARYP, both male and female, reported higher percentages of drug and alcohol use than MARYP who were not sexually active. While almost 14% of female MARYP who were sexually active reported 'ever using drugs' only 0.4 % of female MARYP who never had sex reported so. Similar patterns are observed among their male counterparts. The association between sexual activity and alcohol is also observed but to a lesser extent.

Regarding health services available to MARYP, there were calls for stronger collaboration and coordination between civil society and government stakeholders to ensure that all the programs for young people respond appropriately to the needs of young people and to ensure the sustainability of those programs. In this study, MARYP reported little knowledge of the services available and a reluctance to use public clinics. The main barriers to using health services reported were shyness, concerns for confidentiality, non same sex health providers, long waiting times, and transport or service fees. The MARYP reported a preference for private or NGO run clinics.

Almost 32% of female, sexually active MARYP, had never received a condom and 37% had not received HIV/AIDS information in the past three months. This indicates a significant gap in prevention programs. In contrast, 10.7% sexually active male MARYP never received a condom and 19.7% had not received HIV/AIDS information in the past three months.

Among those who reported having STI symptoms in the past year, up to 43% of female and 30% of male participants did not seek any treatment at all. Abortion was reported among female MARYP who had been pregnant. Up to 12% of female participants who had had sex reported that they had become pregnant, among which 33% experienced induced abortion. Only 21% and 17% of female and male respondents respectively, reported having an HIV test in the past year.

RECOMMENDATIONS

MARYP programming must:

- Understand who is at increased risk, why (personal motivation and structural determinants) and where young people most at risk are located ("hotspots")
- Be appropriate to age, psychosocial development, education level and address the differing needs of males and females
- Address multiple and often overlapping risk behaviors of unsafe sex, alcohol and drug use.
- Use comprehensive approaches which include information on HIV prevention and treatment, sexual and reproductive health services and condoms - in a form young people can understand; harm reduction and drug treatment services (if injecting); services for the prompt diagnosis and treatment of STIs; and HIV counseling and testing, with referral for treatment and care if HIV positive and HIV prevention counseling if HIV negative.
- Promote links to livelihood development opportunities as well as initiatives which support MARYP networking.

- Apply a human rights based approach so that MARYP and those young people living with HIV enjoy the same rights as other young people.

- Employ measures to reduce their social exclusion and inequities experienced by many MARYP and their families. Thus facilitating MARYP's participation in program planning, implementation and monitoring would go a long way in positively role-modeling their inclusion.

- Monitor disaggregated program level and routine data by age, gender, HIV risk behavior and use of services to show whether programs for most at risk young people are reaching them.

- Facilitate legal and psychosocial support and access to alternative education opportunities.

- Address issues of child protection when adolescents under 18 are in situations of sexual exploitation and abuse. In such cases, they need access to child protection services and support to get out of the exploitative situation.

- Develop risk reduction skills among MARYP to help them negotiate condom use in relationships, develop strategies for refusing unprotected sex and avoid clients/partners who are alcohol or drug affected and potentially violent.

- Create protective environments, which support responsible behavior and reduce vulnerability, by engaging school staff, local authorities, police, social workers and parents.

- Consider the use of popular role models and innovative modern materials/items to promote protective behaviors among MARYP.

- Employ family based approaches and support parents of MARYPs to talk with their children about sex education, taking responsibility and overcoming peer pressure and harmful gender norms.

- Strengthen programs creating and supporting community networks for most at risk young people and their families, and link these to appropriate and accessible referral services.

- Engage well trained and motivated young people as peer educators (who are similar to the target group in terms of age, gender, background and interests) working in a group or with existing social networks, as they are more likely to have greater influence on MARYP behavior than those who are not similar to the target group or working alone.

- Create effective partnerships with community based organizations and use peer networks and counselors, including to refer MARYP for health services.

- Review school curriculums and teacher training to include up to date information on the harmful effects of drugs and alcohol and to expand life skills training, with a focus on risk reduction skills, to empower young people to take responsibility, avoid drugs and delay the initiation of alcohol use and sex.

Specific to alcohol related behavior

- Programs targeting female MARYP working in the entertainment industry should consider including information on the harmful effects of alcohol while addressing workplace health and safety. Consideration could also be given to engagement of the private sector owners and managers of the outlets where young women work.

Specific to drug related behavior

- The overwhelming preference for ATS by MARYP confirmed the need for dedicated ATS prevention, treatment and harm reduction programming.

Specific to sexual related behavior

- Rates among sexually active MARYP in this study confirm that condom use is not consistent with

sweethearts for both young men and women; this is compounded with age mixing for female MARYP during their sexual debut. This reiterates the need for appropriate messaging around consistent condom use and VCCT among this vulnerable population. Also the need for more training on sexual health.

Specific to sexual and reproductive health and other social services

- In the higher prevalence or hot spot areas, efforts should be made to build the capacities of both private and public health service providers (including pharmacies, NGOs and others) to better cater to the needs of MARYP.

- To prevent unwanted pregnancy among sexually active MARYP, programs offering referral to reproductive health services (private and public) should be strengthened.

- Adolescent access to psychological counseling services for young people in and out-of-school should be strengthened, with specific services for young women and girls, drug users and MSM.

Policy makers

- Integrated services for MARYP in urban hot spot areas should be advocated for. MARYP have expressed a preference for private or NGO health services, which could be integrated through referral to other social services such as alcohol and drug treatment, and vocational opportunities.

- Smoking and alcohol free-zones should be established in areas where young people gather.

- The sale of alcohol and cigarettes to minors should be banned and penalties imposed on those who are caught selling to minors.

- Community mobilization should engage with establishment and guest house owners, and local authorities to promote safer behaviors and environments for MARYP.

- Strengthen the implementation and respect for human rights broadly without discrimination.

Researchers

- Review legal and policy barriers which impede young people's access to correct HIV information and medical services, particularly for adolescents under the age of 18 years. Conduct a detailed policy and legislative review on regional best practices in limiting the sale of alcohol to young people needs to be conducted.

- Program mapping surveys and participatory action research with MARYP to document the status of services and program implementation should be carried out.

- Secondary analysis of existing data looking at protective factors and drivers of high risk behavior would be advantageous.

BACKGROUND

According to the UNAIDS 2009 AIDS Epidemic Update, it was estimated that by the end of 2008 there were 33.4 million people living with HIV (PLHIV) globally and that those aged 15-24 years account for 40% of all new infections (UNAIDS 2009). While the epidemic affects populations around the world differently, across all populations, adolescents and young adults, and particularly young women, have been identified as the most vulnerable to HIV. This is exacerbated by the fact that only 40% of young people in the same age group have accurate knowledge about HIV and transmission. The lack of a protective environment and high risk behavior puts young people at risk of HIV. Those behaviors include multiple unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with non-sterilized equipment. Helping young people avoid infection is seen as crucial for social and economic development. However, it has been recognized worldwide that reaching those who have never been to school or who have dropped out early and left the formal education sector represents a particular challenge.

The HIV epidemic in Cambodia spread rapidly following the first confirmed case in 1991, with prevalence levels peaking at about 3% in 1997-98. After more than ten years of intensive prevention activities, prevalence began to decline in 2003 and by 2006 HIV prevalence was estimated to be 0.9% (NCHADS 2007). Despite this encouraging development, however, Cambodia risks facing a second wave of the epidemic among populations who practice HIV-risky behaviors such as injecting drug users; female entertainment workers and their clients; and men who have sex with men (NAA 2007). Though a significant proportion of these groups are adolescents and young people, few age-appropriate interventions are in place.

With young people in the age group 10-24 years comprising 35% of the population, Cambodia has the youngest population in Southeast Asia (NIS 2009). One of the critical issues confronting this population is employment. Despite recent rapid economic growth, youth unemployment is high. Rural-to-urban migration of young people has also been observed in Cambodia. While migration represents new job opportunities, it also removes young people from the safety of family and community, and exposes them to possible high-risk behavior associated with dislocation in urban areas.

The Cambodia National Youth Risk Behavior Survey conducted in 2004 provides some insight into young people's vulnerability to HIV. The survey found that only 50% of young women aged 15-24 years and 45% of their male counterparts had comprehensive knowledge about HIV and 33% of young people surveyed said they knew young men who took part in gang rapes (MoEYS 2004). This survey also highlighted that out-of-school young people tend to engage in more risky behavior than those attending school.

A recent review of the youth situation in Cambodia (UN Country Team 2009) revealed that the rural-to-urban migration of young people for employment and education contributes to their exposure to sexual and reproductive health risks, including increased risk-taking behavior associated with HIV infection. Migration also led to other health development risks, including drug abuse and gender-based violence.

Behavior of concern included tobacco use (13.6% of 15-24 year-old males and 0.8% of females) and alcohol consumption (20.9% of males and 7.4% of females). Many young people say they first consumed alcohol as early as 12 years of age. The review also found that more than 80% of known drug users are below the age of 26 years.

Although Cambodia has become a country with a concentrated epidemic, HIV infection rates among high-risk sub-population groups are still a matter of grave concern. Although estimates suggest that HIV prevalence among female sex workers has declined from 21.4% in 2003 to 14.7% in 2006, the 2008 Law on the Suppression of Human Trafficking and Sexual Exploitation mean that HIV infection rates among this group need to be closely monitored. This is because the legislation has resulted in the closure of brothels and a growing number of women selling sex in entertainment establishments such as beer gardens, karaoke bars and massage parlors. As a result, these women, often young, are much more difficult to reach with HIV prevention interventions such as condoms, HIV and STI information, as well as health service referral. Moreover, aggregated data from three sites show an HIV prevalence of 4.5% among MSM and preliminary national data show an alarming prevalence of 24% among injecting drug users (UNGASS Report, 2010). Again, many of these high risk groups are young people under the age of 24 years.

The 2005 Cambodian Demographic Health Survey (CDHS) indicated that the incidence of unplanned pregnancy in the 15-19 year age group has also become a concern. Approximately 8% of Cambodian women aged 15-19 years have become mothers or are currently pregnant with their first child. About 23% of young married women had given birth by the age of 19 years, with early childbearing more common in rural (8.3%) than urban (6%) areas. In addition, abortion among women appears to be increasing. The percentage of women aged 15-49 years reporting an abortion increased from 5% in 2000 to 8% in 2005. Among women aged 15-34 years, the most common place to get an abortion was at private clinics (35.3%), followed by other homes (33.7%), private homes (11.5%), and public health facilities (10.8%). The proportion of women who received help for abortion from a trained professional was 87.3% among urban women and 76.1% among rural women (NIPH et al 2006).

These critical health and HIV related indicators, together with the need for current and practical evidence for programming, set the backdrop for research addressing multiple risk behaviors and risk settings among MARYP in Cambodia.

OBJECTIVES

The overall objectives of the survey were:

- To assess the multiple risk behaviors of MARYP in eight selected provinces in Cambodia.
- To explore MARYP's perceptions and preferences in terms of SRH information and services.

To achieve the above objectives, the survey explored the following:

- To determine the risk behaviors related to drug and alcohol abuse, unprotected sex and sexual violence.
- To assess knowledge on sexual and reproductive health, and health-seeking behavior.
- To assess knowledge on sexual and reproductive health services and their accessibility.
- To explore levels of satisfaction with sexual and reproductive health services.

METHODOLOGY

1. QUANTITATIVE COMPONENT

A. Survey population

The study followed the United Nations global definition which defines young people as aged 10 to 24 years. Globally MARYP are understood as young people practicing behaviors which expose them to the risk of HIV acquisition. As they are difficult to identify, hotspots where MARYP are known to congregate were mapped and participants were recruited from these populations. Inclusion criteria for survey participants were:

- Male or female aged 10-24 years
- Present in the selected hotspot
- Agree to participate in the survey

For the purposes of this survey, 'hotspots' were defined as locations, in higher HIV prevalence provinces, where young people frequently hang out and which are commonly associated with high risk behaviors and/or meeting new sexual partners. Hotspots were defined as one of the following locations:

- bars,
- karaoke parlors,
- massage parlors,
- street corners
- places where youth frequently gather (football field, skating field…)
- public parks,
- snooker clubs,
- computer game shops.

B. Survey sites

Eight provinces in Cambodia (Battambang, Banteay Mean Chey, Kampong Cham, Siem Reap, Phnom Penh, Preah Sihanouk, Koh Kong, and Svay Rieng) were identified as priority sites for the study based on the criteria shown in Table 1. In those eight provinces, hotspots were identified and selected for the survey.

TABLE 1 CHARACTERISTICS OF SELECTED PROVINCES BY SELECTION CRITERIA

CRITERIA \ PROVINCES	PNP	BTB	KCM	SRP	BMC	SVR	KoK	SHV
Higher number of rape cases (out of 1499 cases countrywide) 2007-08	75	193	161	127	110	28	39	29
Border area		X	X		X	X	X	
High number of human trafficking victims out of total 149 cases 2007-08	52	36	5	16	3	1	3	13
High number of sex workers	X	X		X	X			
High number of youth hostels and guesthouses	X	X		X	X			
Major tourist destination	X	X		X	X			
High HIV prevalence among sex workers 2006	11.3	20.6	11.1	20.4	30.7	10	20.7	26.7
Large population of MSM	X	X	X	X	X			

NOTE: BTB: Battambang, BMC: Bantey Mean Chhey, KPC: Kampong Cham, PNP: Phnom Penh, SRP: Siem Reap, SVR: Svay Rieng, SHV: Sihanouk province, KoK: Koh Kong

C. Sample size estimation

The sample size for this survey was calculated based on the expected prevalence of several factors to be measured in this survey. The findings from the National Youth Behavior Survey 2004 (MoEYS 2004) were used as a proxy for the expected prevalence in this estimation. Assuming that the lowest estimated prevalence the survey sought to estimate was 5%; with a 2.2% margin of error, a 5% significance level and a design effect of 1.5, the sample size required for each male and female group was 1,260 participants taking into account 12% refusal rate. In order to enable a deeper analysis on two separate age groups, half of the study participants were aged between 10 and 19 years.

D. Sampling strategy

A two-stage cluster sampling method was used in this survey. Primary sampling units (PSU) were chosen at the first stage of sample selection and individual respondents were chosen from within each of the selected PSUs at the second stage.

Primary Sampling Units (or clusters) were any identifiable site or location where respondent group members congregate. In this survey PSU were defined as a "hotspot". Since the survey populations were not associated with a site, but come and go freely from the sites, a time-location sampling method (which is suitable for a 'floating' population to generate hotspot mapping) was used. By using this method, PSU were defined not as the geographic site alone but were conditional on the time of the day/week/month at which sampling took place.

For each stratum, 63 clusters were selected using an equal probability sampling method. At the second stage, 20 respondents were randomly selected from each cluster. From each cluster, half of the selected respondents were aged from 10-19 years.

E. Survey tool

Data were collected through face-to-face interviews using a structured questionnaire. The main topics covered were: 1) Socio-demographic information; 2) Risk behaviors related to drug and alcohol abuse, unprotected sex and sexual violence; 3) Knowledge of sexual and reproductive health and health-seeking behavior; and 4) Knowledge about sexual and reproductive health services and their accessibility.

F. Sampling frame development

Hotspot mapping (including date and time) was carried out from December 15 2009 to January 1 2010. This intensive work involved 34 field workers coming from 13 organizations in the KHANA network and other NGOs in the eight selected provinces. All mapping field workers were trained for one day on the study protocol. At the training they discussed the definition of a hotspot and developed plan of action for hotspot mapping in their respective provinces. At the end of the workshop, each mapping team received a standardized mapping template for data collection. Close supervision was provided by the principal Investigators and the study team during the mapping process.

2. QUALITATIVE COMPONENT

A. Data collection method

Qualitative methods were specifically designed to obtain a deeper understanding of adolescent life, causes and consequences of alcohol and drug use, sexual behaviors, and the use of health services. The qualitative data collection targeted single gender groups of adolescents in different age groups (10-14 years, 15-19 years, and 20-24 years) and key program providers. Within each age category, purposive sampling was used to select participants. IDI, KII and FGD were conducted.

B. Data collection tools

All FGDs were conducted using gender-specific, guided questions for male and females. For IDIs, only one generic guided questionnaire was used for both male and female adolescents. Another set of questions was prepared for the KIIs (See Annex G for guided questions).

A further participatory tool, to aid discussion and critical reflection with the young people in the group discussions was used. Embedded in each FGD was a drawing of a tree with its roots as causes and branches as consequences. This allowed participants to reflect and explain the causes and consequences of using alcohol, using drugs, and having sex.

3. ETHICAL CONSIDERATIONS

The study was reviewed and approved by the Cambodian National Ethics Committee for Health Research on December 4, 2009.

Verbal consent was sought from the study participants before the start of the interview or discussion. Interviewers signed the consent form to confirm that the study participants had been briefed about the study, assured of their confidentiality, and had given their informed consent to participate in the study. Study participants were also informed of the option for escorted referral to appropriate existing government and non-government services in the province if they so wished.

During the research analysis and report writing all study data was kept in a locked file cabinet which only the principal investigators had access to. Study data was analyzed by the principal investigators (PIs) and stored on the study computer with password. The complete data set will be passed to UNICEF on the completion of this report.

4. TRAINING AND FIELDWORK

The training was conducted over four days. The first two days of training were devoted to explaining the study protocol, and the male and female questionnaires. Day three was devoted to discussion on the participatory tools for FGDs and IDIs. After

three days of training, all field teams had one morning of field practice. The afternoon of day four was spent reviewing the sampling technique, consent form, and organization of documents.

The fieldwork was implemented by four quantitative field teams (two male and two female teams). Quantitative field teams were composed of five people: A team leader and four interviewers. There were two qualitative teams (one male and one female) composed two people: one interviewer and one assistant.

The teams were responsible for collecting quantitative data from 252 survey clusters and qualitative data from six FGDs and 16 IDIs in eight provinces. Data collection was conducted from 13 January 2010 to 5 February 2010.

A fieldwork supervision plan devised by the survey coordinators guided regular field supervision visits. In addition, a quality control program was run by the supervisor team to detect key data collection errors for each team. Based on these data checks, regular feedback was given to each team based on their specific performance.

5. DATA PROCESSING AND QUALITY CONTROL

Data entry personnel attended questionnaire training to become familiar with the survey instruments. Data processing personnel included a data processing chief, four assistants, and ten entry operators. Proper accounting of questionnaires was accomplished on a per-cluster basis. Questionnaire data were entered using EpiData. All questionnaires were entered twice to minimize data entry error.

A cluster analysis method was used to analyze survey data. Overall descriptive analysis stratified by gender, age group and location was performed using STATA (Statistics/Data Analysis) version 11.0. In addition, data presented in this report was weighted to account for the stratification and sampling methodology used in the survey implementation design.

All qualitative interviews performed were tape-recorded, with consent from the participants. The interviewers transcribed the tapes. The transcripts were validated to the tapes. The validation was performed by the survey coordinators and PIs.

The qualitative descriptive analysis was performed by the PIs. Meaning units were identified based on their relevance to the objectives of the survey and coded using NVIVO 8 software. Codes were grouped to create themes. In addition, free coding was used to allow new themes to emerge during the process of data analysis.

The main objective of the qualitative study was to deepen the understanding of MARYP. Therefore, the qualitative analysis intended to provide rich information on the motivation and life experience of MARYP, not all young people in general. The analysis framework was framed by three factors as they relate to MARYP: self, peers, and family, community and society.

6. SAMPLE COVERAGE

All but one of the 252 clusters selected for the sample were surveyed in the 2010 MARYPS, yielding a response rate of 99.6 % (Table 2). In the 251 hotspots surveyed, 1,271 women and 1,312 men age 10-24 years were identified as being eligible for the individual interview. Interviews were completed with 1,237 and 1,253 of these women and men respectively, yielding a response rate of 97.3% and 95.5% respectively. In both the male and female groups, young people aged 10 to 14 years represented less than 15% of the 10 to 19 years age group and less than 6% of the total young population who participated in the study.

TABLE 2 NUMBER OF HOTSPOTS, INTERVIEWS, AND RESPONSE RATES BY AGE GROUP

	AGE GROUP		
	10-19	20-24	TOTAL
Hotspot interviews			
Number of Hotspots selected	126	126	**252**
Number of Hotspots interviewed	126	125	**251**
Hotspot response rate (%)	100.0	99.2	**99.6**
Interviews with young female respondents			
Number approached	645	626	**1271**
Number interviewed	624	612	**1236**
Eligible female response rate (%)	96.7	97.8	**97.2**
Interviews with young male respondents			
Number approached	678	634	**1312**
Number interviewed	629	624	**1253**
Eligible male response rate (%)	92.8	98.4	**95.5**

Five to eight participants were invited to join each FGD and there was one FGD for each stratum of age group and gender. One service provider in each of four provinces (Battambong, Phnom Penh, Svay Rieng and Sihanouk) was interviewed as a KII. Only young people who were known to have high-risk behaviors, (using drugs, drinking alcohol, sexual experience) were invited into FGD and IDI. Three openly HIV positive people participated in IDI.

TABLE 3 SUMMARY OF DATA COLLECTION BY GENDER AND AGE GROUP

	NUMBER OF SESSION						TOTAL
	FEMALE			MALE			PARTICIPANT
	10-14	15-19	20-24	10-14	15-19	20-24	
FGD	1 (BMC)	1(KPC)	1(SRP)	1(BTB)	1(PNP)	1(KoK)	36
IDI	2(SHV and PNP)	2 (BMC and BTB)	2 (KPC and SVR)	1 (KPC)	3 (KoK, SVR and SRP)	2 (PNP and SHV)	12
KII							4

MARYP Survey, January 2010 © KHANA/2010

LIMITATIONS

The reader should note the following when interpreting some of the findings. The populations targeted in the study are MARYP; therefore, they do not represent young people (10 to 24 years) as a whole.

Since this survey included only eight provinces which were purposefully selected to include a higher likelihood of having MARYP, the findings from this survey are not nationally representative even within MARYP. However given that probability sampling was used for the sample selection and the careful mapping of hotspots using time-location method coupled with very low refusal rate, the findings are representative of MARYP within the eight selected provinces.

Due to the fact that the sample size was calculated based on the assumption that the lowest estimated prevalence of any risk factors of the survey was 2.2%, should some of the population estimates be lower than this figure, it is difficult for the survey to precisely estimate that prevalence. However the size estimation is not comprehensive.

It should also be noted that zero prevalence estimated by the survey does not mean there are zero cases of the variable in the population. This just reflects that no variables of interest were found in the sample population.

Since face-to-face interviews were used to collect some sensitive, personal information, there may have been some social desirability bias.

Should further exploration of this data be carried out by researchers or academic professionals, one should be cautious because the sample size can become very small and the estimation can become very unstable.

As this is a cross-sectional study if one intends to look at causal relationship between different factors in this dataset, temporal relationships between those factors should be examined carefully. This is because the design of the survey makes it difficult to tell whether the exposure factor precedes the outcome factor.

The design of the qualitative tool was not flexible enough to allow an opportunity to perform data analysis during the data collection period. The interview could not be tailored to explore additional information on new themes that unexpectedly emerged during the data collection. Furthermore, each qualitative session lasted over two hours and this placed real challenges on the data collector to maintain the necessary level of interest in the study participants throughout the interview.

Team meeting with interviewers © **UNICEF/Ulrike Gilbert/2010**

FINDINGS

Throughout this section, percentages in the tables and narrative of the quantitative findings reflect weighted percentages. Estimates based on an insufficient number of cases are shown in brackets or not shown at all.

HOTSPOT POPULATION CHARACTERISTICS

This section provides a summary of the socioeconomic characteristics of respondents surveyed, including age, sex, place of residence, educational status, and household characteristics. The profile of the hotspots provided in this section will help in understanding the results of the 2010 MARYP survey in the following sections. In addition, it provides useful information for program planning.

Table 4 shows the distribution of socio-demographic characteristics of individuals in the survey by sex and age group. Hotspots were predominantly in urban areas, therefore 83.2% male and 71.6% female respondents reported living in urban areas. Most of them have never married and 53.94% and 55.1% of female and male respondents respectively reported currently attending school. As expected, among the 10-19 year age group, the school attendance was higher than their older counterparts with 77% and 74% in females and males respectively. This reflects similar rates to those reported in the CDHS where 77% of those children who should be attending primary school are doing so and 28% of those who should be in secondary school are doing so (NIPH et al 2006). The median number of years of education at school was 10 years for both groups.

While 72.5% of males reported currently living with parents only 50.8% of females reported so. Females report higher levels of divorce (12%) compared with 0.6% in males which suggests higher risk and vulnerability in these women given findings reported in the CDHS which found that divorced women were more likely than their married or single counterparts to have had higher risk sex in the past year (NIPH et al 2006).

Regardless of sex, almost 20% of respondents were orphaned of father, mother or both. This is expected as the CDHS reported a rate of 79% of children under the age of 18 lived with both parents (NIPH et al 2006).

Less than 20% of respondents were unemployed and the median income in the last month was zero for all respondents. However, both groups reported spending about 1.25 US$ per day. While 56.1% of males owned a motorbike or a car only 38.2% of females reported so. The median duration of living in their current location was much shorter for female respondents (36 months) than for males (159 months).

TABLE 4 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE MOST AT RISK YOUNG POPULATION

CHARACTERISTICS	Female					Male				
	Age group		Location		Total	Age group		Location		Total
	10-19 (624)	20-24 (624)	Urban	Rural		10-19 (629)	20-24 (624)	Urban	Rural	
% of respondents by location where they were interviewed										
Urban	82.3	83.9	-	-	83.2	65.2	76.9	-	-	71.6
Rural	17.6	16.2	-	-	16.9	34.8	23.1	-	-	28.4
% of respondents' marital status										
Married	2.1	8.6	5.6	5.5	5.6	0.1	6.3	3.9	2.6	3.5
Never married	96.3	78.8	86.6	88.0	86.9	99.9	92.2	95.0	97.2	0
Divorce	17.0	18.0	18.0	18.0	19.0	18.0	18.0	18.0	17.5	21.0
Separate	17.0	18.0	18.0	18.0	19.0	18.0	18.0	18.0	17.5	21.0
Living together	0.4	0.4	0.4	0.3	0.4	0	0	0	0	0
Median age at first marriage	17.0	18.0	18.0	19.0	18.0	17.5	21.0	21.0	22.0	21.0
(IQR**)	(16-18)	(18-20)	(17-19)	(17-20)	(17-19)	(16-19)	(20-22)	(20-22)	(20-23)	(20-22)
% of respondents who are currently in school	76.6	34.7	52.5	61.6	53.9	73.7	39.7	53.0	60.2	55.1
Median year of schooling	10.0	9.0	10.0	9.0	10.0	9.0	11.0	10.0	9.0	10.0
(IQR**)	(7-12)	(6-13)	(7-12)	(6-12)	(7-12)	(7-11)	(8-13)	(8-12)	(7-11)	(7-12)
% of respondents by type of person they are currently living with										
Parents	69.8	34.7	47.9	64.8	50.8	84.3	62.8	68.2	84.1	72.5
Sibling	10.4	15.6	14.0	9.8	13.2	12.2	13.8	13.8	11.5	13.1
Grand parents	28.0	23.1	26.6	19.5	25.4	9.7	14.1	14.1	7.1	12.1
Relatives	2.3	8.3	8.3	8.3	5.4	8.3	5.5	8.3	0	5.0
Friends	8.8	28.5	20.6	13.8	19.4	3.0	11.8	9.8	3.1	7.8
Alone	0.5	2.9	1.8	1.7	1.8	0.1	3.0	1.9	1.1	1.7
Spouse/sexual partner	2.3	8.3	5.5	5.4	5.5	0	5.0	3.0	2.2	2.7
Median number of sibling (IQR**)	3 (2-4)	4 (3-5)	3 (2-5)	4 (2-5)	3 (2-5)	3 (2-4)	4 (2-5)	3 (2-4)	3 (2-5)	3 (2-5)
Median last month income- USD* (IQR**)	0 (0-14.5)	52 (0-104)	0 (0-83)	0 (0-52)	0 (0-75)	0 (0-15)	37.5 (0-100)	0 (0-75)	0 (0-50)	0 (0-70)

CHARACTERISTICS	Female					Male				
	Age group		Location		Total	Age group		Location		Total
	10-19 (624)	20-24 (624)	Urban	Rural		10-19 (629)	20-24 (624)	Urban	Rural	
Median daily expenses- USD* (IQR**)	1.3 (0.7-1.5)	1.3 (1-1.5)	1.3 (1-2.5)	0.8 (0.5-1.25)	1.3 (0.7-1.5)	1.0 (0.5-1.2)	1.5 (1.2-2.5)	1.3 (1-2.5)	1.0 (0.5-1.25)	1.3 (0.7-1.2)
% of unemployed respondents***	28.12	11.0	13.4	25.1	15.0	22.9	18.2	19.8	18.3	19.4
% of respondents by type of daily accommodation										
Guesthouse/ hotel	0.2	0.9	0.7	0	0.6	0	0.7	0.5	0	0.4
Town house	44.4	52.9	56.3	13.1	49.0	23.8	25.5	30.4	10.2	24.8
Hut	2.7	3.8	3.0	4.7	3.3	5.2	3.5	4.2	4.1	4.3
Mid size country house	11.2	14.7	5.1	52.6	13.1	48.9	40.2	32.7	73.4	44.1
Villa	39.8	27.2	34.0	28.7	33.0	12.2	15.4	16.9	6.9	14.0
Others	1.6	0.5	1.0	1.0	1.0	10.0	14.7	15.2	5.5	12.6
Median duration of living in current location –month (IQR**)	75.0 (14-192)	24.0 (4-132)	36.0 (5.5-156)	168.0 (18-228)	36 .0 (6-180)	168.0 (48-204)	120.0 (24-252)	120.0 (24-216)	192.0 (72-228)	156.0 (36-228)
% of respondents by transportation ownership										
No transportation	33.8	51.0	44.0	38.6	43.1	23.7	26.9	24.4	28..3	25.4
Bicycle	27.3	16.9	17.9	40.2	21.7	43.4	24.1	29.6	41.3	32.8
Motorcycle	41.2	33.8	39.8	24.5	37.2	45.2	60.9	57.3	44.7	53.8
Car	0.9	1.2	1.0	0.8	1.0	2.4	2.3	2.2	2.7	2.3
% of respondents' parents living status										
Both parent alive	86.4	77.2	80.4	86.9	81.4	86.3	79.3	81.8	84.3	82.4
Orphan of father	10.0	17.0	14.9	7.7	13.8	10.7	13.7	12.9	11.2	12.3
Orphan of mother	1.9	3.2	2.8	2.1	2.6	1.9	3.8	3.0	2.7	2.9
Orphan of both	1.6	2.6	1.9	3.4	2.2	1.2	3.2	2.4	1.7	2.3

1USD= 4000 Riel **IQR: Inter-Quartile Range*Among those MARYP who are not currently in school*

UNDERSTANDING MOST AT RISK YOUNG PEOPLE

The qualitative methods were designed to explore how MARYP view their lives, what makes them happy, what makes them look cool/trendy, and what they want most. In addition, questions were asked to determine if male and female MARYP valued their lives differently. From those discussions, four main themes emerged. These themes were:

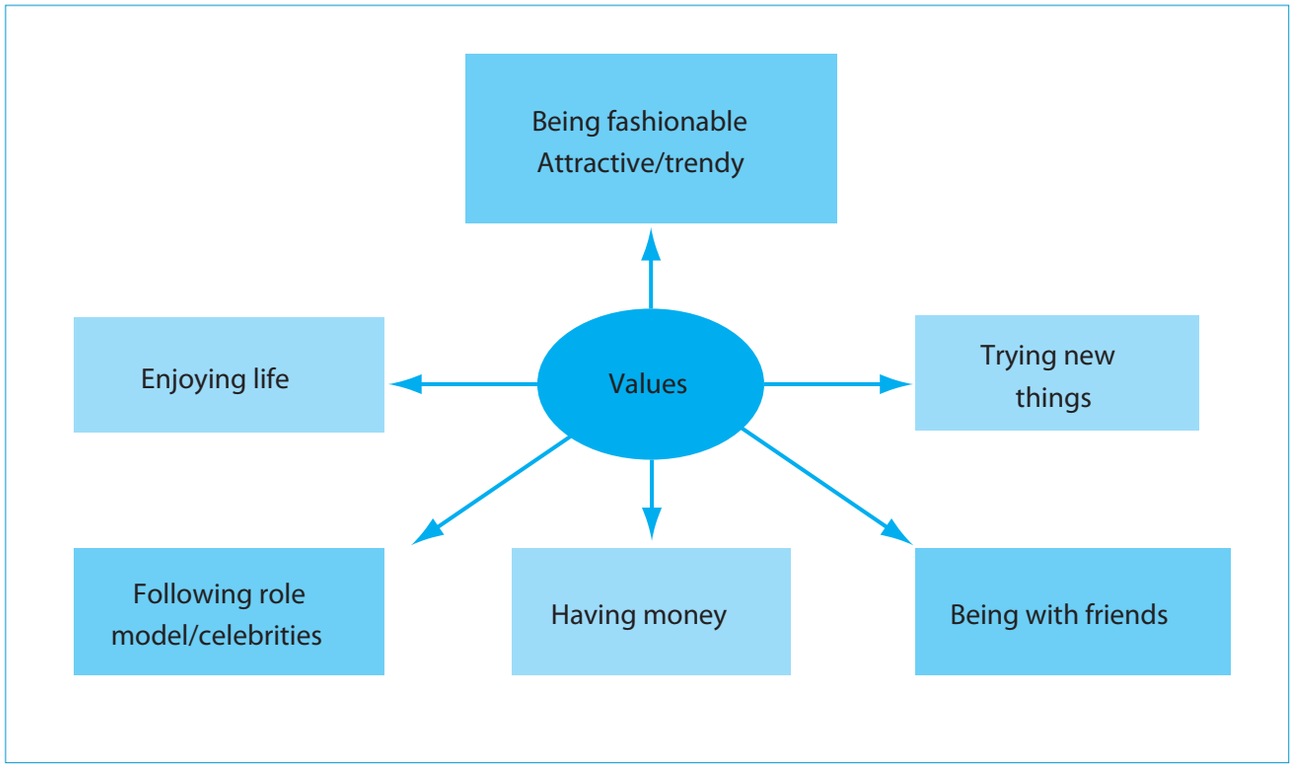
- The things MARYP valued most in their life.
- The concept of peer pressure.
- Similarities between males and females regarding life values.
- Perspectives on the social distinction between good and bad young people.

MARYP values

Life values of MARYP were guided by three key factors: self, peers, and family, community and societal norms. For example, some values have been set because the young person him/herself feels that those things are important or necessary (important self beliefs). Some adolescents rank the importance of things based on what their friends or peers think and value, while others may value things based on the norms or current practices of family, society or their communities. The findings discussed below are framed by these three groups.

Generally, MARYP attributed greatest importance to their happiness, new experiences, and wealth. These values are considered very important by MARYP and influence them on an individual level. Establishing and maintaining networks with their peers was also seen as critical. Peers influence MARYP considerably (both positively and negatively) and fear isolation from them. This need for acceptance can drive high risk behaviors. Peer networks should therefore feature in programming responses attempting to reach young people.

FIGURE 1 MOTIVATIONAL VALUES OF MARYP



Additionally MARYP want to be trendy or fashionable by keeping up with rapid changes in contemporary society or following a popular role model.

Being a good student or having a good education was not systematically mentioned as valued among MARYP. Very few participants acknowledged the value of education when directly asked to discuss this. The study participants often expressed that the value of education can only be clearly seen or understood by those who are studying.

"… only those who are studying admire well-behaved students…they are not admired by those who always cruising around [not study]. They are different. They are from different planets" (male, 20-24 years)

Some MARYP also felt that an education couldn't guarantee them success in life. This could be a concern as generally the higher the level of education, the better one's health outcomes are.

"…education is not important, money is more important…" (female, 10-14 years)

"…some [adolescents] always studying and they completed their education, then they cannot find any job" (male, 20-24 years)

Physical appearance is very important to MARYP. Both young men and young women reported that they liked to look trendy through their clothes, hairstyle and other accessories. These are valued higher than a good education. Female MARYP in particular reported valuing their beauty greatly as they believed that if they are beautiful they can earn money more easily.

The MARYP agreed that the things that make young males look cool are drinking, having sex, visiting bars, having girlfriends and racing vehicles. A similar trend was heard from young women in the study.

"…Apart from having sweetheart, having motorbike, mobile phone and wearing sexy dress may make also them look cool" (female, 10-14 years)

Peer pressure

The MARYP acknowledged that peer pressure can be both good and bad. Many risky behaviors adopted by MARYP were attributed to peers. It was generally believed that the high risk behaviors of their peers were more influential than positive behaviors.

However peer pressure used within the right context, such as program interventions, was cited as possibly having a positive influence on MARYP. Age and the maturity of the adolescent were also recognized as strong factors associated with risky behaviors. This indicates that older young people could be employed to positively influence their younger peers.

"Not all young people are the same, friends can lead us to become involved in doing bad things or good things" (female, 15-19 years)

Similarity between male and female MARYP in terms of values in life

In general, male and female young people hold similar values and no stark differences were apparent. At this stage of life, MARYP most wanted to be happy, entertained and to be free from all worries while having the opportunity to try out new things.

"…they want happiness, want to try new things,…they are the same" (female, 20-24 years)

However, female MARYP reported that while expressing their freedom or searching for what they value in their lives, they faced relatively strong resistance from families and society to conform to expected female gender norms that restrict their social interactions and expression of sexuality. This was attributed to strict Cambodian cultural norms and traditions. Consequently young women's behaviors are usually more conservative than those of their male counterparts.

"…most boys rarely stay home [they always go cruising around], while girls are more likely to like [respect] their parents" (female, 15-19 years)

It was however acknowledged that young girls are increasingly demanding to exercise their freedom or to behave in the same way as boys do. For example MARYP also reported high risk behaviors in females.

"…when they [young females] got drunk, they start fighting" (female, 15-19 years)

Perceptions of "good and bad" young people

An unexpected theme emerged from the discussions. It appeared that MARYP perceived that young people can be classified according to behaviors and they used the terms "good young people" and "bad young people" on many occasions when talking about the life values of young people. Although the definitions of these terms were not further probed by the field interviewers, the perception appears to be that "good young people" are those who like studying, who listen to their parents' advice, and are not involved in any risky behaviors, while "bad young people" are the opposite.

"…Those who study are different from those who always go out [not study]. They are in different societies [groups]. There are totally different in terms of clothing, attitude and languages…" (male, 20-24 years)

Some MARYP expressed the belief that these two groups of young people took different paths right from the very beginning, with money being a key differentiating feature. This indicates that socio-economic circumstances do influence MARYP beliefs about themselves, including their self esteem/self worth and self efficacy, which in turn can influence their behavioral outcomes.

"…we don't have money and we are not smart like others" (male, 10-14 years)

ALCOHOL CONSUMPTION RELATED BEHAVIOR

Alcohol consumption was very common among MARYP in the study. To understand why MARYP consumed alcohol, study participants were asked to discuss why they drink alcohol and the reasons behind that.

It was found that MARYP drink because they wanted to experience new things, to cope with their working conditions, to conform to peer pressure and because of their family, school, or relationship issues. For MARYP aged from 10 to 14 years, compared with older age groups, the decision to start drinking alcohol was strongly influenced by external social factors (i.e. they were highly influenced by their surroundings).

"…[Drinking alcohol] is fashionable" (male, 10-14 years)

"…I saw people drinking [alcohol] it looks very tasty, I tried it myself" (male, 10-14 years)

TABLE 5 CAUSES AND CONSEQUENCES OF USING ALCOHOL

SELF		PEER		FAMILY, COMMUNITY, SOCIETAL NORMS	
Causes	Consequences	Causes	Consequences	Causes	Consequences
Trying new things Working conditions Under-estimating addiction	Entertainment Releasing stress or sadness Feeling brave/ strong	Peer pressure	Making friends	Family/school/ love issues Alcohol advertisements Role models	Trendy practice Looking cool

Drinking alcohol was very common among respondents. Almost 70% and 91% of female and males respectively had drunk alcohol. Wide access to alcohol is reported by MARYP as a factor leading to use of alcohol.

"…most of the time after a new wine come to the market and if [the wine] is not very expensive, people will try it and if they satisfy with it they will start drinking it regularly" (male, 20-24 years)

Stress and depression also were also often reported as a reason for drinking alcohol.

"I was very depressed because my mom love her husband [step-father] than me, so I learnt to smoke cigarette, drink alcohol…now I cannot quit smoking or alcohol" (female, 20-24 years)

" I am a drunkard, I am the one who wheedle other to drink. Before, I was very depressed" (female, 20-24 years)

It was also observed that drinking habits among family members had a strong influence on the perception and practice of drinking alcohol among MARYP, particularly in males aged 10 to 19 years.

"all my older brothers drink everyday…" (male, 15-19 years)

School issues were also reported as factors that led MARYP to drink alcohol. Things occurring at school such as failing exams, deadline stress or arguing with friends or sweethearts led to feelings of shame and depression which resulted in alcohol consumption.

"I drink when I was disappointed with my exam" (female, 15-19 years)

"My [boy]friend left me for another girl [so I started drinking]" (female, 15-19 years)

The community and environment where MARYPs live also impacted on alcohol use. A few MARYPs reported no history of alcohol or drug use within their family but that they have been repeatedly exposed to alcohol, smoking and drugs in their communities and neighborhoods.

"[does your father drink?] no, not at all,…all my family did not drink, they not even smoke" (male, 20-24 years)

"first, I sat watching older people drink, then they offered me a try and later on my friends offered me a try…and I drink alcohol till now" (male, 15-19 years)

Drinking alcohol was a very common practice among MARYP when they socialized. By drinking together they felt that their networks were strengthened. Negative consequences were reported by MARYP (such as being excluded from the group or being beaten) when they refused to drink when offered by peers or the elders of their groups.

"we are friends, when are offered to drink a glass [of beverage] we have to drink [why?] if we do not drink, it means we look down at them or we don't want to be friend with them" (female, 20-24 years)

" My friend proposed me a drink and I refused, so they threatened to beat me…so I had to drink a glass" (male, 15-19 years)

" If I refuse to drink, it means I could not be trusted in the group" (female, 10-14 years)

While only 2.3% of males self identified as heavy drinker, 18% of female MARYP thought that they were, especially in urban areas and among the older age group (Figures 2 and 3). This may relate to the type of employment of the female respondents. Female MARYP reported that working in karaoke or nightclubs requires women workers to drink with their customers.

"In general, we have to drink with customers, if we do not drink, we cannot have this job [Karaoke worker]" (female, 20-24 years)

Alcohol was accessed at drink shops, by friends, family and at bars. For more detailed information by age group and location please refer to Table A1 in Annex A.

FIGURE 2 PERCENTAGE DISTRIBUTION OF YOUNG PEOPLE WHO HAVE EVER CONSUMED ALCOHOL

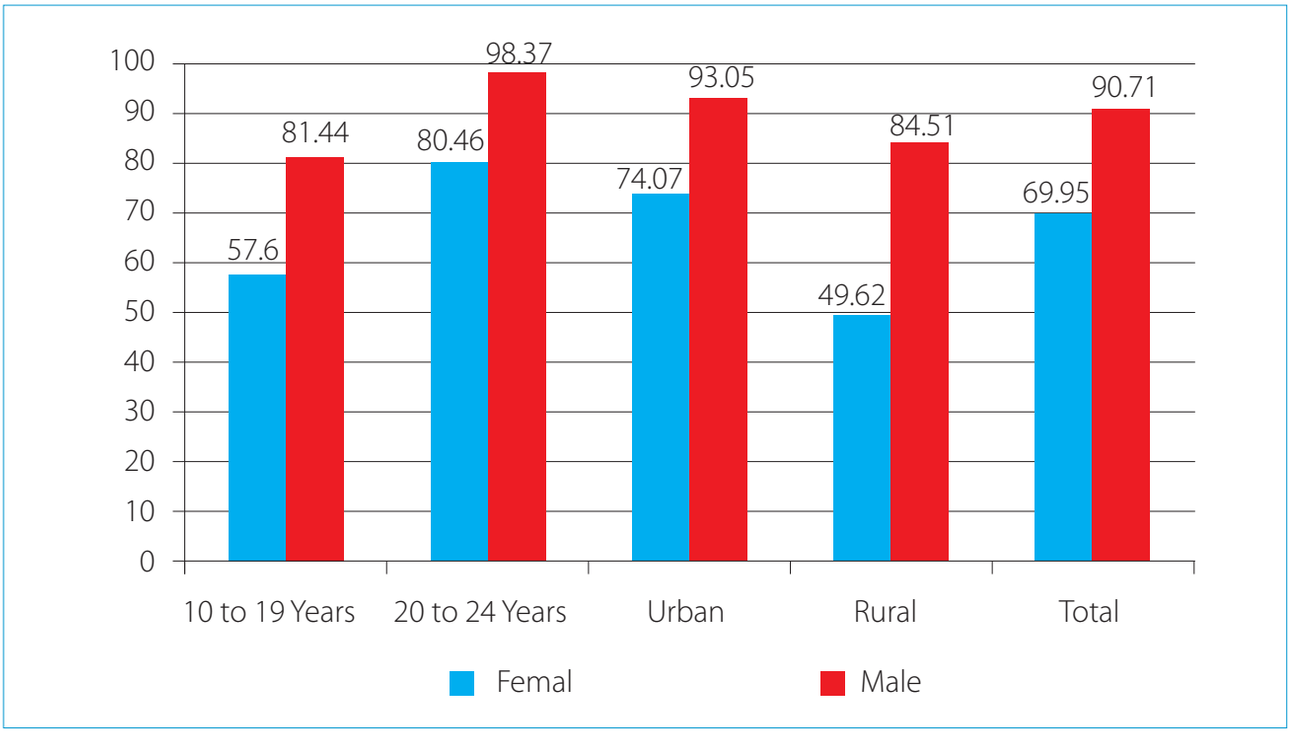
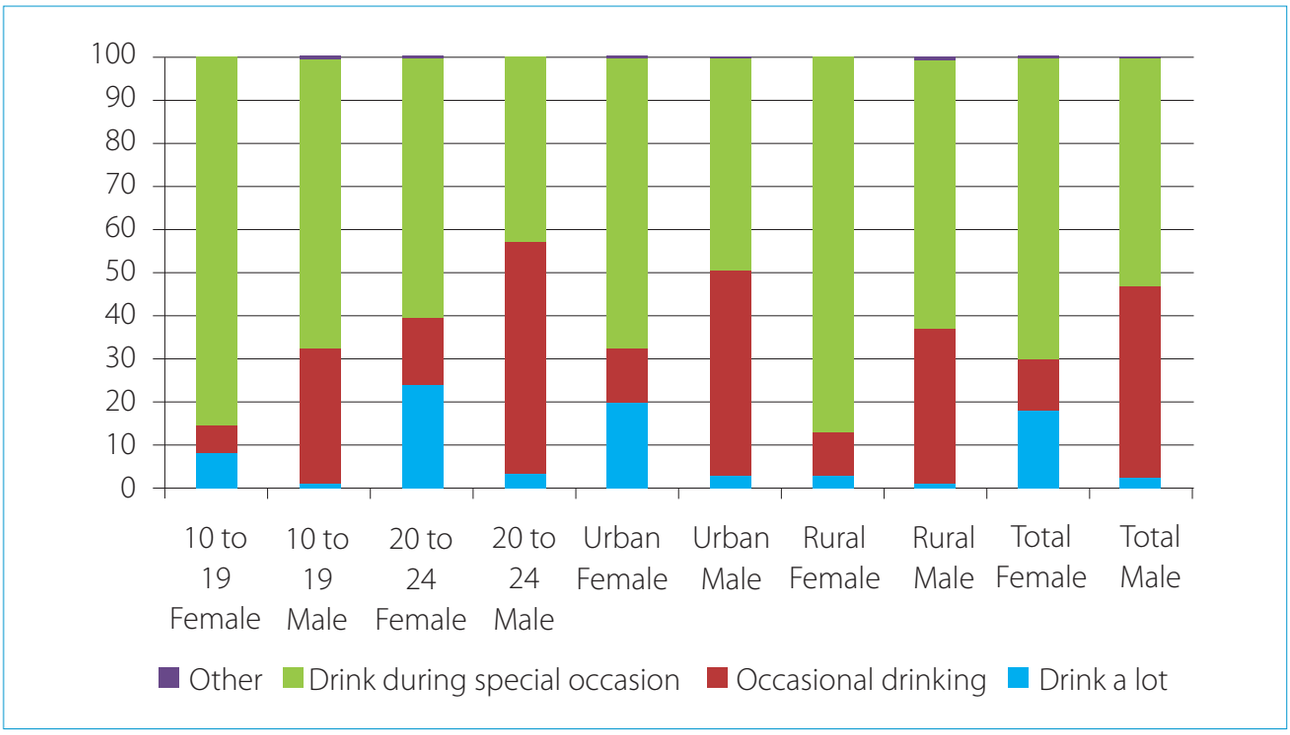


FIGURE 3 PERCENTAGE DISTRIBUTION OF SELF-RATED LEVEL OF ALCOHOL CONSUMED



DRUG USE RELATED BEHAVIOR

Out of the female respondents, 3.5% reported that they had 'ever used drugs', while 15% of males did so (Figure 4). Older age groups (20-24 years) and those living in urban areas report higher prevalence of drug use. Yama, yaba and ice (meth-amphetamine based power) were the most common type of drugs used (Figure 5).

Injecting drug use was not a common practice among this population, representing 1.4% of those respondents who had used drugs in the last six months. Interestingly only females reported having injected in the last 12 months. Predominantly, it was the younger female respondents (10-19 years) or those living in rural areas who reported higher frequency of injecting drug use.

While 9.4% 10-19 year old males reported ever using drugs, the average age of first drug use was 18 years for both males and females and more than 92% of these respondents had 'ever attempted to stop using drugs'.

FIGURE 4 PERCENTAGE DISTRIBUTION OF MARYP WHO EVER USED DRUGS

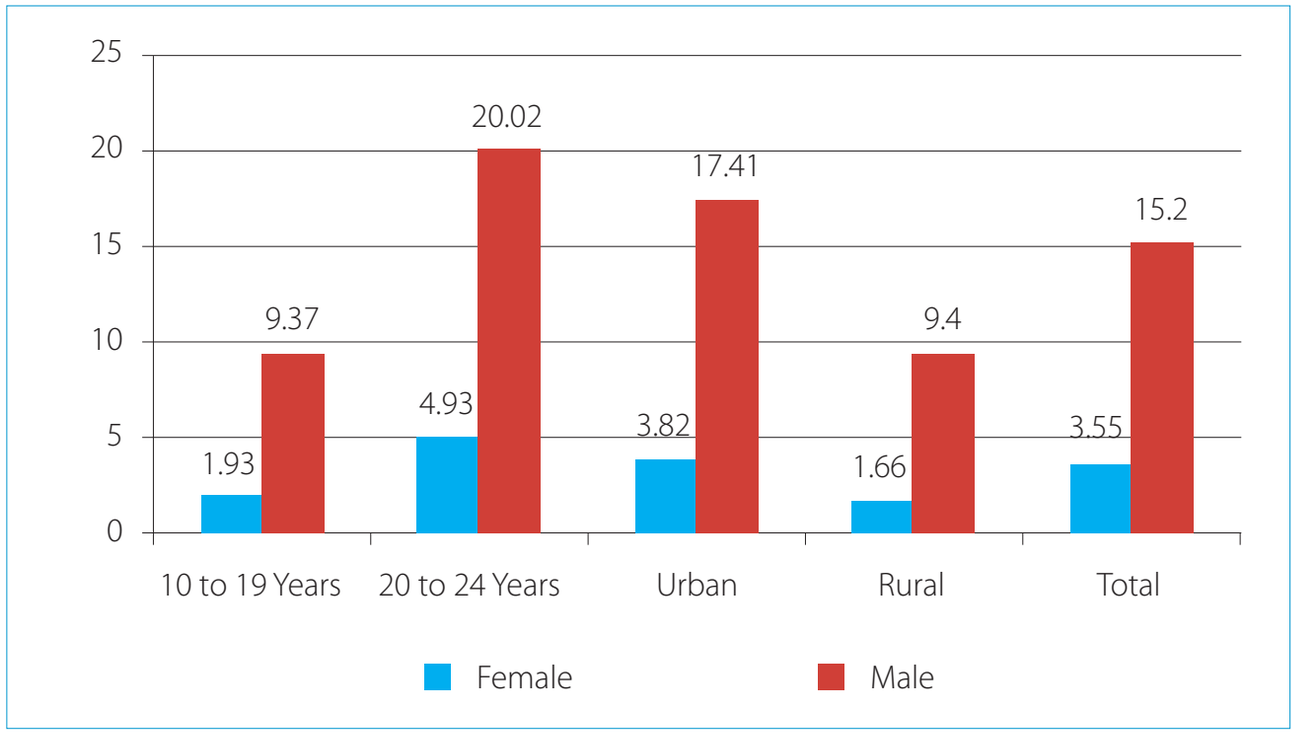
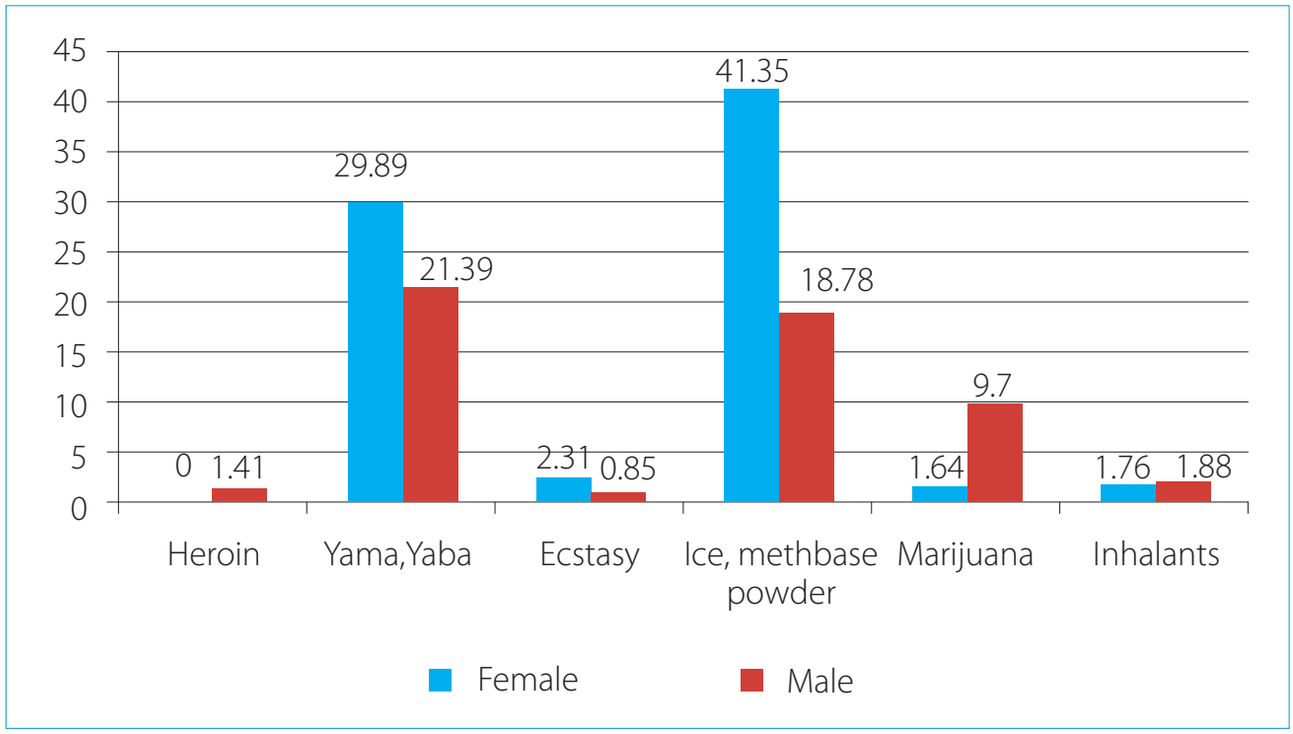


FIGURE 5 PERCENTAGE DISTRIBUTION OF THE TYPE OF DRUGS USED IN THE PAST SIX MONTHS



Additional more detailed information on the above information by age group and location, is presented in Table B 1 of Annex B.

In order to explore causes and consequences of using drugs, during qualitative discussions MARYP were asked to talk about why adolescents/young people used drugs and to list all factors that lead to drug use.

Long working hours and onerous working conditions were reported as important causes of why male MARYP used drugs.

"…Fisherman at sea, when they return to shore they buy drug, some time their boss buy drug for them" (male, 15-19 years)

Of those who reported using drugs most MARYP reported using drugs with their friends. Only 15% and 0.9% of female and male respondents respectively reported using drugs alone (Figures 6 and 7). This gender difference is considerable and confirms the need for gender differentiated drug treatment programs.

Purchasing drugs was reported as a complex and difficult process since it requires a hidden illegal network. To purchase drugs MARYP reported using networks recommended by their peers.

"if we want to buy drug we have to contact friends who know where to buy it, then they go buying it and bring it to a quiet place such as a guesthouse for us" (male, 20-24 years)

Family factors also played a role in creating drug use problems among MARYP. Domestic violence and family break-up were reported by MARYP as sources of stress.

" I was very depressed because my parents got divorced. I followed my friends since then. My friends help comforting me" (female, 10-14 years)

FIGURE 6 PERCENTAGE DISTRIBUTION OF THE LAST DRUG USE PARTNER AMONG FEMALE MARYP

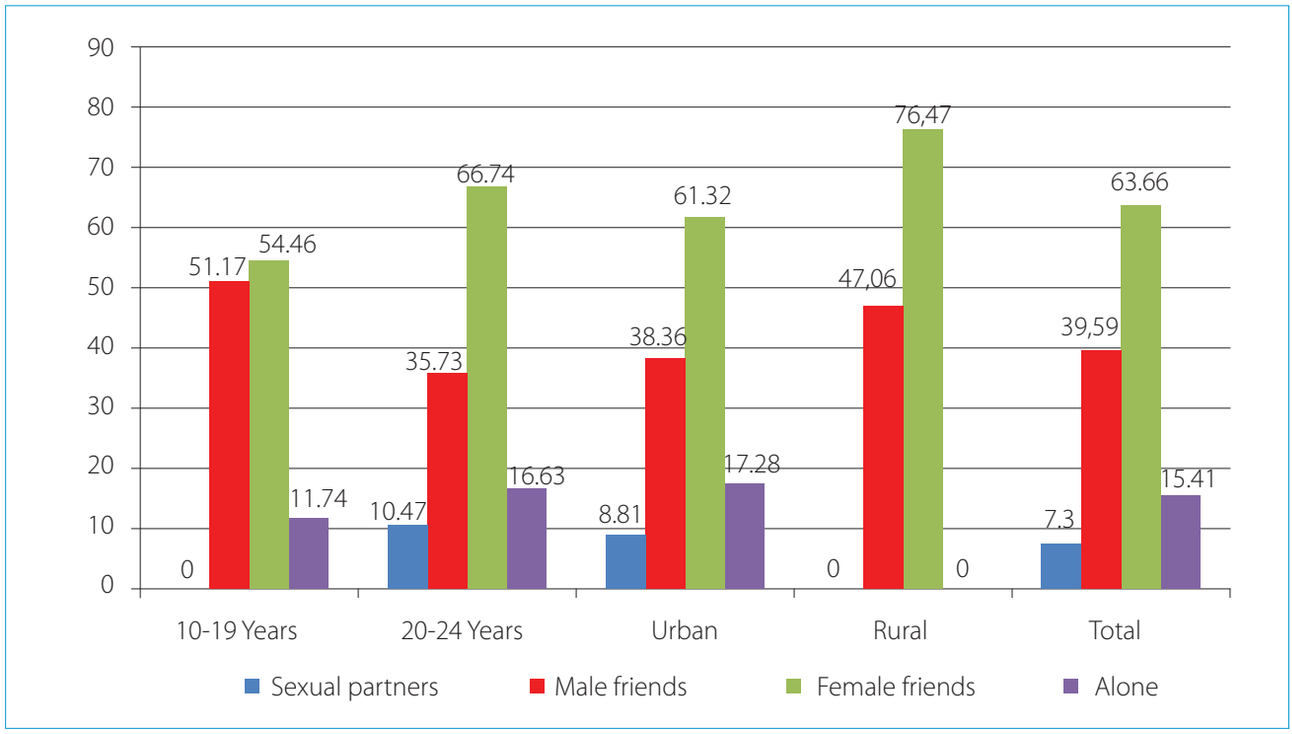
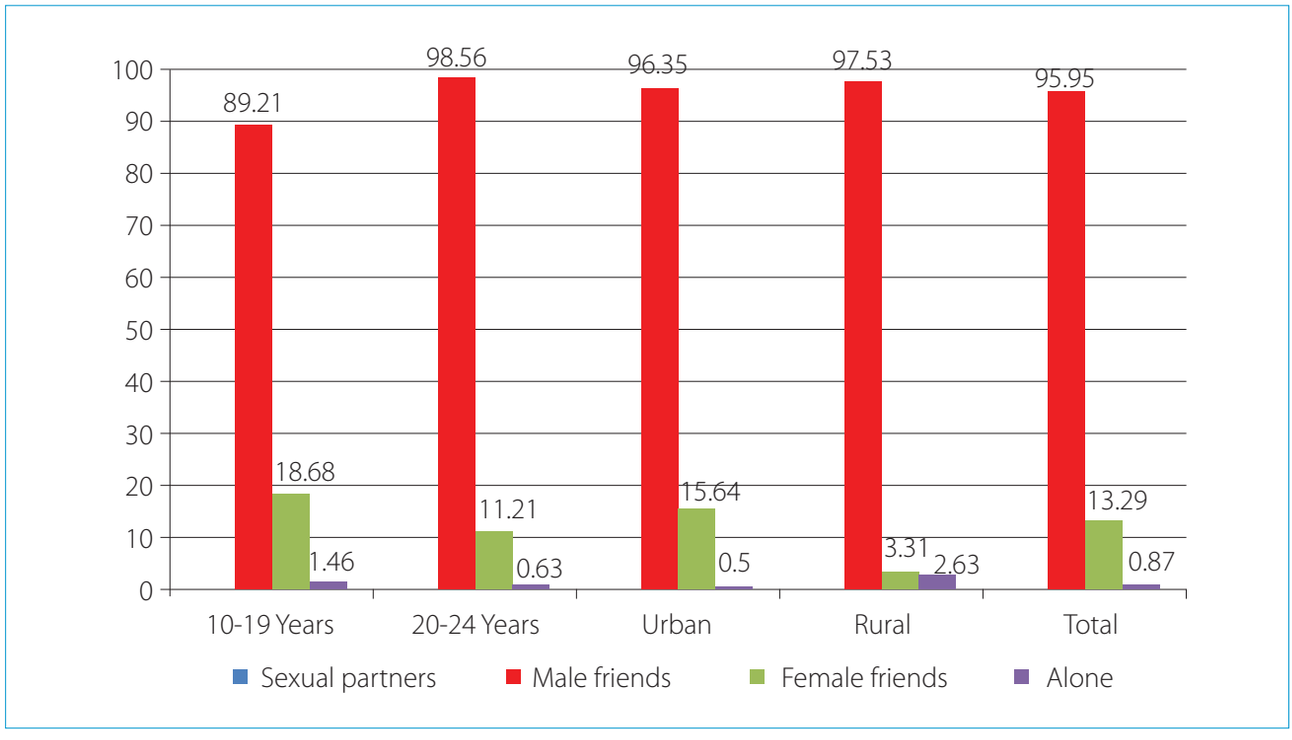


FIGURE 7 PERCENTAGE DISTRIBUTION OF THE LAST DRUG USE PARTNER AMONG MALE MARYP



With male MARYP in particular, their parents' reaction to their high risk behavior influenced MARYP in both positive and negative ways. This reinforces the importance of parenting, especially of older children, and the need to promote positive parental dialogue with their children.

"…my mom told me that if I keep smoking drugs I will not be allowed to return home, so I stop using it" (male, 15-19 years)

"…my mom blamed me for not staying home and not helping around the house" (male, 10-14 years)

" I have been cruising around the town, visiting bars… when I returned home it was very late and my parents did not allow me to get in…[what did you do next?] I went to sleep with female [sex worker]" (male, 20-24 years)

Like the consumption of alcohol, the use of drugs among family members had a strong influence on MARYP drug use. Adolescents (aged between 10 and 19 years) appeared to be particularly susceptible to alcohol and drug use exposure within their families or communities.

"my brother uses it, when I grow up I try to use it [drug] like him" (male, 15-19 years)

"all my older brothers drink everyday…" (male, 15-19 years)

" I saw one family with 7 siblings, 2 of them used drug…" (female, 10-14 years)

Also being in a love relationship with someone who is a drug user influenced the initiation of drug use.

"…my boyfriend asked me to use drug. I first refused. After I got drunk I lost my consciousness I don't know when I was drugged…now, I am addicted to drug" (female, 10-14 years)

Male MARYP who reported using drugs did not report using drugs with a sexual partner while 7.8% of females took drugs with their sexual partners (Figures 6 and 7). Female MARYP reported the perception that using drugs did have some positive effects.

"when I was very stressed and I smoked [drug], it helped releasing stress" (female, 20-24 years)

" If we are always afraid of other people, after we smoke we are brave" (female, 20-24 years)

Misconceptions about the benefits and harmful effects of using drugs were heard often throughout the interviews. Those aged 10 to 14 years seemed most at risk of adopting high risk behaviors such as drinking alcohol or drug use because of a lack of knowledge or understanding.

"Some young people want to have good complexion…so they smoke drug" (female, 10-14 years)

"drinking beer make good skin complexion" (female, 15-19 years)

"I was convinced to use drug since I was told that there is no problem [addiction] in the future, then I followed my friend advices till now" (female, 10-14 years)

In contrast, many negative consequences, such as committing violent crime, domestic violence, being arrested, and dropping out of school, were also identified.

" we get money from stealing from parents or rob people, bullying small kid…" (female, 10-14 years)

It is useful to consider the causes of using alcohol and drugs in terms of whether they are immediate or long-term drivers (Table 6). However, the table below should be read with caution because the survey did not probe the time sequences of the drivers. That is; it is not certain which driver occurred first.

TABLE 6 RISK DRIVERS OF USING ALCOHOL/DRUGS AMONG MARYP

	SELF	PEER	FAMILY, COMMUNITY SOCIETAL NORMS
Immediate drivers	Misconceptions that using alcohol/drug can reduce stress Underestimating the effect of addiction	Having friends who drink alcohol or use drugs Having a network that can access to drugs	Failing exams Arguments with friends or family Arguments with sweethearts Easy access to alcohol Socializing or cerebrating Family break up Feeling depressed
Long-term drivers	Having an urge to try new things Onerous working conditions Lack of knowledge about the harmful effects of drugs or alcohol	Social acceptance and inclusion Demonstrating loyalty and trust with peers Socializing	Failure at school Looking trendy Exposure to alcohol or drugs in the community environment Unstable family environment Parents lack of skills to deal with their children's high risk behavior Drinking habits in a family Following role models or celebrities

SEXUAL BEHAVIOR

General sexual behavioral patterns

Over 41% of male respondents were sexually active. Those from urban areas or in the higher age group (20-24 years) are more sexually active. On average, their first sexual experience was between 18 and 19 years. For the majority, their first sexual partner was their sweetheart and there was no age difference between them. In the past 12 months, sexually active young males had sex on average with one to two female partners. Their sexual partners in the past 12 months were mainly their sweethearts followed by karaoke workers and brothel based sex workers (Table 7).

Just over 23% of female respondents were sexually active (Table 8). Like the males, females from urban areas or in the higher age group (20-24 years) were more sexually active. Overall, sexual debut was at around 18 years old and for a majority of them it was with their husbands. In contrast to their male counterparts, their first sexual partner (on average) was five years older than them. Such age mixing can increase exposure to HIV/STIs because older men have longer sexual histories and younger women are less likely to be able to negotiate safer sex with older men, particularly in Cambodian society. On average, in the past 12 months, sexually active female respondents had sex with one male partner.

Only 2.7% of sexually active females had sex while under the influence of drugs in the last 12 months. However, in the same period, almost 8% of them experienced sex with a partner who was under the influence of drugs in the same time period. This may negatively impact on the ability of women to negotiate safe sex.

TABLE 7 SEXUAL BEHAVIOR OF MALE RESPONDENTS

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Ever had sex	18.5	59.8	46.4	27.8	**41.1**
Median of age at first sexual intercourse (IQR)*	18	19	19 (18-20)	19 (18-20)	**19**
The first sexual partner is*					
Wife	0.6	5.2	3.7	6.6	**4.2**
Girlfriend/sweetheart	66.5	56.1	59.3	54.4	**58.2**
Sex worker	11.7	18.7	17.3	16.9	**17.3**
EW	10.7	13.4	11.2	19.0	**12.9**
Friend	6.9	4.2	5.2	3.2	**4.8**
Relative	1.2	0.2	0.5	0	**0.4**
Girl in the village	0	1.4	1.4	0	**1.1**
Man	2.3	0.7	1.3	0	**1.1**
Median of age of first sexual partner (IQR)*	18 (17-18.5)	19 (18-20)	18 (17-20)	19 (18-20)	**18 (17-20)**
Median of age difference between male to female sex partner (IQR)*	0 (-1-1)	0 (0-2)	0 (0-1)	0 (-1-1)	**0 (-1-1)**
Median number of female sex partner in the past 12 months (IQR)*	1 (1-3)	2 (1-4)	2 (1-4)	1 (1-3)	**2 (1-4)**
Women in nightclub/discotheque	12.8	20.9	21.1	12.6	**19.3**
Massage place	6.2	10.7	10.4	7.5	**9.8**
Beer promoter	6.4	15.9	16.1	5.7	**13.9**
Karaoke worker	22.2	30.5	29.7	25.0	**28.8**
Beer garden/restaurant	5.8	7.2	7.6	4.6	**6.9**
Brothel/ street based sex worker	21.0	34.6	31.6	32.5	**31.9**
Female factory worker	0.6	3.8	3.0	4.2	**3.2**
Girlfriend/ sweetheart	56.1	50.0	53.0	41.3	**51.0**
Wife	1.8	6.9	5.4	8.5	**5.9**

TABLE 7 SEXUAL BEHAVIOR OF MALE RESPONDENTS (CONTINUE)

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Ever had sex in the past 12 months with a partner who was under influence of drug*	5.5	3.2	4.3	1.2	3.7
Ever had sex in the past 12 months when respondent were under influence of drug*	7.0	5.1	5.4	5.8	5.5

**the percentage presented here is among sexually active male MARYP*

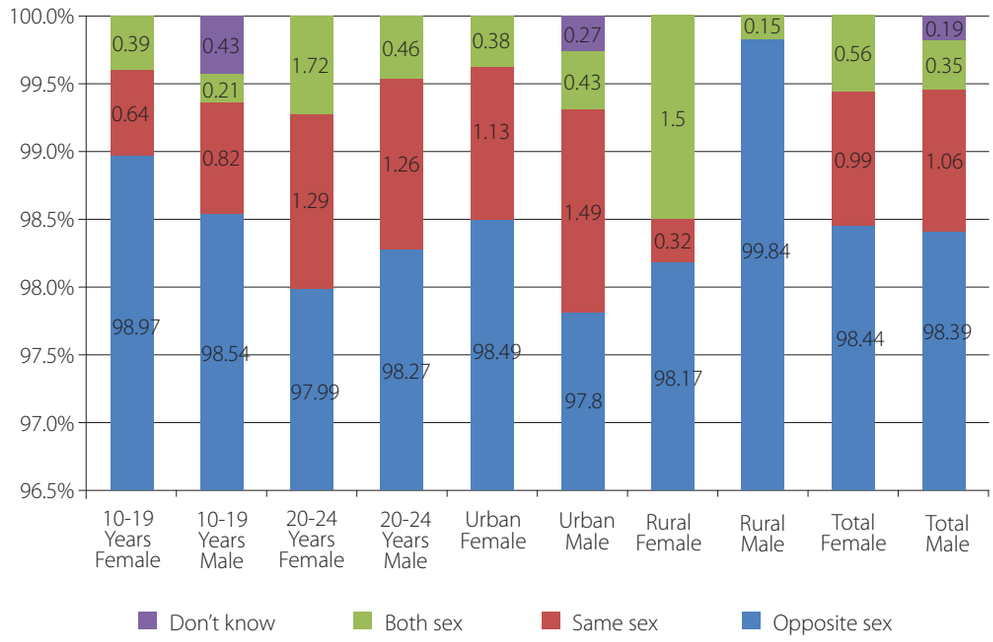
TABLE 8 SEXUAL BEHAVIOR OF FEMALE RESPONDENTS

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Ever had sex	8.8	36.2	25.4	14.5	**23.6**
Median Age at first sexual intercourse (IQR)*	17 (16-18)	19 (18-20)	18 (17-19)	18 (17-19)	**18 (17-19)**
The first sexual partner is*					
Husband	31.9	54.0	47.9	73.4	**50.2**
Boyfriend/sweetheart	51.8	34.1	39.8	12.7	**37.2**
Friend	2.6	0.3	0.8	0	**0.7**
Relative	2.8	0.3	0	2.8	**0.3**
Others	11.0	11.2	11.5	11.1	**11.6**
Median Age of first sexual partner (IQR)*	22 (20-25)	24 (21-27)	24 (21-27)	22 (20-26)	**23 (21-27)**
Age difference between male to female sex partner (IQR)*	5 (3-9)	5 (2-8)	5 (3-9)	4 (2-7)	**5 (3-8)**
Median number of male sex partner in the past 12 months (IQR)*	1 (1-4)	2 (1-10)	1 (1-7)	1 (1-61)	**1 (1-7.5)**
Ever had sex in the past 12 months with a partner who was under influence of drugs*	5.7	8.4	8.0	7.7	**8.0**
Ever had sex in the past 12 months when she was under influence of drugs*	3.7	2.5	2.6	3.8	**2.7**

**the percentage presented here is among sexually active female MARYP*

Heterosexuality is by far the greatest reported sexual preference. Figure 8 shows that among male and female respondents, just over 1.5% reported a sexual preference for the same-sex or both sexes. Rural males reported higher proportions of heterosexual preference than their counterparts in urban areas (99.8% vs. 97.8 %).

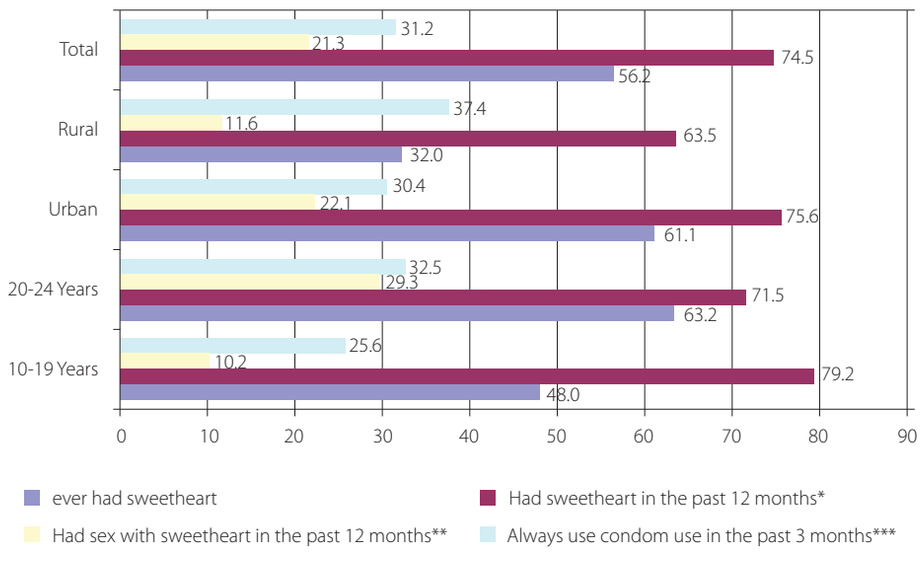
FIGURE 8 SEXUAL PREFERENCES AMONG MARYP



Sweethearts:

Over 56% of females surveyed had 'ever had a sweetheart' (Figure 9). Those who were older (20-24 years) or resided in urban areas reported higher rates than their younger, rural counterparts. Among those who 'ever had a sweetheart', 74.5% had one in the past 12 months and of those, 21.3% had had sex with him. Among female MARYP who had sex with their sweetheart in the past 3 months, only 31.2% used condoms consistently.

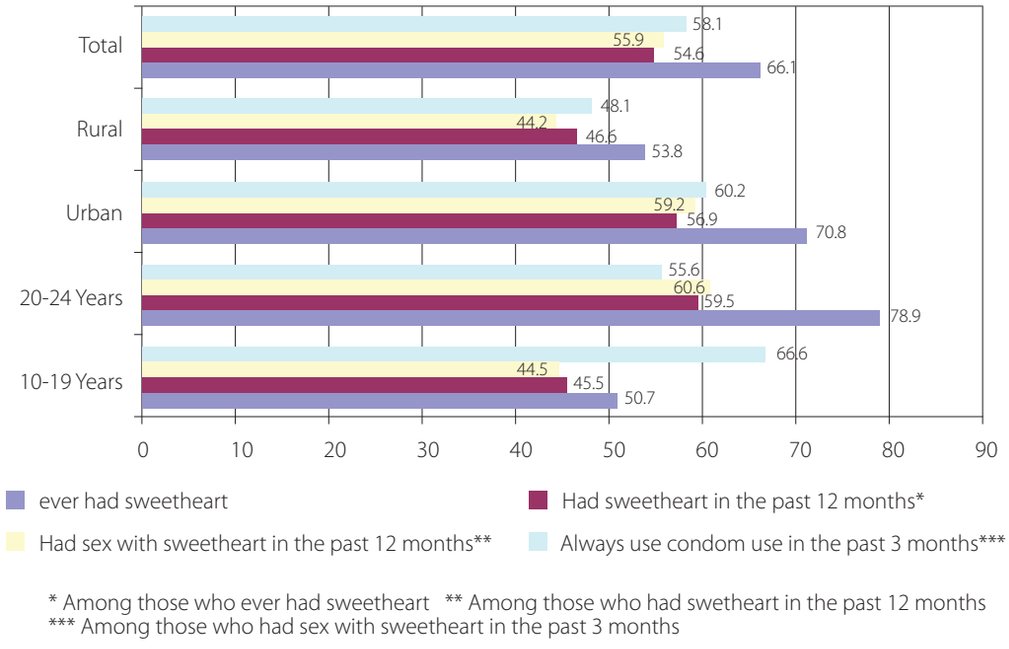
FIGURE 9 SEXUAL BEHAVIOR IN THE SWEETHEART RELATIONSHIP AMONG FEMALES



* Among those who ever had sweetheart ** Among those who had swetheart in the past 12 months
*** Among those who had sex with sweetheart in the past 3 months

Among male respondents 66% had ever had a sweetheart. Those who were older (20-24 years) or resided in urban areas reported higher percentages than their counterparts in the younger age group or rural areas. Among those who had ever had a sweetheart, 54.6% had one in the past 12 months and among them 55.9% had had sex with her. Among male MARYP who had sex with their sweetheart in the past three months, only 58.1% used condom consistently (Figure 10). While this is not an uncommon finding, it reiterates the need for appropriate messaging around consistent condom use among this vulnerable population.

FIGURE 10 SEXUAL BEHAVIOR IN THE SWEETHEART RELATIONSHIP AMONG MALE RESPONDENTS



* Among those who ever had sweetheart ** Among those who had swetheart in the past 12 months
*** Among those who had sex with sweetheart in the past 3 months

TABLE 9 REASONS REPORTED FOR HAVING A SWEETHEART BY GENDER

SELF		PEER		FAMILY, COMMUNITY, SOCIETAL NORMS	
Male	**Female**	**Male**	**Female**	**Male**	**Female**
To be loved and cared for To gain benefits To satisfy sexual needs To have a companion to go cruising with	To be happy/to enjoy life To have a companion To have someone for support	Peer pressure	Peer pressure	Trendy practice fashionable young people	Trendy practice fashionable young people

Both male and female MARYP reported having a sweetheart for companionship and support. Having a sweetheart is believed to bring happiness to their lives, and can be a positive influence.

" I feel that when having sweetheart, we are happier than having no sweetheart" (female, 10-14 years)

" [Young people] want to have sweetheart because they want to enjoy life, to be happy [why?] they can go cruising round town together, kissing…" (female, 20-24 years)

"when we have sweethearts, they[our sweetheart] love us and take care of us…" (male, 20-24 years)

" when someone loves their sweetheart very much, they may quit using drug if they sweetheart asks" (male, 15-19 years)

Some male MARYP exploited their sweethearts for other reported benefits.

" …having sweetheart so that we can go cruising together and also we can swindle her to get money or ask her to buy things" (male, 15-19 years)

" …no need to pay for sex" (male, 10-14 years)

FACTORS ASSOCIATED WITH HAVING SEX WITH SWEETHEARTS

The consequences of using drugs or alcohol, showing love and seeking sexual pleasure were cited as the key reasons for having sex with sweethearts among male MARYP. Female MARYP reported having sex with their sweethearts to show love and to strengthen their relationship.

"a good effect of sex is to make us have feeling for each other…" (female, 20-24 years)

In contrast, male MARYP reported other factors including sexual pleasure or release.

"after having sex with sweetheart, I am satisfied with [my] sexual pleasure" (Male, 20-24 years)

"to me, if I cannot have sex with my sweetheart, I will break up with my sweetheart" (male, 20-24 years)

"If we not agree to have sex, we[my boyfriend] will break up[with me]" (female, 15-19 years)

Social factors, such as the wide availability of pornographic films and commercial sex were commonly reported by male MARYP as reasons for having sex with female sex workers (Table 10).

TABLE 10 FACTORS ASSOCIATED WITH ENGAGING IN SEXUAL ACTIVITY WITH SWEETHEARTS AND COMMERCIAL SEX WORKERS

SELF		PEER		FAMILY, COMMUNITY, SOCIETAL NORMS	
Male	**Female**	**Male**	**Female**	**Male**	**Female**
Sexual pleasure Using drugs or alcohol	Showing love Using drugs or alcohol Strengthening relationship	Peer pressure	Peer pressure	Fashionable Pornography Availability of commercial sex Modern society (TV)	Fashionable Modern society (TV)

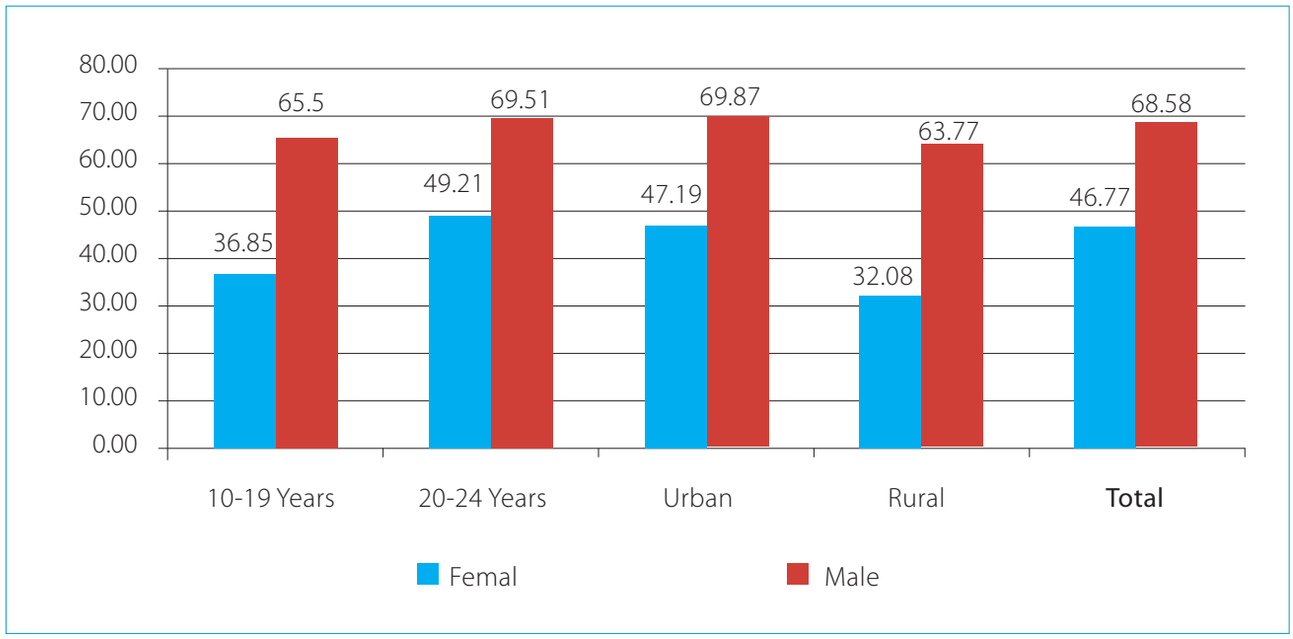
It is also possible that media such as TV and adult films can also influence MARYP when deciding to engage in sexual relations.

"Now, on TV, they always have sex with their sweethearts so I think, girls think like that too" (female, 15-19 years)

UNSAFE SEXUAL PRACTICES

Figure 11 shows that while only 46.8% of female MARYP reported using condoms during their last sexual encounter with their sweetheart, 68.6% of male MARYP did so. This indicates lower condom negotiating skills among young women than young men. Additional findings by age group and location can be found in table C3 and C4 in Annex C.

FIGURE 11 PERCENTAGE DISTRIBUTION OF USING CONDOM DURING LAST SEX WITH SWEETHEART



Unprotected sex is reported when MARYP were under the influence of alcohol or drugs. Some female MARYP reported accepting money in exchange for unprotected sex.

When asked, When you used drug and had sex with him, did you use condom? ["I did not know what I did, I was delirious" (female, 20-24 years)

"I know that he has a wife, so he may not have it [HIV], but I am not sure about him, but he gave me a lot of money 50$ or 100$ so I took a chance [to have sex without condom]" (female, 20-24 years)

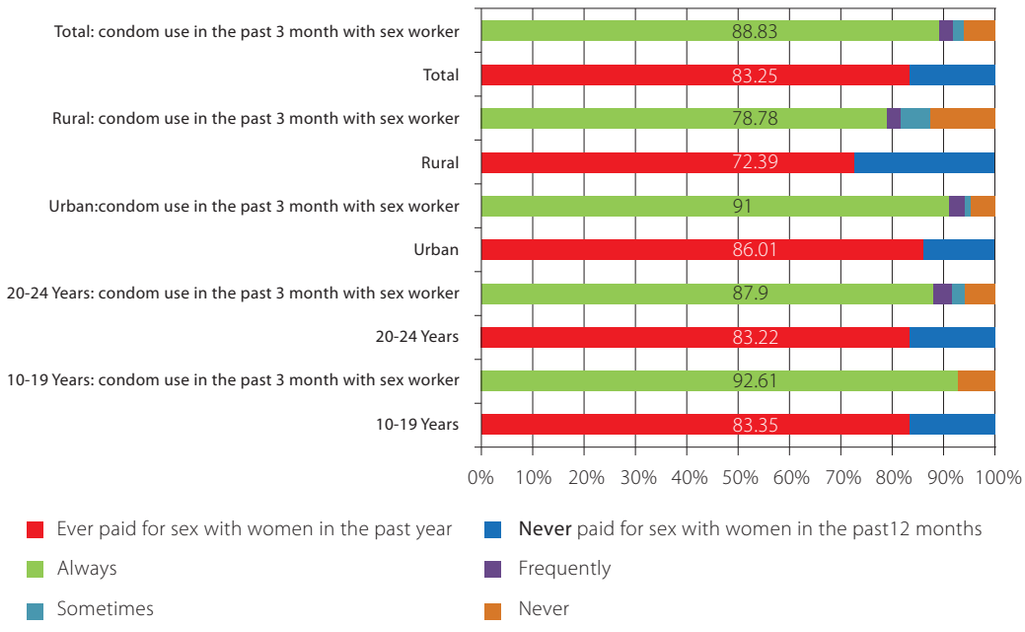
Male MARYP also reported that condoms reduce sexual pleasure, despite the fact that they know using condoms can prevent diseases.

"I did not use it [a condom – probed why?] I think using condom make sex less pleasurable" (male, 15-19 years)

ENGAGEMENT IN COMMERCIAL SEX

Figure 12 below shows that more than 83% of sexually active male MARYP paid for sex with women in the past 12 months – making them at risk of HIV/STI exposure. While the trend of buying sex in young men is consistent with what was reported by 15-24 year old men in the CDHS the rates reported in this survey are significantly higher (83% vs 36%). However, more than 80% of them reported consistent condom use in the past three months (regardless of age group). Urban males reported higher consistent condom use than their counterparts from rural areas (86% vs. 72%). It is also interesting to note that the survey found that 4.2% of male MARYP had sold sex in the past 12 months.

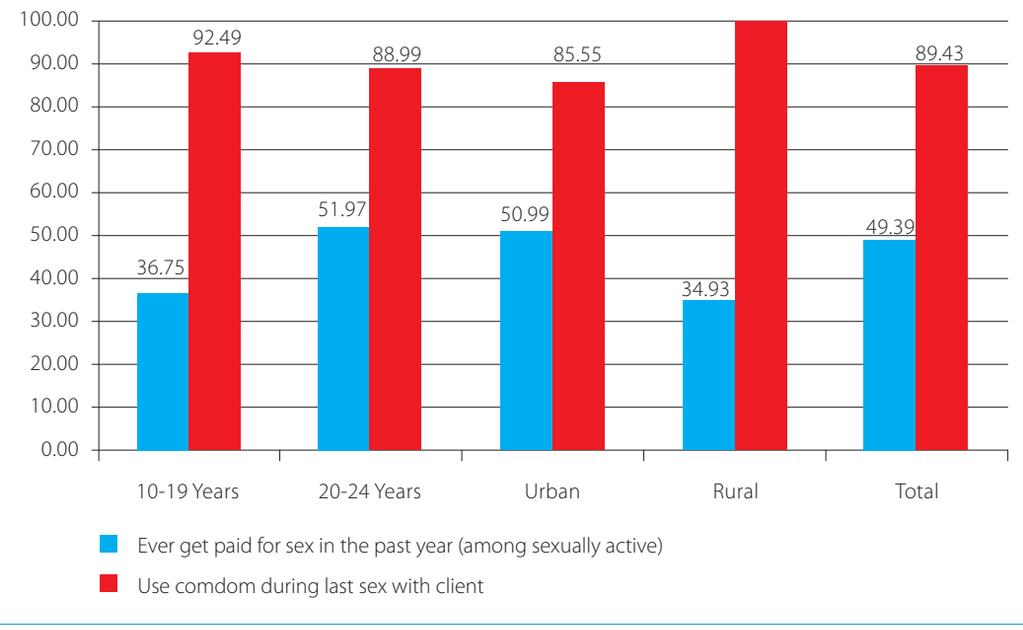
FIGURE 12 PERCENTAGE DISTRIBUTION OF MALES WHO BOUGHT SEX AND THEIR CONDOM USE IN THE LAST THREE MONTHS



Additional findings on the number of condoms used during the last commercial sex engagement; places where male MARYP met with their last sex partner; level of alcohol use during the last sex; and who proposed to use condoms in the commercial sex relationship are presented in Table C1 of Annex C.

Figure 13 shows that almost 50% of sexually active female MARYP engaged in a commercial sex relationship in the past 12 months. Urban females in the older age group (20-24 years) reported higher proportions of paid sex with a client. When asked about their condom use during last sex with a client, over 85% used condoms regardless of age group or location.

FIGURE 13 PERCENTAGE OF SELLING SEX IN THE PAST YEAR AND CONDOM USE DURING LAST SEX WITH CLIENT AMONG SEXUALLY ACTIVE FEMALE MARYP



Additional findings on the places where female MARYP met with their last commercial sex client, frequency of condom use in the past three months and who proposed to use condom in commercial sex relationship; are presented in Table C2 of Annex C.

FACTORS ASSOCIATED WITH ENGAGING WITH HIGH-RISK BEHAVIORS

Factors reported in FDGs and IDI to be associated with high risk behaviors were; family issues, peer pressure and poverty. Besides, social-environmental factors such as the exposure to alcohol drugs or pornography at younger age or living in an unstable family were also reported by MARYP as reasons for their high risk behavior.

" …I had a step father…I felt that my step-father had a sexual desire toward me because he attempted to enter my room…I left home since then and doing what I am doing now [karaoke worker]" (female, 20-24 years)

MARYP reported wide access to all types of films, including pornography and violence. They also reported that this was a reason for having sex.

"…it's porn disc. Adolescents in their tenth already have experienced watching porn…and when they have desire for sex they go to find sex workers" (male, 10-14 years)

"some watched porn movie, then they want to try" (female, 10-14 years)

Young people often talk with each other about what they have done or been doing and at times they convince their group members to try something similar to them. Some female MARYP were persuaded by their sweethearts to adopt risky behaviors.

"…some kids were told by their friends that they can have good sexual pleasure and it costs only 5$ ..." (male, 10-14 years)

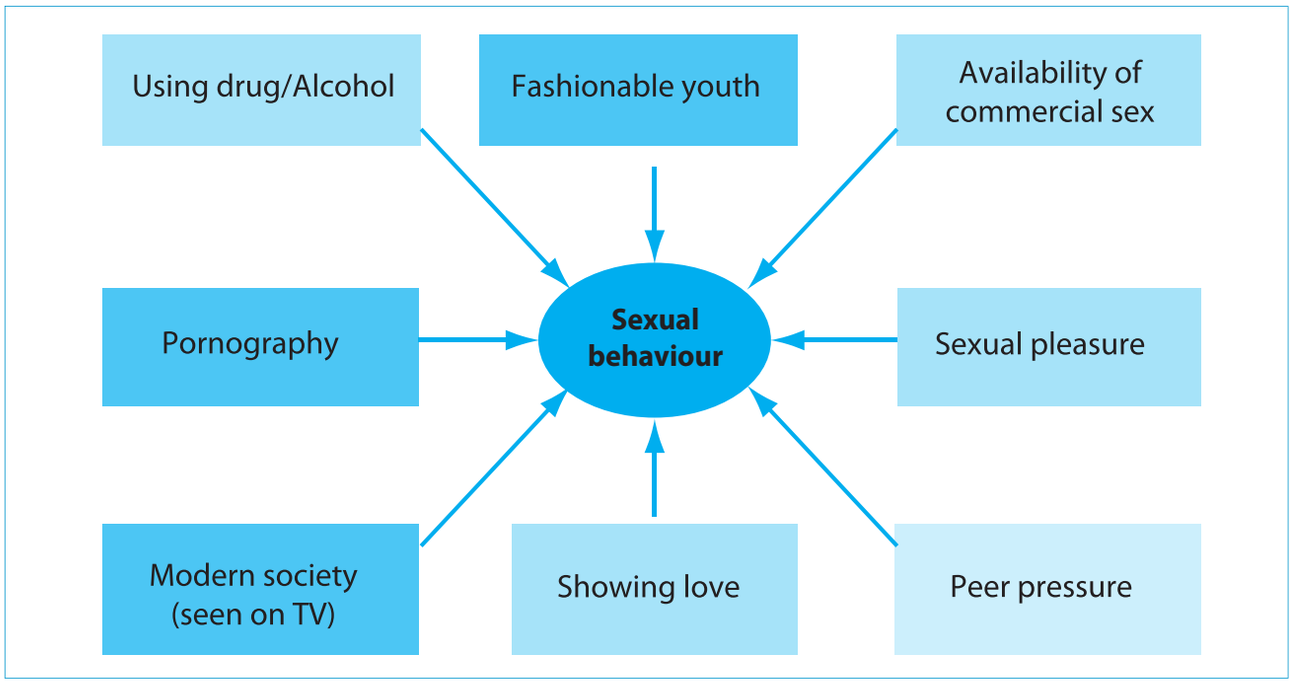
" some [young people] love their sweetheart so much , so when sweetheart offer drug, they accept" (female, 10-14 years)

The lack of money or employment was reported as a significant cause of vulnerability for female MARYP to engage in high risk behavior.

"any job that I can make money I will do it. If I work as Karaoke worker and clients want to buy sex from me, I will go with them, when I have money I can buy drug" (female, 10-14 years)

"our parents are poor, then we go to work as karaoke workers or house maid" (female, 15-19 years)

FIGURE 14 FACTORS ASSOCIATED WITH SEXUAL BEHAVIOR



INTERACTION BETWEEN ALCOHOL, DRUGS AND SEX

In fact, risk behaviors do not occur in isolation. There are strong interactions between all risk behaviors.

Table 11 shows that both male and female MARYP who are sexually active reported higher percentages of experiencing drugs and drinking alcohol. While almost 14% of female MARYP who were sexually active reported 'ever using drugs' only 0.4 % of female MARYP who never had sex reported so. Similar patterns are observed among their male counterparts. The association between sexual activity and alcohol is also observed but to a lesser extent.

TABLE 11 PERCENTAGE DISTRIBUTION OF DRUG AND ALCOHOL USE AMONG MARYP BY SEXUAL ACTIVITY STATUS, AGE GROUP, LOCATION AND SEX

	Ever used drugs		Ever drink alcohol	
	Female	Male	Female	Male
Ever had sex				
Age group				
10-19	17.8	27.5	89.2	99.3
20-24	12.9	29.7	94.0	99.6
Location				
Urban	14.0	30.5	94.2	99.8
Rural	11.5	23.5	84.8	98.4
Total	**13.8**	**29.2**	**93.2**	**99.5**
Never had sex				
Age group				
10-19	0.4	5.3	54.6	77.4
20-24	0.4	5.4	72.7	96.6
Location				
Urban	0.5	6.4	67.2	87.3
Rural	0	3.4	43.4	79.3
Total	**0.4**	**5.3**	**62.7**	**84.5**

Male MARYP reported using drugs and alcohol to increase sexual pleasure or to prolong sexual acts. This was not common among females.

"When I got drunk I want to have sex…since I want sexual pleasure" (male, 15-19 years)

" my friend gave me [drug] to try… I was told that after using drug, it will increase sexual pleasure and we can prolong sexual intercourse" (male, 20-24 years)

" when using drug, it increases sexual desire. It has even stronger effect among female" (male, 20-24 years)

"[after using drug] I had sex till the condom became hot, then I changed it sometimes I changed 2 to 3 times" (male, 15-19 years)

"…whenever I use drug, I feel I want to have sex. I can do whatever they[my sexual partner] want" (female, 20-24 years)

Disturbingly, drugs were reported by MARYP as sometimes being used for committing violent crime such as rape. Female MARYP reported having been drugged by their sweethearts before having sex. Others, after becoming addicted to drugs, agreed to have sex in exchange for drugs.

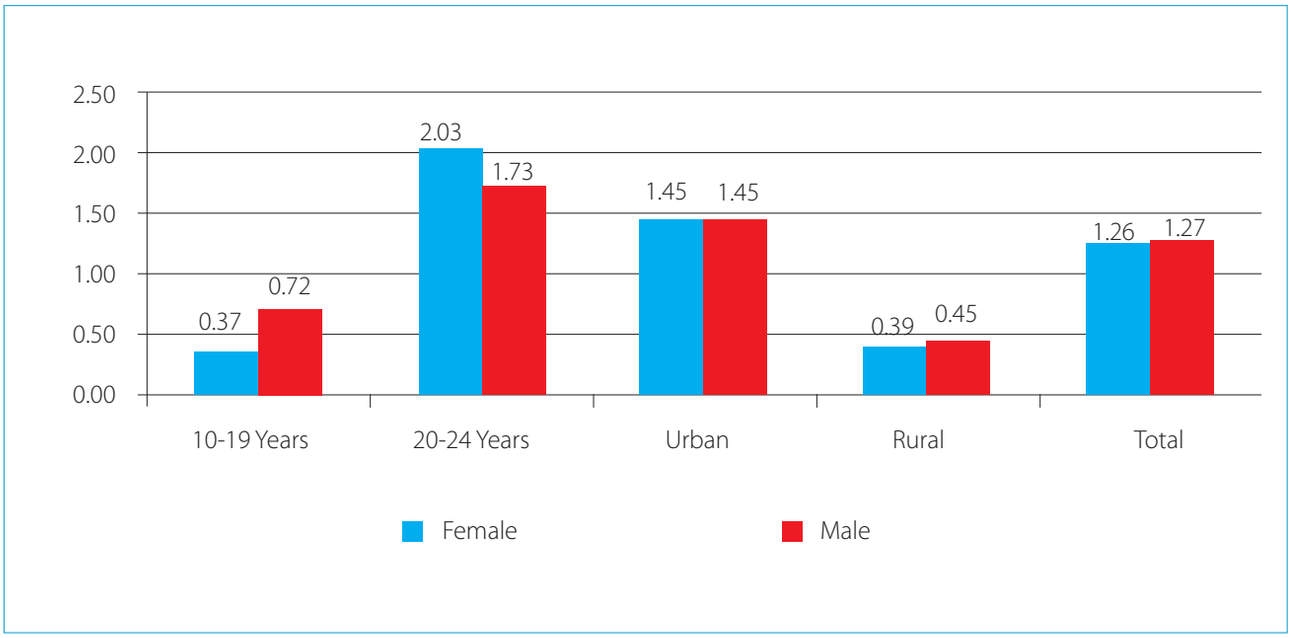
"when I don't have money to buy drug, [my boyfriend] ask me to have sex with him, I agree as long as I can have drug" (female, 10-14 years)

FORCED SEX

Figure 15 shows that 1.3% of both male and female sexually active MARYP reported that they were forced to have sex against their will in the past 12 months. Unfortunately further information on the perpetrator and condom use was not explored because the size of the sub-sample was too small.

"Days ago, 5 males [had sex] with one girl…[how?] we forced her" (male, 15-19 years)

FIGURE 15 PERCENTAGE OF RESPONDENTS WHO HAVE BEEN FORCED TO HAVE SEX IN THE PAST 12 MONTHS



MEN HAVING SEX WITH MEN

Among male sexually active MARYP, 3% reported having ever had sex with men and among those 73% had sex with a man in the past 12 months. Unfortunately condom and lubricant use among those who had sex in the past 12 months were not explored because the size of the sub-sample was too small. The survey also found that 21% of those who had ever had sex with men had paid to have sex and 69.9% of them had been paid to have sex (Table 12). While this appears to reinforce that money and the desire for material wealth seem to be significant motivating factors for MARYP, engaging in transactional sex may also be for livelihood and survival.

UTILIZATION OF HEALTH SERVICES AND KNOWLEDGE ON REPRODUCTIVE HEALTH AND OTHER SERVICES

Current programs for young people

Programs for young people have been explored through interviewing key informants in Phnom Penh, Sihanouk Ville, Battambong and Svay Rieng. These key informants were asked about the existence of services for young people in their communities. In addition, MARYP were also encouraged to discuss the availability of services (alcohol and drug rehabilitation centers, safe abortion, HIV testing, STI care and treatment, anti retroviral treatment) for young people.

TABLE 12 PERCENTAGE DISTRIBUTION OF SEXUAL BEHAVIOR WITH MEN WHO HAVE SEX WITH MEN

	Age group		Location		
Sexual behavior	**10-19**	**20-24**	**Urban**	**Rural**	**Total**
Ever had sex with men (%)	1.3	4.4	4	0.5	**3.0**
Ever had sex with men in the past 12 months*(%)	[79.5]	71.5	74.9	[34.6]	**73.1**
Median number of male partner in the past 12 months (IQR)	2 (2-6)	1 (1-10)	2 (1-8)	1 (1-1)	**2 (1-6)**
Ever paid to have sex with men*(%)	[9.3]	23.9	22.0	[0]	**21.0**
Ever received money in exchange for sex with men*(%)	[50.3]	[75.1]	69.8	[72.7]	**69.9**

**Among those who reported ever had sex with men*

Although there are programs currently providing services to young people in the provinces surveyed (for example STI clinics, reproductive health services, VCCT and harm reduction) it appears that the scope of those programs does not specifically focus on MARYP. Existing programs are focused on specific high risk groups such as street children, female sex workers, MSM or children affected by HIV/AIDS. While these specific programs do include some MARYP in their targets, those MARYPs who do not self identify, or fall outside the definition, may not be reached.

"Friends aims at integrating street children to society through the provision of life skills training, work and out-of-school education…" (a key informant)

There were calls for stronger collaboration and coordination between civil society and government stakeholders to ensure that all the programs for young people appropriately respond to their needs and to ensure the sustainability of those programs.

"…thus, we need to collaborate and provide services to children according to their need" (a key informant)

It was reported that there is a need to consider the geographically specific environments and related risks when designing programs for MARYP.

" In Svay Rieng, migration is the main problem for young people…since the land is not fertile for agriculture" (a key informant)

"some kids, mostly orphans, have been forced to use drug to serve a particular gang…" (a key informant)

It was widely acknowledged that problems faced by MARYP were very complex. This indicates the need for flexible holistic programs that address multiple issues at the same time. For example, service providers could consider delivering or providing referral to a range of services including health, protection and legal support, general education, livelihood support and vocational training.

"Services that NGO offers to young people are providing education, referral to health services or drop in centers or occupational training…" (a key informant)

" there is a service to help us starting small business through a loan" (male, 20-24 years)

Service providers noted that young people are curious and want to try new things. Where a protective environment is not in place it may not be feasible to prevent them from experimenting. Some service providers reported focusing more on prevention

or minimizing the risk by providing knowledge on possible consequences of high risk behaviors.

"We think that young people's groups are at risk…they often want to try new things, then we think they are at risk of HIV" (a key informant)

"young people most at risk are out-of-school young people…and especially those who work as fisherman at sea" (a key informant)

Shortage of programs for MARYP

While programs or services targeting changing risk behaviors, providing counseling, harm reduction, life skills training, or social safety nets to MARYP may be available, very few were mentioned by MARYP in this study. Similarly, service providers also highlighted the difficulty of delivering services for MARYP.

"I want TV programs discussing on the issues of drug use, alcohol use…" (female, 15-19 years)

"our education sessions are suitable only for in-school young people, out-of-school young people do not have time to attend our education sessions since they work from morning to night" (a key informant)

"Some young people are poor and living in remote areas, when the school provides food young people can come and learn tailoring" (female, 10-14 years)

Usage of the current health services (STI/ ART/ RH and VCCT)

Respondents were asked to list all barriers that prevent them from using services for sexually transmitted diseases and other diseases. As shown in Figures 16 and 17 the two main barriers that prevent MARYP from using health services are fear that confidentiality cannot be maintained and fees for services.

FIGURE 16 BARRIERS TO HEALTH SERVICES USAGE AMONG FEMALE MARYP

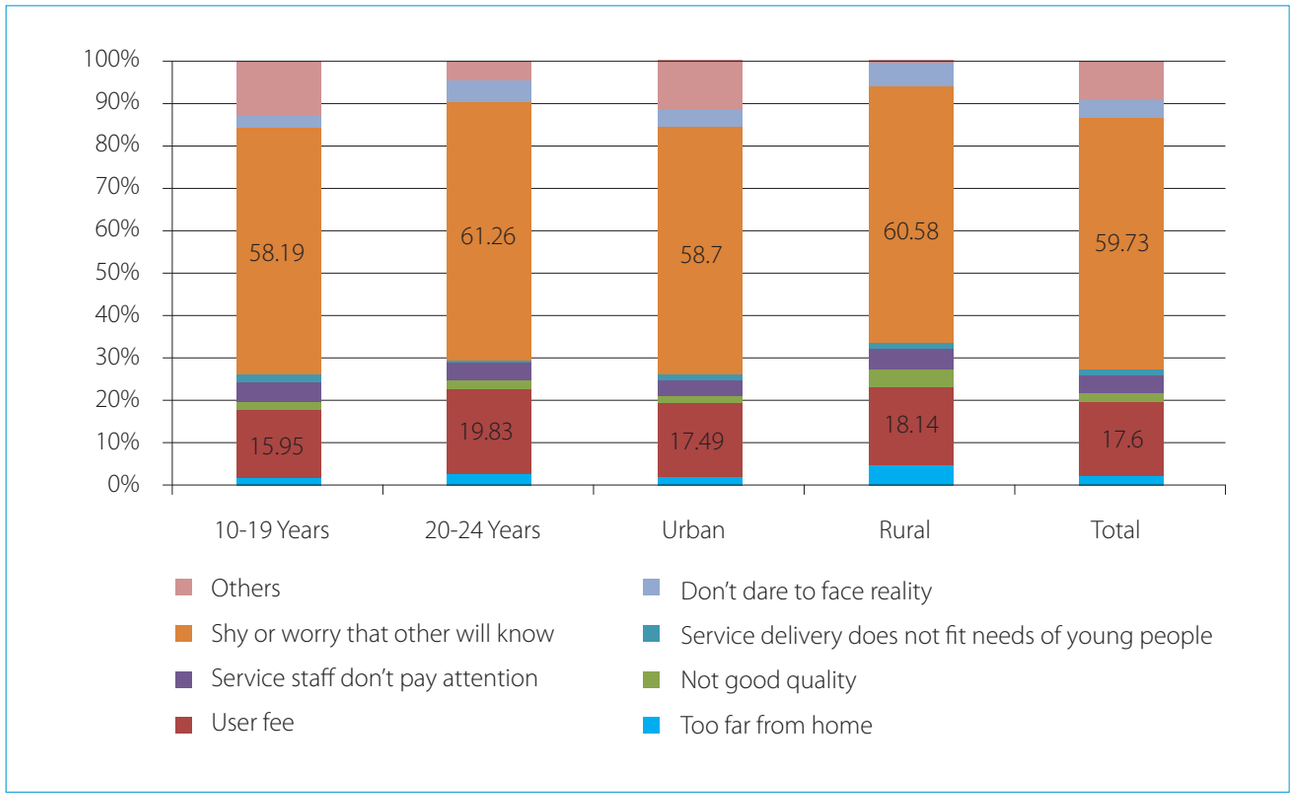


FIGURE 17 BARRIERS TO HEALTH SERVICES USAGE AMONG MALE MARYP

Table 13 sets out the reasons why MARYP were reluctant to use health services. The limited use of existing health services among MARYP was partially due to the lack of information about the services. The MARYP held a negative perception of public clinics citing the poor quality of services, low skills levels of medical staff, fees charged, and poor hygiene at the facilities as the main obstacles for young people to access public health services.

" …because I am afraid they charge me money" (male, 10-14 years)

"…those place shared the needle with many patients" (male, 10-14 years)

"…public hospitals do not have a service for safe abortion…" (female, 15-19 years)

TABLE 13 REASONS FOR NOT USING HEALTH SERVICES

SELF	PEER	FAMILY, COMMUNITY, SOCIETAL NORMS
No money Disease heals itself Feeling ashamed of using services	Peer advice	Opposite gender of health care providers Long waiting times in public areas Losing confidentiality User fees

Some MARYP refused to use health services such as VCCT or ART services, because they anticipated strong negative consequences in their communities if they are recognized. This is because using VCCT is thought to be linked with risky sexual behaviors. Fear of stigma and discrimination was also a major barrier preventing HIV positive young people from regularly going to receive opportunistic infection/anti-retroviral therapy (OI/ART) services.

"[why didn't you go to receive ART? I don't want people to know [why?] I am afraid people will hate me" (male, 15-19 years)

"…[why adolescents/young people do not test for HIV?] Feeling ashamed" (male, 10-14 years)

Most MARYP reported using health services only when their symptoms become serious. For example, they test for HIV only when they have been treated for other diseases or when their illness is severe. However, a few tested for HIV after engaging in high risk behaviors.

"...I had the test because I felt not well, I had headache, dizziness, constant ever…I cannot do anything" (male, 15-19 years)

"I want to know whether I got HIV or not, [why?] I had sex without condom" (female, 10-14 years)

A reason MARYP reported for attending VCCT clinics was the money given by service providers as an incentive. This method could be an area of manipulation and should be approached with caution by service providers.

"NGO told me to go having blood test, I will got 2$. Other young people only go to get tested so they can get money for drinking" (female, 10-14 years)

Other reported factors that discourage MARYP from using public services were long waiting times at the clinics, being afraid of being examined by doctors of the opposite sex, and losing confidentiality. Advice from peers is also often sought before adolescents decide to select any health service provider.

Quality of health services

Overall MARYP reported greater client satisfaction with NGO health services.

"Health workers are friendly, they do not look down at us…I am satisfied with the services" (female, 20-24 years)

"To me, I like NGO services, I like the service of providing education at home/communities" (female, 20-24 years)

Both MARYP and service providers reported that they were not aware of any specific strategies in place to promote the use of health services, especially at STI clinics and VCCT sites, among young people. The information about the existence of such services reached adolescents only from their peers.

" we do not encourage them to come again, we only give them condom or leaflet" (a key informant)

" there have been very few school students visiting the clinics via a word of their friends" (a key informant)

"their other friends used to go to that place for abortion" (male, 20-24 years)

Perceived ideal health services for young people

Generally health care providers assumed that the limited use of current health services among young people was because they decide to use health services only when the illness is serious. Paradoxically, MARYP reported that there is a need for substantial changes to the way health services are delivered to make them more suitable for young people. The following recommendations were made by MARYP:

- Affordable service fee
- Short waiting periods
- Ensuring confidentiality for young people
- Highly skilled clinicians
- Hygienic facilities
- Respectful environment
- Same sex doctors

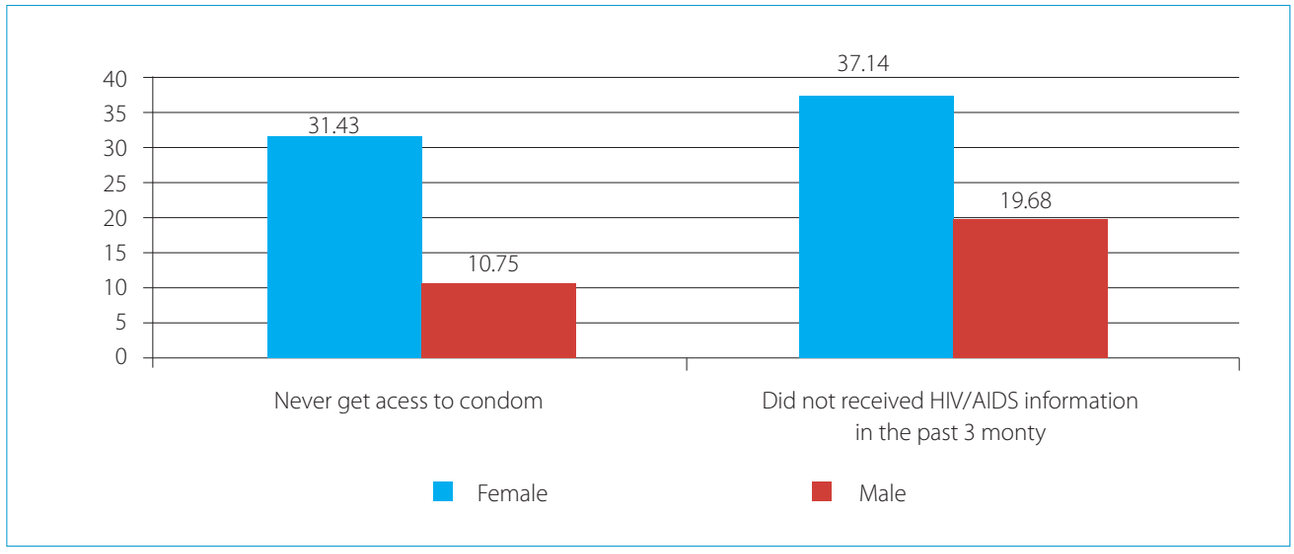
"at the VCCT, I want to have male health worker to provide service to male clients since male health worker may understand male issues better…with male health workers we can ask what we want to know [because] we are not shy" (male, 20-24 years)

HIV/AIDS related services and information

Figure 18 shows that almost 32% of sexually active female MARYP had never received a condom and 37% of them had not received HIV/AIDS information in the past three months. This indicates a significant prevention program gap. In contrast 10.7% sexually active male MARYP never received a condom and 19.7% had not received HIV/AIDS information in the past three months.

While almost 21% of female MARYP had been tested for HIV and more than 95% of them returned for their last test result, only 16.5% of male MARYP had been tested for HIV and more than 98% returned for their last test result (Figure 19).

FIGURE 18 PERCENTAGE OF SEXUALLY ACTIVE MARYP WHO HAD NEVER RECEIVED A CONDOM AND DID NOT RECEIVE HIV/AIDS INFORMATION IN THE PAST THREE MONTHS



More detailed information on the location where HIV testing was done and places to access condoms by age group and location is presented in Table D2 of Annex D.

Sexually transmitted infections and treatment seeking behavior

All sexually active respondents were asked to recall their STI symptoms in the past 12 months. Figure 20 shows that cuts or sores in the genital area was the most common STI reported symptom (1.8%) among sexually active male MARYP followed by discharge with unpleasant smell and swelling in the genital area. Among sexually active female MARYP, vaginal discharge with unpleasant smell was the most commonly reported symptom (17.8%) followed by swelling in the genital area and cuts or sores in the genital area.

FIGURE 19 PERCENTAGE DISTRIBUTION OF EVER TESTED FOR HIV AND GOT RESULTS AMONG MARYP

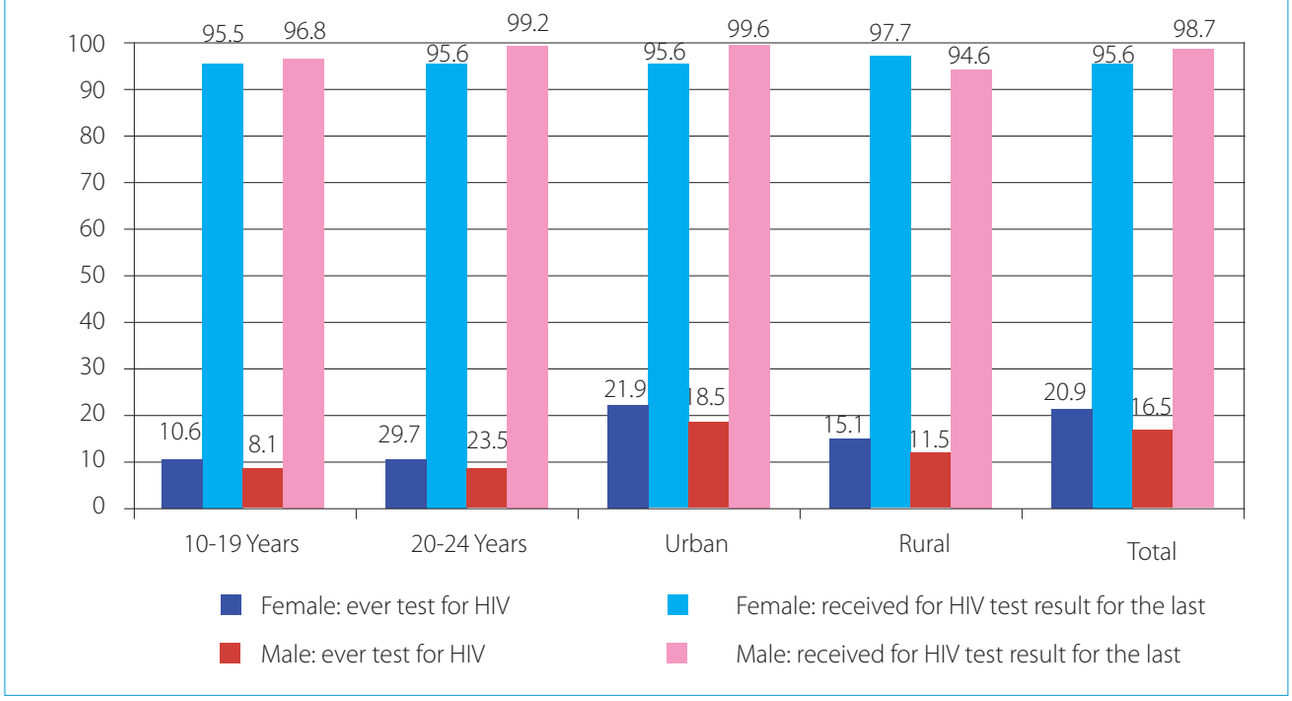
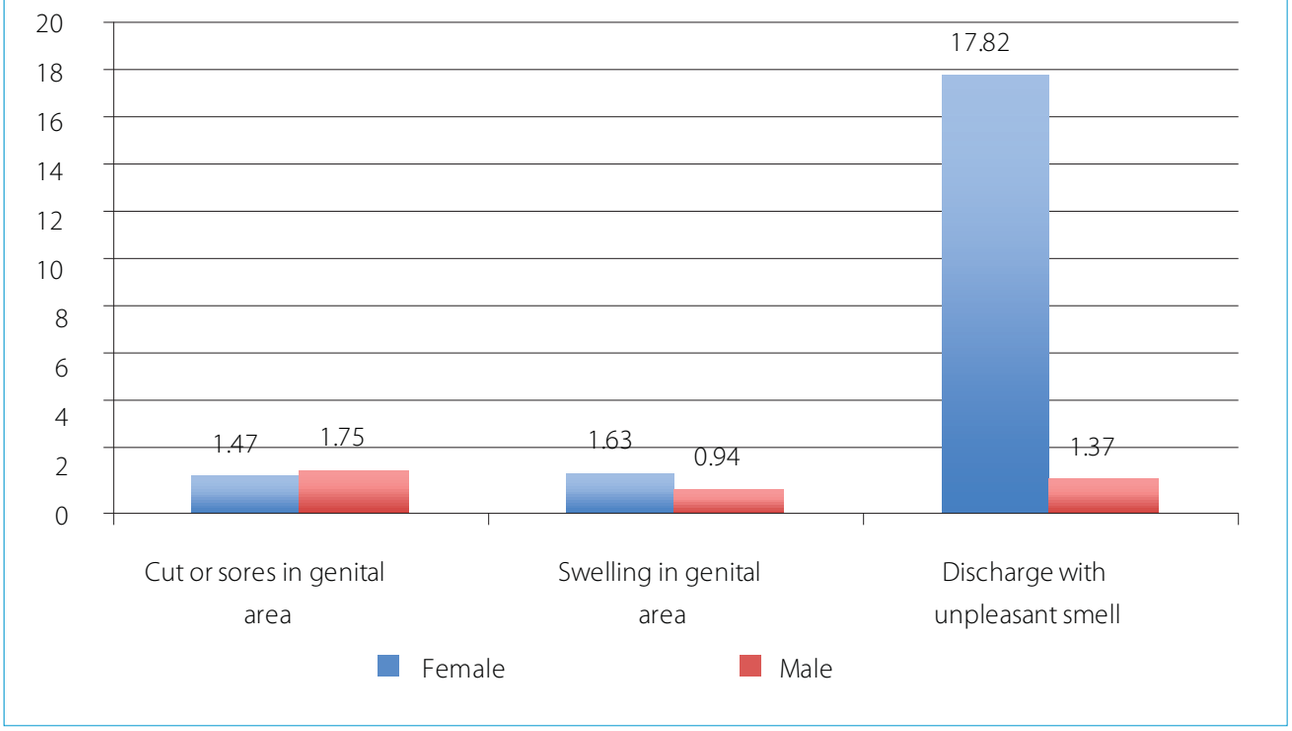
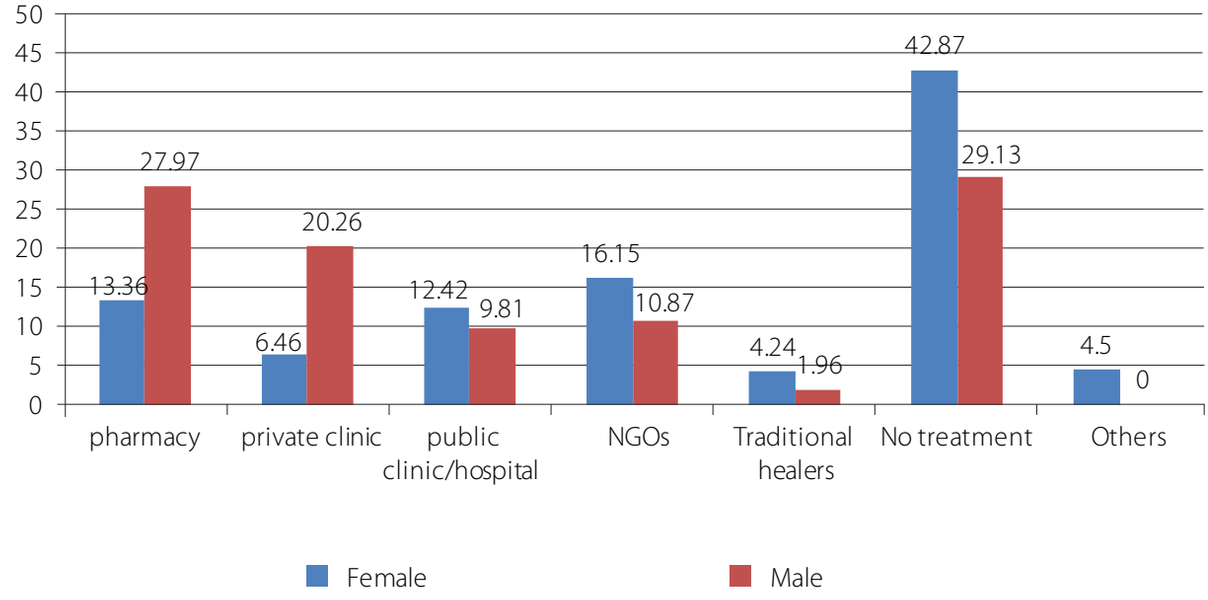


FIGURE 20 PERCENTAGE OF STI SYMPTOMS AMONG MARYP IN THE PAST 12 MONTHS



Alarmingly, among those who reported any STI symptoms, almost 43% and 30% of female and male MARYPs respectively did not seek treatment at all (Figure 21). Younger respondents and those living in rural areas fared worse than their older or urban counterparts. The reasons for not attending STI services reported by MARYP in qualitative discussions are noted above and include confidentiality concerns, service providers of the opposite sex, and fees charged.

FIGURE 21 PERCENTAGE DISTRIBUTION OF LAST STI TREATMENT SEEKING BEHAVIOR



Additional detailed information on places for STI treatment and stigma experienced in STI services, by age group and location can be found in table D3 of Annex D.

Reproductive health knowledge and services

In general, MARYP recognized some contraceptive methods and they were also able to correctly list places from which different health services could be obtained. However, there were some examples demonstrating a lack of specific knowledge about health services or misconceptions about how to correctly use contraception.

"I asked [her] to take OK [an oral contraceptive]…[how?] to take the drug after having sex for a week" (male, 10-14 years)

Almost 12% of sexually active female MARYP had experienced at least one pregnancy and 33% of their last pregnancies were terminated by an induced abortion. Younger women (aged 10-19 years) reported the highest rate of induced abortion for the last pregnancy. In terms of the last induced abortion, more than half of the women received the service from private clinics and 35% self induced (figure 23).

"[if a woman gets pregnant and they don't want the child] they can have an abortion from pharmacy" (female, 10-14 years)

Additional findings on knowledge about contraception methods and places where women can get abortion services by age group and location are presented in table D1 and D4 of Annex D.

FIGURE 22 PERCENTAGE OF FEMALE MARYP THAT HAD HAD A PREGNANCY AND PERCENTAGE OF INDUCED ABORTION OF THE LAST PREGNANCY

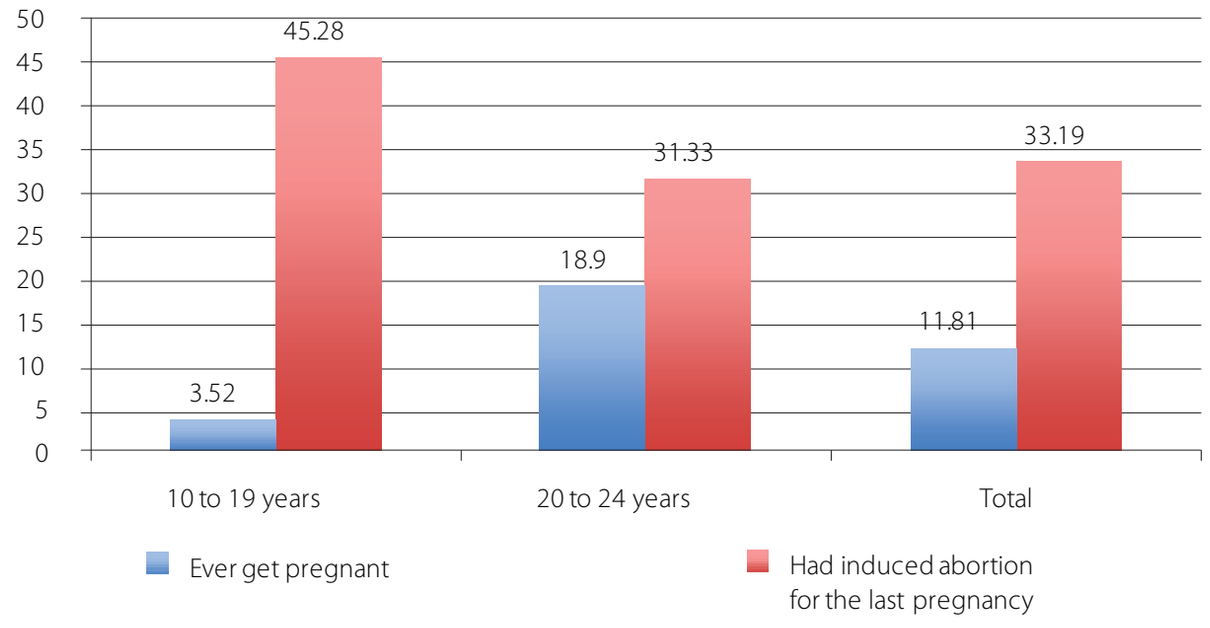
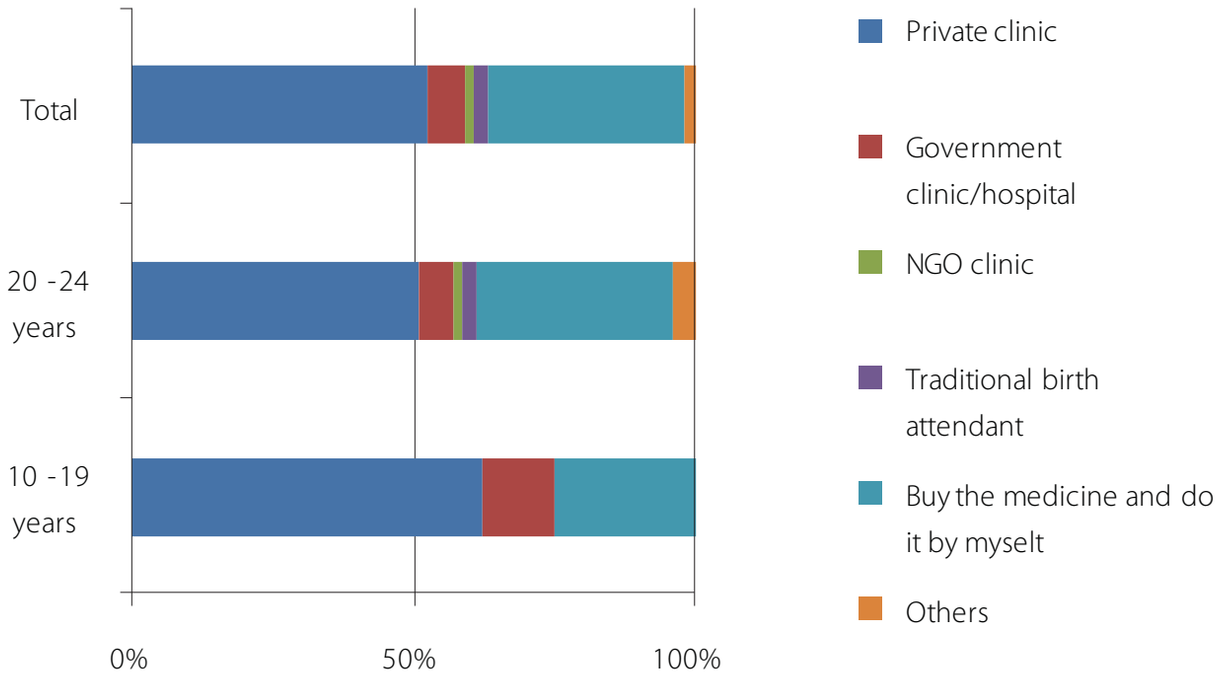


FIGURE 23 LOCATION OF THE LAST INDUCED ABORTION



Knowledge on negative consequences of alcohol/drugs and access to related services

Although alcohol consumption by MARYP was reported at high levels, more than 90% of respondents (male and female) reported that they are aware of the dangers caused by drinking.

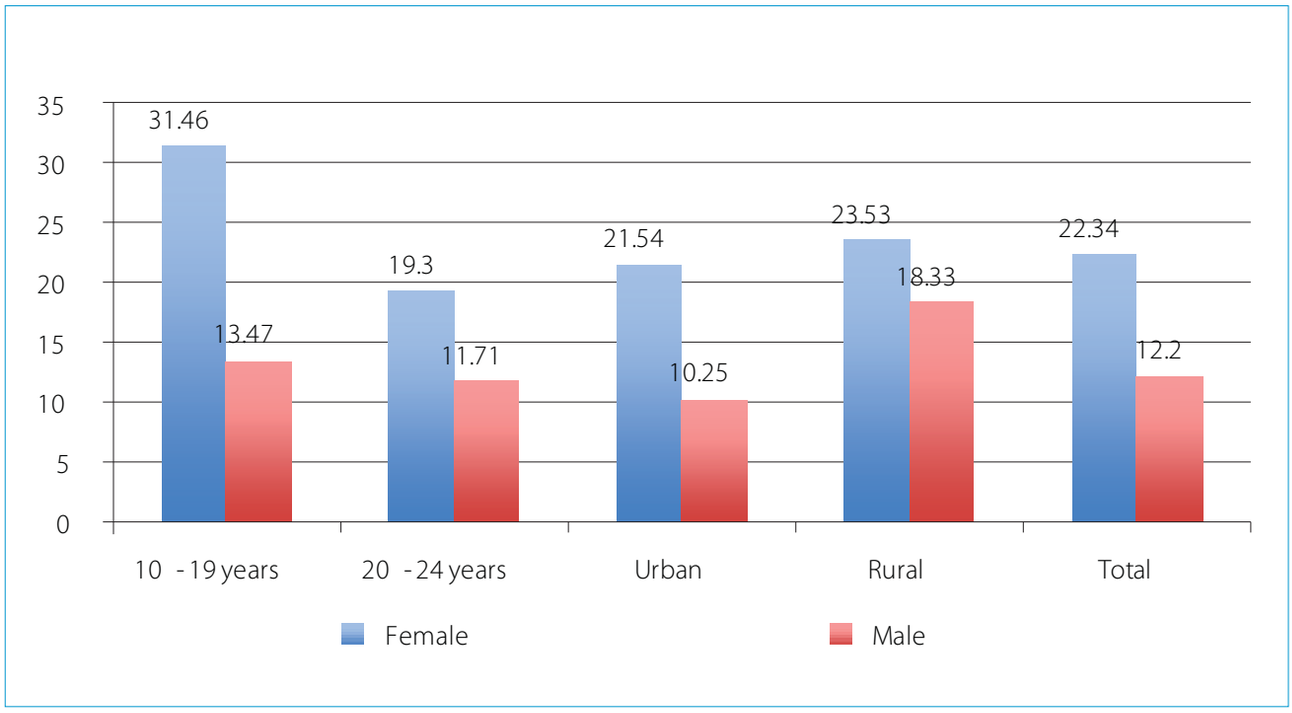
Among MARYP there was no reported knowledge of programs available to help them deal with drinking problems or that work towards delaying the initiation of alcohol drinking.

"[is there any place that can help young people to solve their drinking problem?], no" (male, 10-14 years)

There was a similar lack of knowledge relating to voluntary drug rehabilitation centers. Particularly noted was the lack of those specifically tailored for young women. Figure 24 shows that 12% and 22% of male and female respondents respectively never received any information regarding the harmful effects of drugs on health. Further 16.7 % and 32.9% of male and female respondents respectively reported that they do not know where to go when they want to stop using drugs (Figure 25).

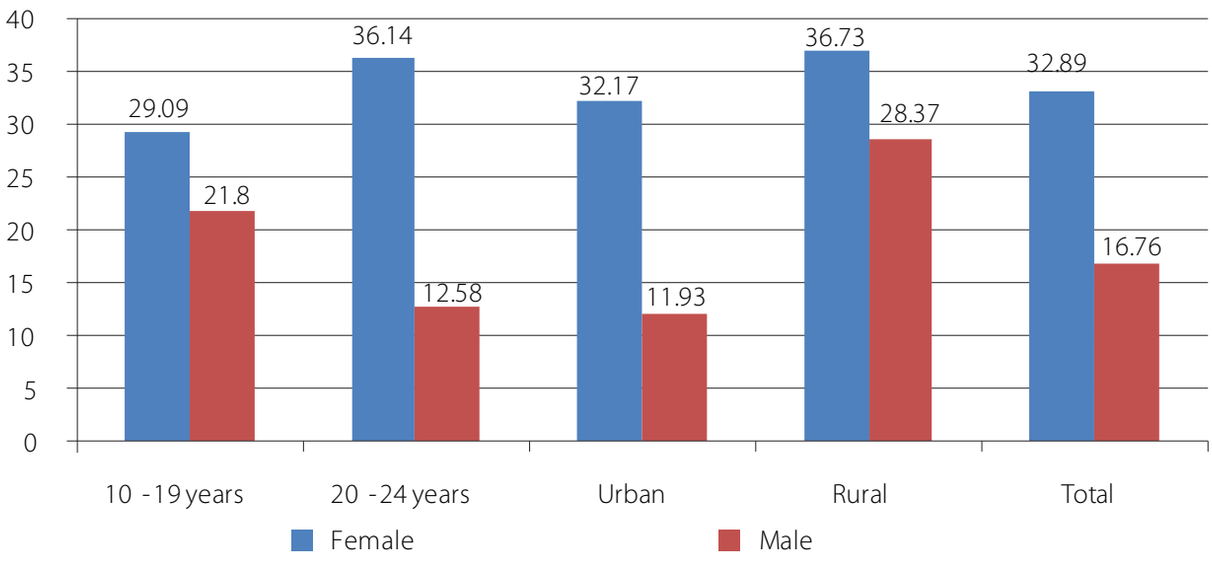
"I haven't heard on the news about rehabilitation center for female drug user" (female, 10-14 years)

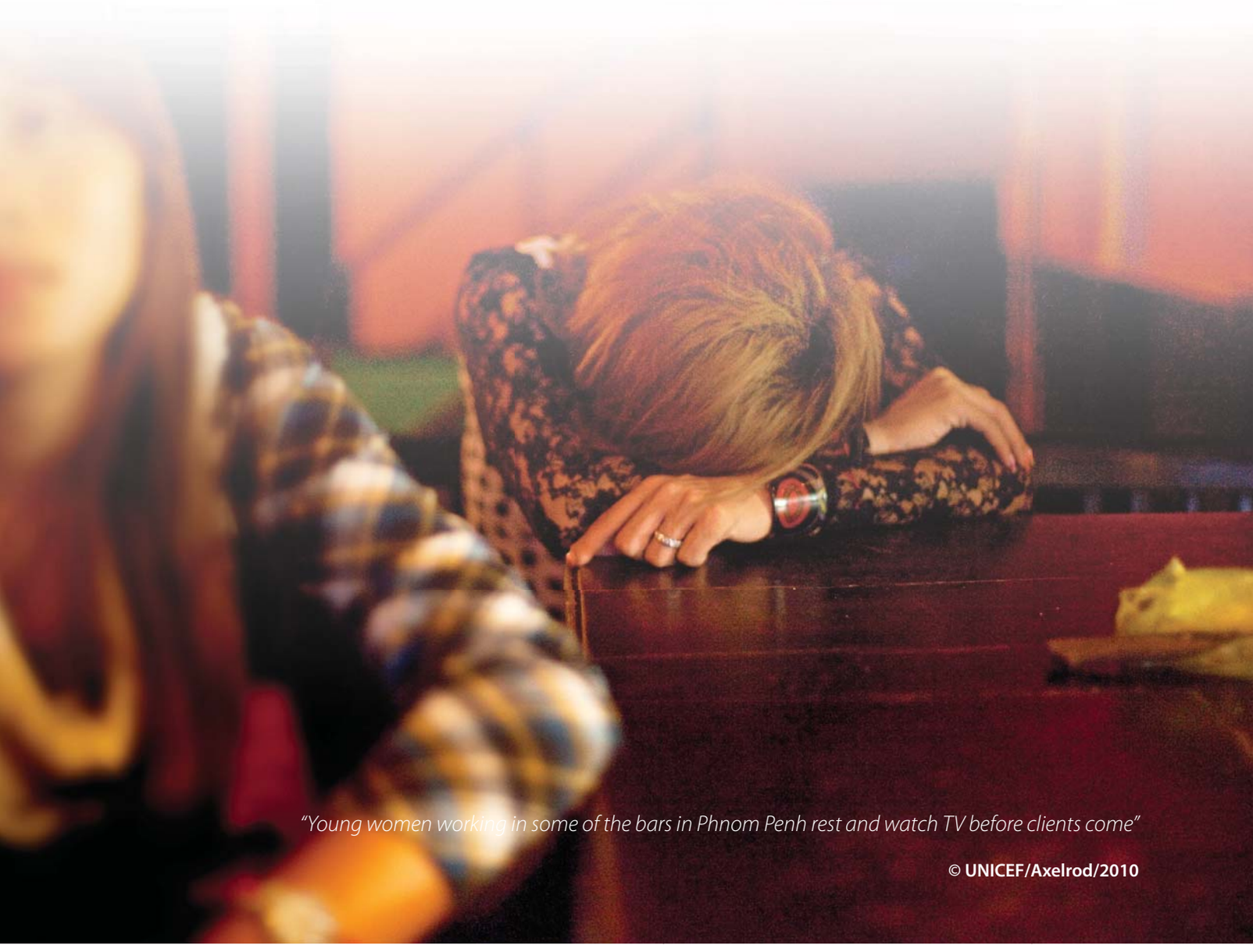
FIGURE 24 PERCENTAGE OF RESPONDENTS WHO NEVER RECEIVED ANY INFORMATION ON THE HARMFUL EFFECTS OF DRUG USE



Additional findings on where MARYP received information about the effects of alcohol on health are presented in table D5 of annex D. Also additional findings on where drug users can find clean needles and syringes, sources of information on harmful effects of drugs on health, and places for drug treatment are presented in table D6 of annex D.

FIGURE 25 PERCENTAGE OF RESPONDENTS WHO DO NOT KNOW WHERE TO GO WHEN THEY WANT TO STOP USING DRUGS





"Young women working in some of the bars in Phnom Penh rest and watch TV before clients come"

© UNICEF/Axelrod/2010

DISCUSSION & PROGRAM RECOMMENDATIONS

The findings from this survey are abundant and need to be understood and applied in an appropriate context. Due to the cross-sectional nature of the study, the findings are only a snapshot of the MARYP behavioral spectrum. The discussion below is organized based on the different topics and themes that arose from the data analysis.

Analysis showed that in most aspects of their lives, peers and family/ community/ societal norms are as equally important behavioural drivers as the self-beliefs of the adolescent themselves. This is in part because MARYPs are the product of their Cambodian society. Their young lives and beliefs are shaped by the level of development, socio-economic status and values of society. Similarly, MARYPs are strongly influenced by their families and the communities where culture and traditions are embedded. Traditionally, within Cambodian families, boys and girls do not share the same experiences or rights regarding education, behaviors and freedom of movement. This gender imbalance can disempower girls and women making them more receptive, conforming and passive, although this was observed to be slowly changing.

Like other most at risk populations such as MSM or entertainment sector workers, MARYP are not a homogenous group and the needs of sub-populations must be recognized and addressed, depending on age, gender, behavioral risk, and vulnerability.

Recommendation: Understanding the interactions between social, family and community factors and how these influence young people's values in life are crucial to clearly understand MARYP behaviors, attitudes and practices and inform the design of interventions. Interventions should be based on an understanding of who is at increased risk, why (personal motivation and structural determinants) and where young people most at risk are located ("hotspots"). Further, they should be appropriate to the age, psychosocial development of MARYP and address the differing needs of males and females.

Education, peer and other popular influences

Although education is believed to trigger socio-economic development, resulting in poverty reduction and bridging disparity within society (UN Country Team 2009), having an education and good discipline were not highly valued by MARYP. While the government has made great efforts to provide access to nine years of basic education to all young people (UN Country Team 2009), MARYP felt that having an education would not guarantee them a job. They perceived that the availability of appropriate employment and livelihood/income generation opportunities were more critical. The longer-term benefits associated with attending school regularly were frequently overshadowed by the more instant gratification of survival, using high-tech materials or wearing fashionable outfits. Possessing such items made adolescents feel more special and admired and promoted by their peers.

Recommendation: Aspirations of MARYP include happiness and popular, materialistic things which may be considered for use in BCC programs targeting MARYP. Role models and peers have been observed as one of the strongest influences in MARYP lives. Therefore, consideration should be given particularly to the use of popular role models and/or trendy items or materials when promoting positive or protective behaviors to MARYP. Well trained and motivated

young people should be engaged as peer educators (who are similar to the target group in terms of age, gender, background and interests) working in a group or with existing social networks, as they are more likely to have greater influence on MARYP behavior than those who are not similar to the target group or who work alone. It is also important to create environments enabling risk-free behaviors for MARYP such as sport games to congregate with their peers. Effective partnerships with community based organizations and the use of peer networks and counselors could be created, which include the systematic referral of MARYP to sexual and reproductive health services.

Earning money

Having money was cited as one of the most important things in life for MARYP. In addition to materialism, it is likely that the MARYP included in the study were working to support their families and driven to satisfy their basic needs of food and shelter. Consequently, MARYP did not seem to care much about what type of employment they have as long as it allows them to earn a living and in the shortest possible period of time. This can mean that illegal work may be more preferable to more legal/formal work. This in turn can mean that they are more vulnerable or open to sexual exploitation and engagement in higher risk or illegal behaviors.

Recommendation: Young people are in great need of a variety of life skills and vocational training opportunities that are suitable for their level of general education and increase their employability. This indicates the need for youth programs to include opportunities and training for holistic livelihood and income generation or to increase their access to existing formal and in-formal school education systems. In primary prevention or harm reduction interventions, links to livelihood development opportunities as well as initiatives which support MARYP networking should be regularly promoted.

Alcohol

Although MARYP are aware of the harmful effects of alcohol to their health, drinking alcohol was high among MARYP (up to 91% in males) regardless of gender, age and location. This differs significantly when compared to the study among young people conducted by the Ministry of Education Youth and Sports in 2004, where only 14% of young Cambodians reported drinking alcohol (MoEYS 2004). This difference may be explained by the fact that the survey conducted in 2004 was among all adolescents (not those most at risk) and in a younger age group (11 to 18 years old). There has also been a more extensive range, availability and advertising of alcoholic drinks in recent years.

To young people, drinking alcohol is reported to be a way of socializing with their peers, to celebrate, as a way of coping with stress, or as symbol of wealth and popularity. Drinking alcohol is linked with high-risk sexual and violent related behaviors. High levels of alcohol consumption has been linked to having friends or parents who drink alcohol and young people who drink are also more likely to drink and drive (Feldman et al 1999).

Recommendation: Drinking alcohol has become a norm among MARYP, implying that in order to change the current perception and practices towards alcohol drinking, crosscutting approaches addressing individual as well as environmental factors need to be adopted. Consider also the use of popular celebrities to promote more responsible behavior and knowledge of the consequences caused by risky behavior.

According to the Ministry of Education, Youth and Sport, information about the negative consequences of drug use, in addition to reproductive health and HIV information had been included in the school curriculum. However, the topics on alcohol and its consequences have not yet been fully integrated.

Recommendation: School curriculums and teacher training could be further reviewed and strengthened to include up-to-date information on the harmful effects of alcohol and to expand life skills training, with a focus on risk reduction skills to empower young people to take responsibility, avoid drugs and delay the initiation of alcohol use and sex.

Among females, the highest levels of drinking were reported among the older age range (20 to 24 years). This is likely to have arisen because of alcohol consumed during employment in entertainment outlets such as karaoke and beer gardens. This is consistent with research done by employers of beer promotion women on alcohol consumption during work hours. In that survey, 73% of 500 beer promotion women surveyed reported drinking with customers and 85% of 500 being forced by customers to drink (CAS 2009).

Recommendation: Programs targeting female MARYP working in the entertainment industry should consider including information on the harmful effects of alcohol while addressing workplace health and safety. Consideration could also be given to the engagement of private sector owners and managers of the outlets where women work to promote protective work environments.

Drugs

There is a gender difference regarding drug use, as only 3.5% of female MARYP reported ever using drugs while over 15% of males reported so. However the highest levels of injecting drug use (in the last 12 months) were recorded by females.

Recommendation: There is a critical need for gender sensitive and specific approaches to be applied in drug treatment and harm reduction programming.

Of those who had used drugs, ATS such as yama, yaba or methamphetamine-based powder were by far the most commonly drugs used. These findings are consistent with those from a study conducted in 2007 among drug users in Cambodia (Chhea et al 2007).

Recommendation: This finding further confirms the need for dedicated and community-based ATS prevention, treatment and harm reduction programming.

Most of the drug-use activity occurred among groups of friends. This finding was also reflected in the drug buying patterns noted in MARYP discussions where friends and peer networks were reported as the most common way to access drugs.

Recommendation: This indicates a programmatic opportunity to establish or strengthen youth networks targeting MARYP and linking these via referral to existing harm reduction and drug treatment services.

Sexual behavior and drivers

About 40% of male and 23% of female study participants reported 'ever having sex'. Among the male group, the majority of their first sexual partners were sweethearts (58%), followed by sex workers (17%). In contrast, about 50% of women reported their husbands as their first sexual partners, followed by sweethearts (37%). This difference can be explained by the qualitative findings. To women, having sex with a sweetheart is considered as a way of showing their love or to strengthen their relationship. Consequently, females often decide to have sex with their partners when they believe that their partners will eventually become their husbands. This perception and practice was often not shared by their male counterparts since most men reported having sex with their sweetheart only to satisfy their sexual desires.

Recommendation: These gender specific perceptions on the decision to have sex need to be particularly noted when working with MARYP in HIV prevention and family planning and also education on sexual and reproductive health should be provided.

Sexually active MARYP in this study confirm that condom use is not consistent with sweethearts for both young men and women. This reiterates the need for appropriate messaging around consistent condom use among this vulnerable population.

Among those male respondents who reported 'ever having sex' (41%), the majority (83%) reported 'ever paying for sex with women in the past year'. This is significantly different from CDHS findings where only 6% of young men aged 15 to 24 years reported so (NIPH et al 2006). This may be due to the success of the research methods to identify MARYP, who are prone to higher risk behaviors than the general population.

Interestingly, the percentage of consistent condom use in the past three months among males most at risk young people was as high as 89%. This is consistent with the 87% of female study participants who sold sex who reported using condoms consistently. This percentage is also very similar to the level of consistent condom use reported by karaoke workers in the behavioral sentinel survey 2007 (Chhea et al 2007). This suggests that condom use promotion messages to prevent HIV infection have successfully reached MARYP who engaged in commercial sex.

Among sexually active female MARYP, their first sexual partner was most often their husband who was on average five years older. Such age mixing can increase exposure to HIV/STIs because older men have longer sexual histories and younger women are less likely to be able to negotiate safer sex with older men, particularly in Cambodian society.

Recommendation: This finding further affirms the need for appropriate messaging around consistent condom use and the value of VCCT, especially for couples.

In response to the question of having been forced to have sex against their will in the past 12 months, 1.3% of both male and female answered affirmatively. In 2004, a study among adolescents found that 1.9% of males were forced to have sex (MoEYS 2004). Due to the small sample size in this group within this study, the information about perpetrators was not further determined.

Recommendation: Further research should be conducted to identify the root causes and more details of the extent of the rape problem. This would help to inform programs providing appropriate services supporting young survivors of sexual violence.

Both male and female MARYP believe that having sweethearts makes them look fashionable or trendy. In addition to factors associated with their physical development, peer and societal influences, such as movies or pornography, may encourage young people to start their sexual relationships. This combination of factors influencing the first sexual experience increases the vulnerability of young people. This vulnerability is deepened with the impact of migration of MARYP to work in urban areas. While the independence from the family may be perceived as individually empowering by the MARYP, their vulnerability to gang violence, crime or rape is increased (UN Country Team 2009).

Recommendation: The absence of family support and guidance indicates a program opportunity to develop skills and vocational training or strengthen MARYP networks targeting migrant young people in urban areas, as well as their systematic referral to health services, livelihood, life skills or vocational support.

Among MARYP, 56% of males and 21% of females had had sex with their sweethearts in the past 12 months. The percentages of reported condom use between males and females when having sex with their sweethearts showed similar gender differences (58% vs 31% respectively). The low percentage of condom use with sweethearts (as compared to with commercial sex workers) among male and female sentinel groups has also been well documented in Cambodia (Chhea et al 2007; Heng et al 2005). A qualitative study conducted in 2002 explained the low level of condom use in non-commercial relationships by concluding that the level of condom use is heavily dependent on the level of trust between sexual partners (PSI 2002).

Recommendation: While these are not surprising findings, they confirm the need for more comprehensive HIV prevention, treatment and care information to be linked with family planning

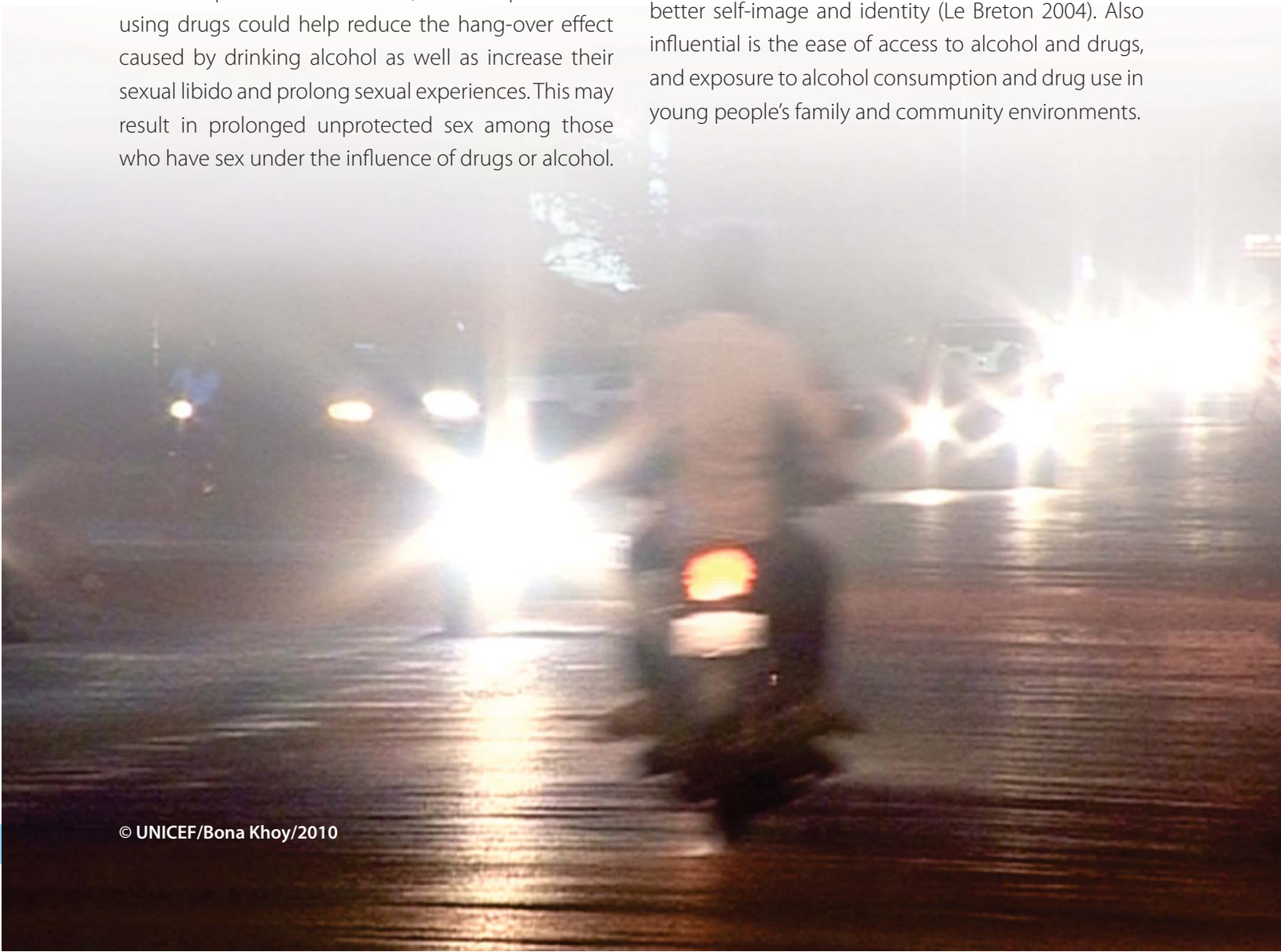
programming for MARYP. These should also include peer education programs which include life skills training and referral linkages to appropriate family planning services.

Drug or alcohol use is more common among those who reported 'ever having sex' than those who reported never having had sex. This finding is consistent in both the male and female groups. This suggests that young people who have been involved in one type of risky behavior are more likely to be involved in other risky behaviors. The link between alcohol and sex was also found in a 2004 study among male and female adolescents aged 11 to 18 years old. They found that 40% of young people, out of school who had sex, did so after drinking alcohol (MoEYS 2004). Similarly, a study in Portugal revealed that alcohol and drug users were more likely to adopt more risky sexual behaviors (Lomba et al 2009) and drug use was also associated with higher rates of sexually transmitted diseases (Galvez et al 2009). From the qualitative discussions, MARYP reported that using drugs could help reduce the hang-over effect caused by drinking alcohol as well as increase their sexual libido and prolong sexual experiences. This may result in prolonged unprotected sex among those who have sex under the influence of drugs or alcohol.

Recommendation: The above findings reinforce the need to address multiple and often overlapping risk behaviours related to unsafe sex, alcohol and drug use among MARYP. Further, risk reduction skills of MARYP need to be fostered to help them negotiate consistent and correct condom use in their sexual relationships (whether with their sweetheart or other sexual partners); develop strategies for refusing unprotected sex; and avoid clients/partners who are alcohol or drug affected and potentially violent. Additionally, teachers or other trusted sources could be equipped with counseling skills so that they can identify young people with behavioral problems and provide timely practical assistance to them.

High risk behavioral drivers

The natural urge to experience new things combined with the need to be included into peer groups make MARYP very vulnerable to risky behaviors. However to adolescents, risk taking has a positive effect in cultivating a sense of independence and leading to better self-image and identity (Le Breton 2004). Also influential is the ease of access to alcohol and drugs, and exposure to alcohol consumption and drug use in young people's family and community environments.



© UNICEF/Bona Khoy/2010

Recommendation: This complexity of influencing factors confirms the need for flexibility and multi thematic approaches in programming, and the need to engage multiple stakeholders beyond the young people themselves. Programs aiming at creating supporting networks for MARYP in the community and family should be developed. Schools, local authorities, police, parents and community should also be involved in activities to prevent young adolescent from engaging substance abuse and high risk behaviors and to minimize the impact of those high risk activities. This key stakeholder engagement will also help to address the social exclusion of MARYP.

Programmers working with MARYP should actively promote and facilitate the involvement of MARYP in the development, implementation and monitoring of programs.

Literature suggests that family problems such as family break up, domestic violence, and alcohol or drug abuse in households where MARYP live create unhealthy environments. Particularly, living in alcohol permissive households was found to have an association with heavy drinking among young people (Tucker et al 2008). Young people often turn to friends for support and comfort when they have conflict within their families. As a result, young people may be ill advised by their peers to use drugs or drink alcohol to cope with their issues. The drinking and smoking habits of friends were strongly related to alcohol use among adolescents (Dick et al 2007). Findings from a study on smoking showed that smoking adolescents were often attracted to the behaviors and image of peer groups who also smoked (McLeod et al 2008). This suggests that peer pressure and social norms, such as the availability of alcohol and drugs and the practice of using alcohol or drugs for socializing are influential determinants of alcohol and/or drug abuse among young people.

Recommendation: This presents a programmatic opportunity to include BCC highlighting the harmful effects of alcohol and drugs, as well as empowering, negotiation skills into life skills and peer education programs.

Despite the fact that family behavior is a strong determinant of MARYP behavior, parents appear to have received very limited support on how to discourage their children from being involved in risky behaviors and how to identify when their children have a drug problem. A study on parenting style found that adolescents who live with authoritative (rather than authoritarian) parents were unlikely to drink alcohol heavily and have friends who drank alcohol (Bahr et al 2010). There seems little guidance or programming on appropriate strategies parents can adopt to deal with their children who have drug or alcohol issues. This study's qualitative findings revealed that the practice of scolding children or punishing children by not allowing them to return home seems to push MARYP toward high-risk behaviors.

Recommendation: Parents can be a powerful ally in interventions preventing high-risk behaviors among young people. Family based approaches should be employed to enable parents to talk with their children about sex education, taking responsibility and overcoming peer pressure and harmful gender norms. Moreover, programs creating and supporting community networks should be strengthened for most at risk young people and their families, linking them as appropriate to accessible referral services.

Arguments and failures in school, friendship or love issues are not psychologically good for adolescent health. Many MARYP reported that such issues are the drivers of stress and depression resulting in high risk behaviors. Another study on suicide in children reported that having a conflict with sweethearts, within the family or at school, or living in an unhappy family were predictors of suicide (Schmidt et al 2002). This study revealed a link between chronic stress exposure at a younger age to alcohol drinking and drug abuse in early adulthood (Enoch 2010). The lack of knowledge of services reported by MARYP reflects a considerable gap in programs for counseling and support services for depressed, vulnerable young people.

Recommendation: Access to legal and psychosocial support as well as alternative education opportunities needs to be actively facilitated. However, the point of delivery of these services needs to be tailored to ensure that it is gender and environmentally appropriate for both in and out-of-school young people so that they can benefit equally from the counseling services. Notably, some success has also been achieved in Cambodia through radio call-in programs for young people, which maintain confidentiality and provide a safe space for adolescents to explore sensitive issues and feelings. Such interventions could be further encouraged.

Programs with and for MARYP

It has been observed that young people living in one geographical region face different barriers compared to those living in other areas. The socio-economic, development and job market in a particular region impacts strongly on the behavior of MARYP who reside there. When faced with a shortage of jobs available locally, MARYP reported accepting any paid work regardless of its legal status. This places young people at greater risk of work hazards, child and sexual exploitation, and abuses. Where this involved unsafe sexual practices, this further exposes them to the risk of HIV infection.

Recommendation: This finding reinforces the need for rapid assessments to identify the local determinants of risk behaviors before developing a program for MARYP.

Young adolescents aged from 10 to 14 years (in comparison with their older counterparts) seem to be the most vulnerable to high-risk behaviors. This is due to their naivety on issues of alcohol, drug and sex. Their knowledge, behaviors and practices are significantly guided by what they have heard and seen in their surroundings. Particularly concerning is that some of these young MARYP have already started to engage in high risk behaviors.

Recommendation: Again, programs for young people should be age and gender specific since young adolescents (10 to 14 years old) have different knowledge and beliefs regarding drugs, alcohol and sexual practices than older peer groups. Furthermore, the needs of younger children and adolescents (under 18 years of age) in situations of sexual exploitation and abuse should be swiftly addressed. In such cases, young people require access to child protection services and support to get out of these exploitative situations.

The Ministry of Education, Youth and Sport has set up guidelines for school-based health promotion in close collaboration with other key ministries including the provision of food and water safety, general sanitation and de-worming (MoEYS 2009). This indicates that the concept of health promotion is already included in school curriculums. Furthermore, the Royal Government of Cambodia has committed to reduce HIV related vulnerability, stigma and risk among young people using education (ICHA 2008). As well as providing services in schools, out-of-school young people are also targeted by the Ministry of Education, Youth and Sport, and civil society organizations. Services for street children, harm reduction programs, drop-in centers, career development, adolescent sexual and reproductive health, and non-formal education have been made available to potential recipients to some extent. However, these services were not widely mentioned by MARYP in this study. This suggests a significant gap in programming in both the education system as well as with service providers who can potentially reach out-of-school young people who are at higher risk and vulnerable.

Recommendation: In order to reach out-of-school young people who are at higher risk of HIV infection, non-formal 'second-chance' or vocational education systems should be strengthened by establishing close collaboration with non-governmental organizations and other involved institutions. Training materials on hygiene, sex education, reproductive health, substance abuse, and HIV should be integrated into existing

services such as peer education and community based health education programs that have well established linkages and referral mechanisms to HIV and RH services. Moreover, practical measures need to be employed to reduce the social exclusion and inequities experienced by many MARYP and their families. Facilitating MARYP's participation in programme planning, implementation and monitoring would go a long way to positively influence their inclusion.

Information about the harmful effects of drug use was very limited among MARYP. Only 22% and 12% of male and female respondents reported ever receiving information on this issue. As well as this, 16.7% of males and 32.9% of females did not know where to go when they want to stop using drugs. The main barriers to accessing information on the harmful effects of drugs and how to stop using drugs are likely due to the high level of stigma and discrimination experienced by young drug users as well as the possible legal repercussions if they are recognized as drug users.

Recommendation: When young drug users can be reached by services or programs it is recommended that behavior change interventions be provided as early as possible to trigger positive behavior change or to prevent young people from relapsing into high-risk behaviors (UNAIDS 2006). The specific needs of female drug users, an often neglected group, should be addressed as well as full implementation of their human rights. Further, programmes should reach older drug users who are 'initiating' drug use among the young ones to reduce the onset of drug use among this especially vulnerable younger population.

Typically, young people are active and curious. Without sufficient entertainment activities available, young people tend to become bored and boredom can lead to destructive behaviors. Therefore, MARYP should be offered opportunities to become involved in different activities with organizations or communities. Support should be given to promote and expand roles and functions of youth associations or networks providing 'safe' spaces at the community level.

Reproductive and HIV health services for MARYP

The MARYP reported an overall reluctance to use health services, more so with public services than those run privately or by NGOs. Compared to private health services, MARYP felt they encountered more barriers at public health services (mainly VCCT, STI clinics and ART centers). Furthermore, those same MARYP may also be harder to reach through passive or institutional HIV/AIDS education and harm reduction programs.

Recommendation: This indicates the need to strengthen the delivery of the national adolescent sexual and reproductive health services including intensive training and sensitization of public health and private service providers on the special needs of MARYP, with a priority focus on hotspot locations. Targeted outreach or mobile services could also be considered. Programs for young people should be designed in a way that they are sensitive to the values that young people have of life and should be age and gender appropriate. Services should be tailored to provide young-people friendly environments by involving young people in the early stage of their development. This may help narrow the gap between what service providers expect and what MARYP in particular need.

Up to 34% of females and 19% of males reported not receiving any HIV information in the past three months. This reflects gender differences in terms of the reach and access to HIV prevention education and is a useful indicator to programmers to design gender specific activities.Also worthy to note was that the usage of VCCT clinics among MARYP was low when compared to other groups considered at high risk of HIV (such as female entertainment workers and MSM) according to the Cambodian behavioral sentinel survey in 2007 (Chhea et al 2007).

Among those who reported having STI symptoms in the past year, up to 43% of females and 30% of males did not seek any treatment. Among the female group, vaginal discharge with an unpleasant smell

was the most commonly reported symptom (18%). Males reported having cuts or sores in the genital area as their most common symptom. Most at risk young people reported a lack of confidence to test for HIV or to access STI services since the waiting time at the public clinic is long and they fear being recognized by their family or community members. This suggests a health service gap which requires dedicated resources and commitment to address the special issues of MARYP.

Recommendation: In response to the low level of service usage among MARYP, it is suggested that one-stop health services may be more suitable for young people since the purpose of their visit cannot be easily determined by the clinics they visited. This of course is a very resource heavy option. Alternatively, health care providers should improve their practice by using strategies (such as flexible time schedules) to encourage MARYP to come and use services when they need. At the same time, they need to reduce the waiting time at the clinics and assure MARYP that their confidentiality is guaranteed. Linkages between health services should be systematically established and facilitated in order to improve the use of services such as VCCT, STI, reproductive health, and ART among young people. In addition, the capacity of private clinics and pharmacies to provide health information and care to adolescents needs to be increased.

Abortion was reported among sexually active female MARYP where 12% reported ever getting pregnant, among which 33% experienced induced abortion. These findings are consistent with abortion rates included in more recent surveys where 23% of rural women (16 to 49 years) reported ever having an abortion and 49% of entertainment workers reported the same (PSI 2010).

Recommendation: To prevent unwanted pregnancy among sexually active MARYP, programs offering referral services to reproductive health services should be strengthened. The program should focus on providing information to MARYP about the availability of reproductive health, family planning and safe abortion services. As noted above, the program should also involve pharmacy owners as focal persons responsible for providing accurate information to MARYP about the services they might need.

Among those who experienced induced abortion, 53% did it in private clinics and 35% had self-induced abortion. Both of these methods present significant risks to the reproductive health of MARYP because of the absence of trained and approved health service providers (PSI 2010). On the other hand, safe abortion services are not widely available. In 2005, only 47% of hospitals, 10% of high-level health centers and 5% of low-level health centers were capable of offering safe abortion services and the lack of training and supplies were the main barriers to providing safe abortion services at the facilities (Tung et al 2005). In 2010, although the availability of safe abortion services has increased nationally, only 5% of hospitals and no health centers treated adolescent abortion in comparison to adults, with services providers either refusing to treat adolescents or requesting parental consent for an elective abortion (RMMP 2010). Providing safe abortion services suitable for young women is a vital life saving measure and presents a continuing and significant health service gap.

The practice of self-induced abortion was also noted during qualitative discussions. Adolescents often consulted with their peers for making decisions on their pregnancy and often chose to buy drugs from the pharmacy or go to private clinics for an abortion rather than going to health centers or public hospitals. Public settings were not their first choice because of confidentiality concerns.

Compounding the shortage of services available for MARYP, existing health services have also failed to attract MARYP. The main barriers reported were shyness, concern that others will know about their illness, and the high cost for using services. Most public health services are actually free of charge; however, MARYP reported having to spend money

for transportation and other non-formal service fees. This finding is well supported by the qualitative findings. Most at risk young people also expressed their concern of having a medical check (for example, STI examination) performed by health staff of the opposite sex.

Recommendation: Findings suggest that from the point of view of MARYP, these main barriers must be removed before health services can attract more of them to use the services. They voiced their preference of having services where their confidentiality is assured and a mutually respectful environment between clients and health care providers is in place. Young people prefer to consult and be examined by same gender doctors and the waiting time should also be reduced. In order to monitor progress, programme data should be routinely disaggregated by age, gender, HIV risk behavior and use of services to show whether programmes for most at risk young people are reaching them.

In the higher prevalence or hot spot areas, efforts should be made to build the capacities of both private and public health service providers (including pharmacies, NGOs and others) to better cater to the needs of MARYP. These approaches should include: information on HIV prevention and treatment in a form young people can understand; harm reduction and drug treatment services (if injecting); services for the prompt diagnosis and treatment of STIs; HIV counseling and testing, with referral for treatment and care if HIV positive and HIV prevention counseling if HIV negative.

FURTHER RECOMMENDATIONS

POLICY MAKERS

Having vertical funding sources for implementing specific programs such as maternal health, family planning, reproductive health, harm reduction, and HIV prevention and care have created considerable obstacles to organizing national integrated services for young people in general and MARYP in particular. It may be useful to advocate for integrated funding sources that aim to address the core societal drivers of high risk behavior(s) in MARYP.

Within their lives, MARYP have faced many challenges and sometimes those challenges are regionally specific. Therefore, it is important to advocate for targeted financial and technical services to be decentralized to the provincial or commune levels where this study has identified hotspots of MARYP.

In most developed countries young people are not permitted to purchase cigarettes or alcohol, and there are policies and laws penalizing those selling to minors. Additionally there are high taxes placed on both cigarettes and alcohol in order to make it difficult for young people to afford buying these items. However, there are no regulations regarding the use of cigarette and alcohol among under age young people in Cambodia. It may be beneficial to advocate for regulations to establish "smoking free" or "alcohol free" zones in the areas where young people frequently gather.

Guesthouses and hotels are the most common location used by MARYP when they use drugs. It would therefore be useful to engage in community level mobilization including both the local authorities and outlet owners in the promotion of safer behaviors and environments for MARYP.

RESEARCHERS

Conduct a detailed review of policy, legislation and regional best practices on limiting the sale of alcohol to minors.

Due to the low rates of sexual violence and injecting drug practice among MARYP who participated in this study, it was not possible to investigate these topics in great detail. Therefore, a dedicated survey could be designed to allow in-depth study on gender, sexual violence, sexual violence against children, and injecting drug use, so that implications for evidence-based programs can be further developed.

A systematic review of programs which aim to improve the level of consistent condom use with sweethearts in Cambodia should be conducted. Lessons learned should be documented from all existing programs before new programs are developed and implemented. Furthermore, regular operational research should be integrated into the monitoring and evaluation systems for newly proposed programs in order to build learning into programming.

Due to the richness of data from this survey it is recommended that secondary analysis of this database be conducted to give more than just descriptive analysis.

One of the overwhelming messages that came from key informants of this study is that it is difficult to reach MARYP through BCC activities and services. The method of hotspot mapping used in this research proved a very practical tool in identifying the places and times where MARYP gather, and so may be useful in future research and program design.

It is recommended that conducting operational research with young people and especially with MARYP may help to improve the implementation of the services designed for young people. This may be particularly useful to document successes, challenges and lessons learned on the implementation of HIV, reproductive health, livelihoods, and life skills activities for out-of-school young people. The development of a national, standardized package of activities targeting MARYP out of school may also be worthy of consideration.

"Korsang drop in centre" © UNICEF/John Vink Magnum/2007

REFERENCES

Bahr S, Hoffmann J (2010) *Parenting style, religiosity, peers and adolescent heavy drinking. Journal of Study Alcohol Drug 2010,71:539-543.*

Centre for Advanced Study (2009) *BSIC Monitoring Survey 2009.*

Chhea C, Kai-Lih L (2007) *Cambodia 2007 Behavioral Surveillance Survey. National Center for HIV/AIDS Dermatology and STD*

Chhea C, Seguy N (2007) *HIV prevalence among Drug User in Cambodia. National Center for HIV/AIDS Dermatology and STD.*

Dick D, Pagan J, Holliday C, Viken R, Pulkkinen L, Kaprio J, Rose R (2007) *Gender differences in friends' influences on adolescent drinking: a genetic epidemiological study. Alcohol Clin Exp Res 2007,31:2012-2019.*

Enoch M (2010) *The role of early life stress as a predictor for alcohol and drug dependence. Psycho-pharmacology 2010.*

Feldman L, Harvey B, Holowaty P, Shortt L (1999) *Alcohol use beliefs and behaviors among high school students. Journal of Adolescent Health 1999,24:48-58.*

Le Breton D (2004) *Risk-taking behaviors among young people. Bull Acad Natl Med 2004,188:1313-1321.*

Galvez-Buccollini J, Delea S, Herrera P, Gilman R, Paz-Soldan V (2009) *Sexual behavior and drug consumption among young adults in a shantytown in Lima, Peru. BMC Public Health 2009,19.*

Heng S, Morineau G, Neal JJ, Chhea C (2005) *Cambodia STI Prevalence Survey. National Center for HIV/AIDS Dermatology and STD.*

ICHA Technical Secretariat (2009) *Annual Operational Plan 2009. Ministry of Education Youth and Sports.*

Lomba L, Apostolo J, Mendes F (2009) *Drug and alcohol consumption and sexual behaviors in night recreational settings in Portugal. Adicciones 2009,21:309-325.*

McLeod K, White V, Mullins R, Davey C, Wakefield M, Hill D (2008) *How do friends influence smoking uptake? Finding from qualitative interviews with identical twins. Journal of Genetic Psychol 2008,169:117-131.*

Ministry of Education Youth & Sports (2004) *Cambodia National Youth Risk Behavior Survey.*

Ministry of Education Youth & Sports (2009) *Guideline for health promotion at school.*

NAA (2007) *A Situation and Response Analysis of HIV and AIDS in Cambodia: 2007 Update.*

NCHADS (2007) *Report of a Consensus Workshop: HIV Estimates and Projections for Cambodia, 2006 – 2012.*

National Institute of Public Health, National Institute of Statistics [Cambodia], and ORC Macro (2006) *Cambodia Demographic and Health Survey 2005.*

National Institute of Statistics (2009) *Census 2008.*

Population Services International/Cambodia (2010) *Safe Abortion in Cambodia.*

Population Service International (2002) *Sweetheart relationships in Cambodia: Love, Sex & Condoms in the Time of HIV.*

Reduction in Maternal Mortality Program (2010) *Increasing the Availability and Quality of Abortion Services across Cambodia- an Evaluation of the Reduction in Maternal Mortality Project.*

Schmidt P, Muller R, Dettmeyer R, Madea B (2002) *Suicide in children, adolescents and young adults. Forensic Science International 2002,127:161-167.*

Tucker J, Ellickson P, Klein D (2008) *Growing up in a permissive household: What deters at-risk adolescents from heavy drinking? J Stud Alcohol Drugs 2008,69:528-534.*

Tung R, Fetters T, Sherman J, Saphonn V, Saray V, Lam P, Thou C (2005) *Ready or not? A national needs assessment of abortion services in Cambodia.*

UNAIDS (2009) *AIDS Epidemic Update.*

UNAIDS I-ATToYP (2006) *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries. WHO Technical Report Series -938: World Health Organization.*

United Nations Country Team (2009) *Situation Analysis of Youth in Cambodia.*

UNFPA (2008) *Global Guidance Brief: HIV interventions for most at risk young people.*

ANNEX A: ALCOHOL RELATED BEHAVIOR

TABLE A1 PERCENTAGE DISTRIBUTION OF ALCOHOL DRINKING RELATED BEHAVIOR AND MEDIAN AGE AT FIRST DRINKING OF ALCOHOL AMONG MARYP BY GENDER, AGE GROUP AND LOCATION

ALCOHOL-DRINKING RELATED BEHAVIOR	Female					Male				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
% of respondent ever drink alcohol	57.6	80.5	74.1	49.6	**70.0**	81.4	98.4	93.1	84.5	**90.7**
Median age at first drinking of alcohol (IQR)	17 (15-18)	19 (18-20)	18 (16-20)	18 (17-20)	**18 (16-20)**	16 (15-17)	18 (17-19)	17 (15-18)	17 (14-18)	**17 (16-18)**
% of respondents by location where they get access to alcohol										
Bar	8.6	12.0	11.8	2.6	**10.7**	5.9	9.7	10.3	2.3	**8.1**
Drink shop	68.4	65.9	67.1	64.9	**66.8**	56.2	70.8	67.5	56.8	**64.8**
Friends	27.2	23.8	24.9	26.6	**25.1**	48.0	54.2	53.4	46.3	**51.7**
Family	22.6	18.0	20.1	18.1	**19.8**	23.3	23.2	23.2	23.5	**23.2**
% of respondents by perceived effect of drinking alcohol										
Make people happy	16.1	19.4	17.8	20.2	**18.2**	37.0	50.3	46.1	40.8	**44.9**
Lost control	27.2	27.9	27.9	24.9	**27.6**	40.9	46.2	46.8	36.7	**44.1**
Give courage to people	3.1	2.4	2.5	4.2	**2.7**	9.6	12.5	12.0	8.8	**11.3**
Make people sad	2.1	5.0	3.5	7.5	**3.9**	4.7	9.4	7.8	6.3	**7.5**
Make people have diseases	85.8	87.4	86.8	86.4	**86.8**	67.7	70.4	70.3	67.2	**69.3**
% of respondent by self-rating level of drinking										
Drink a lot	8.1	24.0	20.0	3.0	**18**	1.1	3.2	2.9	0.9	**2.3**
Occasional drinking	6.3	15.6	12.4	9.5	**12.1**	31.2	53.5	47.2	35.9	**44.4**
Drink during special occasion	85.6	60.2	67.5	87.5	**69.8**	66.8	43.4	49.6	62.6	**52.9**
Other	0	0.2	0.1	0	**0.1**	0.9	0	0.3	0.6	**0.4**

ANNEX B: DRUG RELATED BEHAVIOR

TABLE B1 PERCENTAGE DISTRIBUTION OF DRUG USE RELATED BEHAVIOR AND MEDIAN AGE AT FIRST DRUG USE AMONG MARYP BY GENDER, AGE GROUP AND LOCATION

DRUG RELATED BEHAVIOR	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Ever used drugs	1.9	4.9	3.8	1.7	**3.6**	9.4	20.0	17.4	9.4	**15.2**
Injected drugs in the past 12 months*	[22.1]	11.3	11.0	[52.9]	**14.0**	0	0.3	0	1.8	**0.3**
Type of drug use in the past 6 months*										
Heroin	[0]	0	0	[0]	**0**	0	2.0	1.7	0	**1.4**
Yama, yaba	[31.5]	29.1	29.6	[23.5]	**29.9**	24.2	20.3	21.5	32.7	**21.4**
Ecstasy	[0]	3.1	0	2[9.4]	**2.3**	0	1.2	1.1	0	**0.9**
Ice, meth-based powder	[20.7]	48.3	44.5	[0]	**41.4**	32.2	13.6	18.8	19.9	**18.8**
Marijuana	[6.6]	0	1.8	[0]	**1.6**	14.5	7.8	13.1	8.6	**9.7**
Inhalants	[7.0]	0	2.0	[0]	**1.8**	6.7	0	2.3	0	**1.9**
Age at first drug use* (IQR)	[17] (16-18)	20 (18-21)	19 (17-21)	[19] (18-21.5)	**18 (18-21)**	17 (15-18)	19 (17-20)	18 (17-20)	18 (16-20)	**18 (17-20)**
Ever want to stop using drugs*	[100]	97.7	98.1	[100]	**98.3**	91.1	94.7	95.1	90.1	**93.7**
Type of last drug use partner*										
Sexual partners	[0]	10.5	8.8	[0]	**7.8**	0	0	0	0	**0**
Male friends	[51.2]	35.7	38.4	[47.1]	**39.6**	89.2	98.6	96.4	97.5	**96.0**
Female friends	[54.5]	66.7	61.3	[76.5]	**63.7**	18.7	11.2	15.6	3.3	**13.3**
Alone	[11.7]	16.6	17.3	[0]	**15.4**	1.5	0.6	0.5	2.6	**0.9**

**Calculated among those who have ever used drugs*

ANNEX C: SEX RELATED BEHAVIOR

TABLE C1 PERCENTAGE DISTRIBUTION OF SEXUAL BEHAVIOR WITH ENTERTAINMENT WORKERS

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Among sexually active, ever paid for sex with women in the past year	83.4	83.2	86.0	72.4	**83.3**
Place where respondent met with the last sex worker					
Brothel	11.8	16.6	13.2	24.6	**15.6**
Massage parlor	0	0.7	0.7	0	**0.6**
Hotel/guesthouse	61.0	59.1	64.6	39.5	**59.5**
Street or park/garden	3.2	0.9	1.0	3.3	**1.4**
Karaoke/bar	4.8	2.3	1.4	9.0	**2.8**
Own house	8.9	6.8	7.6	6.2	**7.3**
Girl house	2.4	2.4	1.7	3.9	**2.4**
Frequency of condom use with sex worker in the past 3 months					
Always	92.6	87.9	91	78.8	**88.8**
Frequently	0	3.6	2.9	2.8	**2.9**
Sometimes	0	2.6	1.2	5.8	**2.1**
Never	7.4	6.0	4.8	12.6	**6.2**
Number of condom during the last sex with sex worker					
One condom	81.8	73.7	74.8	79.7	**75.2**
Two condom	18.2	25.9	25.2	13.4	**24.5**
More than two		0.4	0	2.0	**31.4**
He proposed to use condom during sex with sex worker	77.2	75.8	74.1	85.8	**76.0**

TABLE C2 PERCENTAGE DISTRIBUTION OF SEXUAL BEHAVIOR WITH MALE CLIENT AMONG FEMALE MARYP

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
During the last sex with sex worker, level of alcohol you had					
A lot (more than 3 cans of beer)	16.2	32.6	27.5	38.7	**29.3**
Some (2-3 cans of beer)	13.6	14.8	14.6	15.5	**14.6**
Little (1 can of beer)	12.8	9.2	10.7	7.2	**9.9**
No drink	57.4	43.4	47.3	38.7	**46.3**
Among all male MARYP, ever got paid to have sex in the past 12 months	2.3	5.8	5.0	**2.4**	**4.2**
Among sexually active MARYP, ever get paid for sex in the past year	36.8	52.0	51.0	34.9	**49.4**
Place where respondent met with client for the last paid sex					
Brothel	3.9	3.5	1.9	25.0	**3.5**
Massage parlor	0.0	0.9	0.9	0.0	**0.8**
Hotel/guesthouse	77.2	64.0	70.0	14.7	**65.6**
Street or park/garden	0.0	0.0			**0**
Karaoke/bar	18.9	27.0	24.9	33.4	**25.9**
Other	0.00	4.7	2.4	27.0	**4.2**
Use condom during last sex with client	92.5	89.0	85.6	100.0	**89.4**
Frequency of condom use with client in the past 3 months					
Always	81.3	88.6	87.2	91.7	**87.7**
Frequently	13.2	6.9	8.5	0.0	**7.7**
Sometimes	0.0	2.8	1.9	8.3	**2.5**
Never	5.6	1.7	2.4	0.0	**2.2**
She proposed to use condom during last sex with client	95.5	90.6	91.1	91.7	**91.2**

TABLE C3 PERCENTAGE DISTRIBUTION OF SEXUAL BEHAVIOR WITH SWEETHEART AMONG MALE MARYP

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Ever had girlfriend	50.7	78.9	70.8	53.8	**66.1**
Had a girlfriend/mistress in the past 12 months (among ever have girlfriend)	45.5	59.5	56.9	46.6	**54.6**
Had sex with girlfriend/mistress in the past 12 months	44.5	60.6	59.2	44.2	**55.9**
Had girlfriend but did not have sex in the past 3 months	22.4	21.7	21.6	24.9	**21.9**
Frequency of condom use with most recent girlfriend in the past 3 months					
Always	66.6	55.6	60.2	48.1	**58.1**
Frequently	2.6	2.3	2.3	3.1	**2.4**
Sometimes	8.6	11.9	11.8	8.5	**11.2**
Never	22.2	30.2	25.7	40.4	**28.4**
Use condom during the last sex with girlfriend	65.5	69.5	69.9	63.8	**68.6**

TABLE C4 PERCENTAGE DISTRIBUTION OF SEXUAL BEHAVIOR WITH SWEETHEART AND FORCED SEX AMONG FEMALE MARYP

SEXUAL BEHAVIOR	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Ever had a boyfriend	48.0	63.2	61.1	32.0	**56.2**
Among those who ever had boyfriend, have one in t he past 12 months	79.2	71.5	75.6	63.5	**74.5**
Among those who had boyfriend in the past 12 months, had sex with him in the past 12 months	10.2	29.3	22.1	11.6	**21.3**
Frequency of condom use with boyfriend in the past 3 months					
Always	25.6	32.5	30.4	[37.4]	**31.2**
Frequently	10.4	5.6	6.9	[0.0]	**6.5**
Sometimes	11.5	18.3	17.9	[0.0]	**17.0**
Never	52.5	43.6	44.8	[62.6]	**45.3**
Use condom during the last sex with boyfriend	36.9	49.2	47.2	[32.1]	**46.8**

ANNEX D: HEALTH SERVICES UTILIZATION

TABLE D1 PERCENTAGE DISTRIBUTION OF FEMALE MARYP REPORTED EVER GETTING PREGNANT, RESULT OF THE LAST PREGNANCY AND PLACE WHERE RESPONDENTS HAD THE LAST ABORTION

	Age group		Location		
	10-19	20-24	Urban	Rural	Total
Among all female MARYP, ever get pregnant	3.5	18.9	12.4	9.0	**11.8**
Result of last pregnancy					
Induced abortion	45.3	31.3	36.2	[9.4]	**33.2**
Still pregnant	5.9	5.2	4.3	[12.5]	**5.3**
Live birth	26.7	53.7	47.5	[69.9]	**50.1**
Miscarriage	22.1	9.8	12.0	[8.3]	**11.5**
Place where respondent had the last abortion					
Private clinic	[62.2]	50.6	51.7	[58.1]	**52.5**
Government clinic/hospital	[12.4]	6.3	6.6	[0]	**6.3**
NGO clinic	[0]	1.5	1.6	[0]	**1.5**
Traditional birth attendant	[0]	2.5	2.7	[0]	**2.5**
Buy the medicine and do it by myself	[25.4]	35.2	35.3	[41.9]	**35.2**
Others	[0]	3.9	2.1	[0]	**2.0**

TABLE D2 PERCENTAGE DISTRIBUTION OF EXPERIENCE WITH HIV TESTING, ACCESS TO CONDOM AND HIV/AIDS INFORMATION

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Ever test for HIV in the past 12 months	10.6	29.7	21.9	15.3	**20.9**	8.1	23.5	18.5	11.5	**16.5**
Place where the last HIV test was done										
Private clinic	41.1	18.6	22.7	30.7	**23.8**	21.2	32.4	30.0	31.3	**30.0**
Government hospital	38.3	43.7	40.8	55.0	**42.5**	44.6	47.3	44.8	51.4	**46.7**
VCCT	16.4	29.1	28.8	7.6	**26.2**	26.1	19.4	22.6	15.2	**20.9**
Surveillance program MoH	3.1	5.5	2.1	0	**4.2**	1.3	0.4	0.8		**0.6**
NGO	1.2	0	0	2.3	**0.3**	3.6	0.5	1.4		**1.1**
Workplace clinic	0.0	3.1			**3.1**	3.2	0	0.4	2.0	**0.7**
Get access to the last condom from										
Never get access	82.3	58.0	66.4	83.3	**69.1**	30.4	5.5	11.3	0	**10.8**
condom selling stall	0.2	3.4	2.1	1.1	**1.9**	38.5	6.3	13.8		**13.1**
pharmacy/drug store	0.7	1.8	1.5	0.3	**1.3**	8.1	32.4	25.0	72.7	**27.3**
Health center/referral hospital	0.5	1.4	0.9	1.2	**1.0**	0	0	0		**0**
Bar/guest house/hotel	1.1	6.8	4.9	0.4	**4.2**	7.5	35.4	31.0		**29.5**
Friends	1.0	0.5	0.8	0	**0.7**	6.2	8.6	7.2	27.4	**8.1**
Client	0.1	0.4	0.3	0.4	**0.3**	0	0	1.7		**0**
Brothel owners/ pimp	0.1	1.2	0.4	2.2	**0.7**	0	2.1	8.0		**1.7**
NGO	12.5	23.0	19.9	9.8	**18.2**	0	9.7	8.0		**7.6**
Gasoline station	1.6	3.5	0.1	0.4	**2.6**	9.3		2.1		**2.0**

Continued

TABLE D2 PERCENTAGE DISTRIBUTION OF EXPERIENCE WITH HIV TESTING, ACCESS TO CONDOM AND HIV/AIDS INFORMATION CONTINUED

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Received information about HIV/AIDS in the past 3 months from										
Never received information	29.9	37.3	36.0	24.0	**33.9**	16.9	22.0	20.0	19	**19.7**
TV	41.7	36.8	38.5	41.4	**39.0**	62.8	57.6	61.1	56.7	**60.0**
Radio	17.3	23.1	18.5	29.9	**20.4**	39.9	35.2	37.2	37.1	**37.3**
Newspapers	2.7	2.9	2.6	3.2	**2.8**	8.2	6.7	7.5	6.9	**7.4**
Billboard/leaflet/booklet	12.5	10.2	12.0	8.1	**11.3**	20.7	22.6	23.4	17.7	**21.8**
Training/workshop	17.7	18.2	18.9	13.6	**18.0**	17.2	18.8	18.8	15.8	**18.1**
Internet	0.5	0	0.2	0	**0.2**	0.3	0.3	0.5	0	**0.3**
Parent/family	7.7	2.9	4.5	7.9	**5.1**	9.1	6.6	7.6	7.8	**7.7**
Friends	12.5	10.7	10.4	17.5	**11.5**	11.9	16.1	16.0	10.1	**14.2**
Health center	2.2	4.1	2.5	7.1	**3.2**	4.3	5.1	4.1	6.5	**4.8**
School	32.4	11.2	18.5	33.1	**21.0**	30.4	13.4	19.5	25.0	**21.1**

TABLE D3 PERCENTAGE DISTRIBUTION OF STI SYMPTOMS, STI TREATMENT SEEKING BEHAVIOR, AND STIGMA RELATED TO STI SERVICE

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
In the past 12 months, had the following symptom										
Cuts or sores in the genital area	0.7	2.1	1.6	0.7	**1.5**	0.2	3.0	2.3	0.4	**1.8**
Swelling in the genital area	0.3	2.7	1.8	0.7	**1.6**	0.2	1.6	1.2	0.4	**0.9**
Vaginal/Urethral discharge with an unpleasant smell	11.2	23.5	18.0	16.9	**17.8**	0	2.5	1.7	0.6	**1.4**
Place where respondents go to for STI treatment (among those who experienced STI symptom in the past 12 months)										
Pharmacy	8.3	15.4	14.1	9.7	**13.4**	[21.1]	28.6	[27.4]	[32.7]	**28.0**
Private clinic	6.2	6.6	7.4	2.0	**6.5**	[18.3]	20.4	[23.0]	[0]	**20.3**
Public hospital/STD clinic	9.2	13.7	11.6	17.1	**12.4**	[0]	10.7	[11.1]	[0]	**9.8**
NGO clinic	8.2	19.3	18.2	4.1	**16.2**	[0]	11.9	[12.3]	[0]	**10.9**
Traditional doctor	5.2	3.9	3.6	7.6	**4.2**	[0]	2.1	[0]	[16.8]	**2.0**
Didn't get care	61.8	35.5	40.2	57.4	**42.9**	[60.6]	26.2	[26.3]	[50.6]	**29.1**
Others	1.2	5.8	5.0	2.2	**4.5**	[0]	[0]	[0]	[0]	**[0]**
Experience stigma and discrimination during last STI treatment	10.1	2.4	3.7	5.0	**3.8**	[0]	[5.0]	[2.9]	[16.8]	**4.6**

TABLE D4 PERCENTAGE DISTRIBUTION OF KNOWLEDGE ON DIFFERENT BIRTH SPACING METHODS AND PLACE WHERE YOUNG WOMEN CAN GO IF SHE WANTS TO HAVE AN ABORTION

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Birth spacing method that respondent knows										
Don't know	91.2	64.0	74.8	85.1	**76.5**	6.5	2.1	3.1	6.8	**4.1**
Condom	41.2	53.4	53.0	38.7	**51.3**	72.0	88.5	83.8	74.4	**81.2**
Pill	19.6	17.1	16.3	27.1	**17.6**	81.6	81.1	80.0	85.0	**81.3**
Injectable methods	1.0	5.7	4.5	8.4	**4.9**	50.0	53.1	50.1	55.3	**51.8**
IUD	0	1.5	1.4	0	**1.3**	60.2	65.5	63.7	62.5	**63.2**
Norplant	0	0	0	0	**0**	13.4	14.6	13.5	15.6	**14.1**
Female sterilization	0	0.8	0.5	2.2	**0.7**	10.2	12.3	11.1	12.4	**11.4**
Male sterilization	0	0	0	0	**0**	6.1	7.3	8.0	3.7	**6.8**
Withdrawal	6.0	15.3	13.5	15.9	**13.4**	4.2	10.7	8.7	5.9	**7.8**
Place where young women could go, if she wants to have an abortion										
Don't know	4.0	2.6	2.7	5.8	**3.2**	5.9	1.4	2.4	6.1	**3.5**
Public hospital	69.8	63.7	65.8	70.6	**66.5**	77.4	72.7	73.1	79.6	**74.8**
Private clinics	55.9	61.9	59.6	56.5	**59.1**	55.7	67.5	65.8	52.8	**62.2**
Self induced abortion	34.5	43.8	40.9	33.4	**39.5**	4.2	7.2	6.3	4.9	**5.8**
Pharmacy	17.4	22.3	21.2	13.2	**20.5**	7.3	14.0	12.2	8.1	**10.9**
Traditional birth attendant	8.9	14.6	11.0	17.0	**12.0**	2.7	3.5	3.1	3.3	**3.1**

TABLE D5 PERCENTAGE DISTRIBUTION OF PLACE WHERE RESPONDENTS FIND CLEAN NEEDLE AND SYRINGES, INFORMATION ON HARMFUL EFFECTS OF DRUG, AND GET HELP TO STOP USING DRUGS

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Place where respondent who ever used drug can find clean needle and syringe among drug users										
Pharmacy	65.7	28.8	40.6	23.5	**38.0**	46.5	44.5	47.3	39.5	**45.4**
Health center/hospital	43.7	26.5	31.9	29.4	**30.8**	33.6	26.1	28.8	23.8	**28.2**
Harm reduction NGO	0	0	0	0	**0**	0.9	0	0.3	0	**0.2**
Received information about harmful effect of drug use in the past 12 months from										
Never received any information	31.5	19.3	21.5	23.5	**22.3**	13.5	11.7	10.3	18.3	**12.2**
School/teacher	7.0	0	2.0	0	**1.8**	25.6	11.0	15.1	16.0	**15.1**
Peer educators	4.7	0	1.3	0	**1.2**	14.4	17.0	17.6	11.4	**16.3**
Health workers	16.9	5.5	7.3	23.5	**8.4**	12.1	11.1	11.4	8.6	**11.4**
NGOs working with young people	22.1	35.1	31.1	52.9	**31.9**	39.4	31.7	37.6	15.3	**33.9**
Place where people could go when they want to quit drug use										
Don't know where to go	29.1	36.1	32.2	36.7	**32.9**	21.8	12.6	11.9	28.4	**16.8**
Rehabilitation center	46.8	39.4	44.3	35.3	**42.8**	57.2	76.4	74.5	50.9	**67.7**
Health center/hospital	10.4	9.1	9.6	11.6	**9.9**	11.9	7.5	8.2	12.8	**9.5**
NGO working with DU	18.7	21.0	19.2	23.2	**19.9**	12.4	15.5	15.1	11.5	**14.1**

TABLE D6 PERCENTAGE DISTRIBUTION OF AWARENESS OF NEGATIVE CONSEQUENCES OF DRINKING ALCOHOL AND INFORMATION ON HARMFUL EFFECTS OF ALCOHOL

	Women					Men				
	Age group		Location		Total	Age group		Location		Total
	10-19	20-24	Urban	Rural		10-19	20-24	Urban	Rural	
Aware of danger caused by drinking alcohol	92.4	90.1	91.2	90.4	**91.1**	91.8	95.1	95.5	88.6	**93.6**
Received information on effect of alcohol on health in the past 12 months from										
Never received any information	15.1	22.1	19.4	16.3	**18.9**	14.0	14.5	11.6	20.8	**14.3**
School/teacher	56.1	46.2	50.8	53.2	**51.2**	62.3	50.7	53.6	61.6	**56.5**
Peer educators	4.4	4.3	4.2	5.2	**4.3**	11.1	14.9	14.4	10.4	**13.2**
Health workers	2.4	7.4	5.1	5.2	**5.1**	8.5	15.8	14.5	7.3	**12.5**
NGOs working with young people	4.2	2.8	3.9	1.1	**3.5**	7.0	12.3	11.0	6.5	**9.9**
Television	24.4	25.2	25.1	23.6	**24.8**	4.0	6.1	3.9	7.3	**4.7**
Friends	7.6	10.3	9.3	7.2	**8.9**	3.0	1.4	2.8	1.3	**2.2**
Parents	14.0	5.6	10.1	8.4	**9.8**	22.6	17.2	20.4	19.0	**19.9**
Relatives	10.3	5.9	5.3	8.4	**7.3**	26.2	26.0	27.2	25.1	**26.0**

ANNEX E: MARYPS STEERING COMMITTEE

ORGANIZATION	NAME
1. MoEYS/ICHAD Leadership	HE. Mak Vann / HE. Ou Eng
2. MoEYS/ICHAD Leadership	Mr. Pen Saroeun / Mr. Kim Sanh / Dr. Yung Kunthearith
3. UNFPA	Ms Sarah Knibbs / Ms Hou Vimol
4. UNESCO	Mr Ung Polin
5. UNICEF	Ms Ulrike Gilbert / Ms Julie Forder
6. UNAIDS	Mr Thea Phauly
7. UNODC	Dr. Anand Chaudhuri
8. WHO	Mr. Graham Shaw
9. NAA	HE.Dr. Hou Bunleng / Dr. Sou Sophi
10. NACD	Dr Thong Sokunthea
11. PSI	Ms Long Dianna
12. Friends International	Ms Caroline Schaap
13. Korsang	Mr Taing Phoeuk
14. FHI	Dr. Kai Lih Liu
15. Mith Samlanh	Mr Mann Phally
16. KHANA	Mr Tuot Sovannary / Ms Paula Gleeson

ANNEX F: YOUTH ADVISORY GROUP

NO	NGO	NAME	SEX
1	CARAM	Sok Srey Chhin	F
2	Life of Hope	Thorn Chanthareach	M
3	Friends	Pok Nary	F
4	Friends	Chhum Chetra	M
5	Korsang	Gnek Bunlaeng	M
6	RHAC	Pang Vichay	F
7	KANHNA	Phorng Chanthorn	M
8	CSSD	Sok Chamreun	M
9	KOSHER	Keo Nika	F
10	CARAM	Ses Lida	F
11	CCW	Min Sopheun	F

ANNEX G: QUESTIONNAIRES

MOST AT RISK YOUNG PEOPLE SURVEY (MARYP SURVEY) 2009-2010

Male Adolescent & Young Adult

ID # .....

Cluster .....

Introduction: (The following is to be read by the interviewer to the respondent): "The Ministry of Education, Young people & Sports, in collaboration with UNICEF, WHO, UNFPA, UNESCO, FHI, PSI and , KHANA , is conducting a survey of adolescents and young people in eight different provinces to learn more about their vulnerability to HIV infection, and their knowledge about sexual and reproductive health and health seeking behavior regarding to sexual and reproductive services. We would like to request your cooperation for about 30 minutes to ask you a few questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important. The information from this survey will help the country to support HIV prevention, care and support efforts for adolescents and young people.

Signature of interviewer as a proof of receiving consent from participant

.....Date: ...../...../.....

CITY/PROVINCE:

1- Phnom Penh
2- Battambang
3- Kampong Cham
4- Siem Reap
5- Bantey Mean Chey
6- Svay Rieng
7- Koh Kong
8- Preah Sihanouk

LOCATION:

1- Urban
2- District

Interviewer's name: ..... Date: .....ID..... .....

Supervisor's name.....Date..... .....ID..... .....

Did the interviewee abandon the interview?

1- Yes (precise question number) .....
2- No

Checked by the team leader.....Date:..... .....

Data entry Clerk 1 ..... Date: ....ID.....

Data entry Clerk 2 ..... Date: ....ID.....

PART1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you? ..... years (should between 10-24)
2. Are you married now?
    1. Married and currently living together
    2. Never married (SKIP TO QUESTION 4)
    3. Divorced
    4. Separated (live far away from their spouse)
3. How old were you when you first married.....Years
4. How many years did you complete at school?.....Years
5. Are you currently attending school?
    1. Yes
    2. No
6. Could you read this below statement for me?

"The Kingdom of Cambodia has a territory of 181,035 square Kilometer with a population of 14 Millions. Cambodia has been internationally advertised as the Kingdom of Wonder"

    1. Read with ease
    2. Read with some difficulty
    3. Read only some words
    4. Cannot read
7. Who are you currently staying with?
    1. Parents
    2. Siblings (no parents)
    3. With grandparent(s)
    4. With relatives
    5. With friends
    6. Alone
    7. Wife or sexual partner
    8. Other (specify.....)
8. How many brother and sisters do you have? (Excluding you.....persons
9. How much money did you earn last month? .....riel (0 if the person did not work in the past month)
10. How much money do you usually spend per day? .....riel (in the past month)

11. What is your main profession when you work to earn money for you or your family in the past year?
    1. Did not work
    2. Seller/vendor/trader
    3. Manual/laborer
    4. Farmer
    5. Factory worker
    6. Fishermen
    7. Other (specify.....)
    99. No response

12. Are both of your parents alive?
    1. Yes, I have both of my parents
    2. No, I have only mother
    3. No, I have only father
    4. No, I don't have any parents (SKIP to Q14)

13. What are your parents' main occupations? (More than one answers allowed)

FATHER	MOTHER
1. Does not work	0. Does not work
2. Seller/vendor	1. Seller/vendor
3. Manual/laborer	2. Manual/laborer
4. Farmer	3. Farmer
5. Factory worker	4. Factory worker
6. Fishing	5. Fishing
7. Moto taxi driver	6. Moto taxi driver
8. Business	7. Business
9. Civil Servants	8. Civil Servants
10. Military/Police/Military Police	9. Military/Police/Military Police
11. Other (specify.....)	10. Other (specify.....)
99. No response	99. No response
98. No father	98. No mother

14. What type of house are you living?
    1. Living in the street/ homeless
    2. Living in hotel/guest house
    3. Living in a flat
    4. Living in a hut
    5. Living in mid-size country house

6. Living in a mansion/large country house
7. Other (specify.....)

15. How long have you been living in the present location?.....months

16. What kind of transportation do you have? (More than one answers allowed)
    0. No transportation means
    1. Bicycle
    2. Motorcycle
    3. Car
    4. Boat
    5. Boat with machine
    6. Other (specify.....)

PART 2: RISK BEHAVIORS TOWARDS ALCOHOL (ADOPTED FROM NOSSAL CENTER QUESTIONNAIRE): NOW I AM GOING TO ASK YOU SOME QUESTIONS REGARDING TO DRINKING ALCOHOL.

17. What was your age when you first drank alcohol?.....years old (0: never drink alcohol): If 0 SKIP to Q21

18. Where do you get your Alcohol?
    1. Bar
    2. Shop
    3. From friends
    4. From family
    5. Other (specify.....)

19. How does alcohol affect you? (More than one answers allowed)
    1. It makes me happy
    2. I lose control
    3. It makes me brave
    4. It makes me sad
    5. It makes me feel sick
    6. Other (specify.....)

20. If you are asked to rate yourself regarding to drinking alcohol, how do you describe yourself?
    1. Heavy drinker
    2. Drink occasionally (one or two time a week)
    3. Rarely drink (only drink in some special occasions)
    4. Other (specify.....)

21. Are you aware of the dangers of drinking Alcohol?
    1. Yes.....
    2. No.....
    3. Don't know.....

22. In the past year from whom did you received health information regarding the effects of Alcohol? (More than one answers allowed)
    1. Never received any health information
    2. From school/teacher
    3. From peer educators
    4. From health workers
    5. From NGOs working with young people
    6. Other, please specify.....

PART 3: RISK BEHAVIORS RELATED ILLICIT DRUG USE

Next I am going to ask you about "illicit drugs", which includes Heroin, Yama, Ecstasy and the like. You can refuse to answer any question as you wish.

23. Some people try different drugs for different reasons (such as for recreation, energy boosting for working longer etc). Have you ever used any drug before?
    1. Yes
    2. No (if No SKIP to Q32)

24. In the past 12 months have you ever injected any drug?
    1. Yes
    2. No

25. In the 6 past months which of the following drug, have you tried?
    (Ask one by one – CIRCLE YES OR NO)

	Used in last 6 months			Injected in last 6 months		
Type of drug	YES	NO	DK	YES	NO	DK
Heroin						
Yama, Yaba	1	2	8	1	2	8
Ecstasy	1	2	8	1	2	8
ice, meth-based powder	1	2	8	1	2	8
Marijuana	1	2	8	1	2	8
Inhalants (glue, paint, petrol,	1	2	8	1	2	8
spray cans)	1	2	8	1	2	8
Other (specify.....)	1	2	8	1	2	8

26. What was your age at first time you started using illicit drug?.....years old

27. Last time you used drug, who was using drugs with you? More than one answer allowed
    1. Sexual partners
    2. Male Friends

3. Female friends
4. Alone
5. Other (specify.....)

28. In the past year, did you share your injecting equipments with anyone else (needles, syringes, cottons…)?
    0. Never inject
    1. Yes
    2. No

29. Do you know where you can find clean needles and syringes? (More than one answers allowed)
    1. Never use drugs/inject
    2. Pharmacy
    3. Health centers/ hospitals
    4. NGO with Needle syringe program
    5. Others (specify.....)

30. In the past year, from whom have you received information about the harmful effects of drug use? (More than one answers allowed)
    1. Never received any health information
    2. From school/teacher
    3. From peer educators
    4. From health workers
    5. From NGOs working with young people
    6. Other, please specify.....

31. Have you ever attempted to stop using drugs?
    1. Yes
    2. No

32. Do you know where someone could go when they want to quit using illicit drugs (illicit drugs are s defined as heroin, ecstasy...and the likes)?
    (More than one answers allowed)
    0. Don't know
    1. Rehabilitation centers
    2. Health Center/Hospitals
    3. NGO working with drug user
    4. Other (specify.....)

PART 4: RISK BEHAVIORS RELATED SEX, UNPROTECTED SEX AND SEXUAL VIOLENCE

In the next part, I am going to ask you some private questions, which are related to sexual behavior. You may feel uncomfortable talking about it but please remember that the answers that you give me are confidential. However, you are free to refuse to answer any questions.

33. What is your sexual preference?
    1. Men
    2. Women
    3. Men and women
    4. Don't know

34. Have you ever had sex (with men, women, any kind of sex – oral (mouth to sexual organs), anal (male sexual organ to anus), vaginal (male sex organ to female sex organ), touching (touching sexual organs)?
    1. Yes
    2. No (If NO SKIP to Q46)

35. How old were you when you first had sexual intercourse?.....years

36. Who was your first sexual partner?
    1. Wife
    2. Boyfriend/girlfriend
    3. Sex Worker in Brothel
    4. Beer, karaoke, massage or dancing girl
    5. Friend
    6. Relative
    7. Other (specify.....)

37. What was the age of your first sexual partner? .....years old
    (0 if not remember the age)

38. In the past year, did you ever have sex with: (ask one by one – CIRCLE YES OR NO)
    (If all option answer is NO then SKIP TO 46)

		Yes	No
1.	Woman working in nightclub/discotheque	1	0
2.	Woman working in massage place	1	0
3.	Female Beer promoter	1	0
4.	Female Karaoke worker	1	0
5.	Woman working in beer garden/restaurant	1	0
6.	Female sex worker at brothel/street	1	0
7.	Female factory worker	1	0
8.	Sweetheart/girl friend	1	0
9.	Other (Specify.....)	**1**	**0**

39. In the past year, how many different women have you had sexual intercourse with (including wife, girlfriends, sex workers…)?
    .....(0 Never have sex in the past year IF 0, SKIP TO 46)

40. In the past year have you ever paid or given gifts to have sex with a woman?
    1. Yes
    2. No

41. Which place did you meet (seek/recruit) the last woman that you paid for sex?
    1. Brothel
    2. Massage Place
    3. Hotel or guesthouse
    4. Street or park/garden.....
    5. Karaoke bar
    6. Other (specify.....)

42. In the past three months, how often did you use a condom with a woman that you paid to have sex with?
    0. No sex/no sex with paid sex workers
    1. Always
    2. Frequently
    3. Sometimes
    4. Never

43. During the last time that you paid to have sex with a woman how many condoms did you use?
    1. One condom
    2. Two condoms at the same time
    3. More than two

44. Did you propose using a condom the last time you paid to have sex with a woman?
    1. Yes
    2. No

45. Last time you went to a sex worker, how much alcohol did you drink?
    1. A lot (more than 6 small beers or 3 glasses of wine)
    2. Some (3-6 small beers or 2-3 glasses of wine)
    3. A little (1-3 small beers or 1 glass of wine)
    4. No alcohol
    5. Don't remember

46. Have you ever had girlfriend?
    1. Yes
    2. No (IF NO SKIP TO Q 51)

47. In the past year have you had a girlfriend or a mistress (defined as a sexual partner apart from wife)?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 51)

48. In the past year have you had sex with your girlfriend?
    1. Yes
    2. No (IF NO SKIP TO Q51)

49. In the past three months, how often did you use a condom with your most recent girlfriend (or mistress)?
    0. No girlfriend in the past 3 months
    1. Always
    2. Frequently
    3. Sometimes
    4. Never
    5. Have sweetheart but never sex with her

50. Did you use a condom the last time you had sex with your last or current girlfriend?
    1. Yes
    2. No
    3. Have sweetheart but never sex with her

51. In the past year, have you ever selling sex for money to someone else?
    1. Yes
    2. No

52. In the past year, have you ever had sex when you partners were intoxicated (under the influence of drugs, high or unconscious)?
    1. Yes
    2. No

53. In the past year, have you ever had sex when you were under the influence of drugs?
    1. Yes
    2. No
    3. Not remember

54. In the past year, have you ever been forced to have sex against your will?
    1. Yes
    2. No (IF NO SKIP TO Q56)

55. Last time you had sex against your will, who was the person who forced you to have sex against your will?
    1. Parents/siblings
    2. Relatives
    3. Stranger
    4. Sweetheart/spouse
    5. Others (specify.....)

56. Have you ever had anal sex with a man?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 68)

57. In the past year have you ever had sex (oral, anal, touching genitals, jerking…) with a man?
    1. Yes (short hair or long hair M)
    2. No (IF NO SKIP TO QUESTION 61)

58. In the past year, how many men do you have sex with?.....men

59. In the past 12 months, how often did you use condom when you had anal sex with unpaid man?
    1. Always
    2. Often
    3. Sometime
    4. Never use condom

60. In the past 12 months, how often did you use lubricant (water-based lubricant), when you had anal sex with unpaid man?
    1. Always
    2. Often
    3. Sometime
    4. Never use condom

61. Have you ever paid or given gifts to have sex with a man?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 64)

62. In the past 12 months, how often did you use condom when buying anal sex from a man?
    1. Always
    2. Often
    3. Sometime
    4. Never use condom

63. In the past 12 months, how often did you use lubricant (water based for condom) when buying anal sex from a man?
    1. Always
    2. Often
    3. Sometime
    4. Never use condom

64. Have you ever got paid or received a gift to have sex (selling sex to others)?
    1. Yes
    2. No (IF NO SKIP TO Q67)

65. In the past 12 months, how often did you use condom when you were paid to have anal sex with a man?
    1. Always
    2. Often
    3. Sometime
    4. Never use condom

66. In the past 12 months, how often did you use lubricant (water based for condom), when you were paid to have anal sex with a man?
    1. Always
    2. Often
    3. Sometimes
    4. Never use condom

67. The last time you obtained a condom, where did you get it?
    1. Vending stall /store
    2. Pharmacy / drugstore
    3. Health facility
    4. Bar/guest house/hotel
    5. Friend
    6. Client
    7. Madam/pimp
    8. NGO
    9. Other (Specify.....)
    10. Never have acquired

68. Through what method have you received HIV/AIDS education and/or information in the past 3 months? (more than one answer allowed)
    0. Never get information/education
    1. TV
    2. Radio
    3. Newspaper
    4. Billboard/Poster/Booklet
    5. Lecture/Training
    6. Internet
    7. Parent/Family
    8. Friend
    9. Health centre
    10. School
    11. Others (Specify.....)

69. In this past year, have you experienced the following symptoms?
    If no any kind of STI, skip to question 72

	Yes	No	DK	No answer
69-1. Cuts or sores in the genital area	1	2	8	9
69-2. Swelling in the genital area	1	2	8	9
69-3. Urethral discharge with an unpleasant smell	1	2	8	9

70. Where did you first go for treatment the last time you had any an STI symptom?
    1. Pharmacy
    2. Private clinic
    3. Public Hospital/STD clinic
    4. Clinic NGO
    5. Traditional doctor
    6. Didn't get care
    7. Other (specify.....)

71. Have you ever experienced with stigma or discrimination (defined as being excluded from group or being treated differently or looked down by other) when you sought service for your last STI above?
    1. Yes
    2. No

72. What do you think are the main barriers preventing male adolescent or young people to use services when they have health issues (STI, HIV, other diseases...)? More than one answer allowed
    0. Never used any health services
    1. Far from home
    2. The service is not free
    3. The quality of service is poor
    4. Staff are not supportive
    5. The place is not for adolescent or young adults
    6. Other (specific.....)

73. Have you ever had an HIV test?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 76)

74. Where did you have your last HIV test?
    1. Private lab or clinic
    2. Public hospital
    3. VCCT/NGO
    4. HIV test as a part of survey conducted by Government (HSS)
    5. Other (Specify.....)

75. Last time you got tested did you receive the result of the test you took?
    (I do not want to know your test result)
    1. Yes
    2. No

76. What are the contraceptive methods you know? More than one answer allowed

1. Don't know
2. Condom
3. Pill
4. Injectables
5. Intra-Uterus Devices (IUD)
6. Implants (use under the skin)
7. Female sterilization
8. Male sterilization
9. Withdrawal
10. Other, please specify.....)

77. If young women want to have an abortion, where could she go?

1. Don't know
2. Public hospital
3. Private clinics
4. Self induced abortion
5. Pharmacy
6. Traditional birth attendant
7. Other, please specify.....)

[Interviewer: "Thank you very much for answering these questions. Let me repeat that your answers are totally confidential and there is no way anyone will learn which answers are from you. Here is a token of our appreciation" -- (give respondent a in kind gift or something)]

MOST AT RISK YOUNG PEOPLE SURVEY (MARYP SURVEY) 2009-2010
FEMALE ADOLESCENT & YOUNG ADULT

Questionnaire ID # .....
Cluster #.....

Introduction: (The following is to be read by the interviewer to the respondent): "The Ministry of Education, Young people & Sports, in collaboration with UNICEF, WHO, UNFPA, UNESCO, FHI, PSI, and KHANA, is conducting a survey of adolescents and young people in eight different provinces to learn more about their vulnerability to HIV infection, and their knowledge about sexual and reproductive health and health seeking behavior regarding sexual and reproductive services. We would like to request your cooperation for about 30 minutes to ask you a few questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important. The information from this survey will help the country to support HIV prevention, care and support efforts for adolescents and young people.

Signature of interviewer as a proof of receiving consent from participant

.....Date: ...../...../.....

CITY/PROVINCE:

1- Phnom Penh
2- Battambang
3- Kampong Cham
4- Siem Reap
5- Bantey Mean Chey
6- Svay Rieng
7- Koh Kong
8- Preah Sihanouk

LOCATION:

1- Urban
2- District

Interviewer's name: ..... Date: .....ID.....
Supervisor's name.....Date.....ID.....

Did the interviewee abandon the interview?

1- Yes (precise question number)
2- No

Data entry Clerk 1 ..... Date: .....ID: .....
Data entry Clerk 2 ..... Date: .....ID:.....

PART1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you? ..... years (should between 10-24)
2. Are you married now?
   1. Married and currently living together
   2. Never married (SKIP TO QUESTION 4)
   3. Divorced
   4. Separated (live far away from their spouse)
   5. Not married and currently living with sexual partner
3. How old were you when you first married?..... years
4. How many years did you complete at school?.....Years
5. Are you currently attending school?
   1. Yes
   2. No
6. Could you read this below statement for me?

"The Kingdom of Cambodia has a territory of 181,035 square Kilometer with a population of 14 Millions. Cambodia has been internationally advertised as the Kingdom of Wonder"

   1. Read with ease
   2. Read with some difficulty
   3. Read only some words
   4. Cannot read

7. Who are you currently staying with? (More than one answer allowed)
   1. Parents
   2. Siblings (no parents)
   3. With grandparent(s)
   4. With relatives
   5. With friends
   6. Alone
   7. Husband or sexual partner
   8. Other (specify.....)
8. How many brothers and sisters do you have? (Excluding you.....persons
9. How much money did you earn last month? .....riel (0 if the person did not work in the past month)
10. How much money do you usually spend per day?.....riel (in the past month)
11. What is your main profession when you work to earn money for you or your family in the past year?

0. Do not work
1. Seller/vendor/trader
2. Manual/laborer
3. Farmer
4. Factory worker
5. Fishing
6. Other (specify.....)
99. No response

12. Are both of your parents alive?

1. Yes, I have both of my parents
2. No, I have only mother
3. No, I have only father
4. No, I don't have any parents (SKIP to Q14)
5. I don't know

13. What are your parents' main occupations? (More than one answer allowed)

FATHER	MOTHER
0. Does not work	0. Does not work
1. Seller/vendor	1. Seller/vendor
2. Manual/laborer	2. Manual/laborer
3. Farmer	3. Farmer
4. Factory worker	4. Factory worker
5. Fishing	5. Fishing
6. Moto taxi driver	6. Moto taxi driver
7. Business	7. Business
8. Civil Servant	8. Civil Servants
9. Military/Police/Military Police	9. Military/Police/Military Police
10. Other (specify……)	10. Other (specify.....)
99. No response	99. No response
98. No father	98. No mother

14. What type of the house are you living?

1. Living in the street/ homeless
2. Living in hotel/guest house
3. Living in a flat
4. Living in a hut
5. Living in mid-size country house
6. Living in a mansion/large country house
7. Other (specify.....)

15. How long have you been living in the present location.....months
16. What kind of transportation do you have? (More than one answer allowed)

0. No transportation means
1. Bicycle
2. Motorcycle
3. Car
4. Boat
5. Boat with machine
6. Other (specify.....)

PART 2: RISK BEHAVIORS TOWARDS ALCOHOL (ADOPTED FROM NOSSAL CENTER QUESTIONNAIRE):

Now I am going to ask you some questions regarding drinking alcohol.

17. What was your age when you first drank alcohol?.....years old
(0: never drink alcohol): If 0 SKIP to Question 21

18. Where do you get your alcohol? (More than one answer allowed)

1. Bar
2. Shop
3. From friends
4. From family
5. Other (specify.....)

19. How does alcohol affect you? (More than one answer allowed)

1. It makes me happy
2. I lose control
3. It makes me brave
4. It makes me sad
5. It makes me feel sick
6. Other (specify.....)

20. If you are asked to rate yourself regarding to drinking alcohol, how do you describe yourself?

1. Heavy drinker
2. Drink occasionally (one or two time a week)
3. Rarely drink (only drink in some special occasions)
4. Other (specify.....)

21. Are you aware of the dangers of drinking Alcohol?

1. Yes
2. No
3. Don't know

22. In the past year from whom did you received health information regarding the effects of Alcohol? (More than one answer allowed)
    1. Never received any health information
    2. From school/teacher
    3. From peer educators
    4. From health workers
    5. From NGOs working with young people
    6. Other, please specify.....)

PART 3: RISK BEHAVIORS RELATED ILLICIT DRUG USE

Next, I am going to ask you about "illicit drugs", which include Heroin, Yama, Ecstasy and the like. You can refuse to answer any question as you wish.

23. Some people try different drugs for different reasons (such as for recreation, to boost energy boosting to work longer etc). Have you ever used any drug before?
    1. Yes
    2. No (if No SKIP to Question 32)

24. In the past 12 months have you ever injected any drug?
    1. Yes
    2. No

25. In the 6 past months which of the following drugs have you tried?
    (Ask one by one – CIRCLE YES OR NO)

	Used in last 6 months			Injected in last 6 months		
Type of drug	YES	NO	DK	YES	NO	DK
Heroin	1	2	8	1	2	8
Yama, Yaba	1	2	8	1	2	8
Ecstasy	1	2	8	1	2	8
ice, meth-based powder	1	2	8	1	2	8
Marijuana	1	2	8	1	2	8
Inhalants (glue, paint, petrol, spray cans)	1	2	8	1	2	8
Other (specify.....)	1	2	8	1	2	8

26. What was your age at first time you started using illicit drug?.....years old

27. Last time you used drugs, who were using drugs with you? (More than one answer allowed)

1. Sexual partners
2. Male Friends
3. Female friends
4. Alone
5. Other (specify.....)

28. In the past year, did you share your injecting equipment with anyone else (needles, syringes, cottons…)?

0. Never inject
1. Yes
2. No

29. Do you know where you can find clean needles and syringes?

(More than one answer allowed)

1. Never use drugs/inject
2. Pharmacy
3. Health centers/ hospitals
4. NGO with Needle syringe program
5. Others (specify.....)

30. In the past year, from whom have you received information about the harmful effects of drug use? (More than one answer allowed)

1. Never received any health information
2. From school/teacher
3. From peer educators
4. From health workers
5. From NGOs working with young people
6. Other, please specify.....)

31. Have you ever attempted to stop using drugs?

1. Yes
2. No

32. Do you know where someone could go when they want to quit using illicit drugs (illicit drugs are defined as heroin, ecstasy...and the like)? (More than one answer allowed)

0. Don't Know
1. Rehabilitation centers
2. Health Center/Hospitals
3. NGO working with drug user
4. Other (specify.....)

PART 4: RISK BEHAVIORS RELATED SEX, UNPROTECTED SEX AND SEXUAL VIOLENCE

In the next part, I am going to ask you some private questions about sex. You may feel uncomfortable talking about it but please remember that your answers are confidential. However, you are free to refuse to answer any questions.

33. What is your sexual preference?
    1. Men
    2. Women
    3. Men and women

34. Have you ever had sex (with men, women, any kind of sex – oral (mouth to sexual organs), anal (male sexual organ to anus), vaginal (male sex organ to female sex organ), touching (touching sexual organs)?
    1. Yes
    2. No (If NO SKIP to Question 44)

35. How old were you when you first had sexual intercourse?.....years

36. Who was your first sexual partner?
    1. Husband
    2. Boyfriend
    3. Friend
    4. Relatives
    5. Other (specify.....)

37. What was the age of your first sexual partner? .....years old
    (0 If do not remember)

38. In the past year, how many different men have you had sexual intercourse with (including husband, boyfriends,…)? ..... (0 Never have sex in the past year and SKIP TO QUESTION 44)

39. In the past 12 months have you ever got paid to have sex (selling sex to others)?
    1. Yes
    2. No (If NO SKIP TO QUESTION 44)

40. Which place did you meet (seek/recruit) the last clients the last time you sold sex?
    1. Brothel
    2. Massage Place
    3. Hotel or guesthouse
    4. Street or park/garden
    5. Karaoke bar
    6. Other (specify.....)

41. Did you use condom last time you have sex with your clients?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 44)

42. In the past three months, how often did you use a condom with clients that you had sex with?
    0. No sex with client in the past 3 months
    1. Always
    2. Frequently
    3. Sometimes
    4. Never

43. Did you propose using a condom the last time you had sex with your client?
    1. Yes
    2. No

44. Have you ever had a boyfriend/sweetheart?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 49)

45. In the past year, have you had a boyfriend/sweetheart?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 51)

46. In the past year, have you had sex with your boyfriend/sweetheart?
    1. Yes
    2. No (IF NO SKIP TO QUESTION 49)

47. In the past three months, how often did you use a condom with your most recent boyfriend/sweetheart?
    1. Always
    2. Frequently
    3. Sometimes
    4. Never
    5. Have sweetheart/boy friend but never have sex with him

48. Did you use a condom the last time you had sex with last or current boyfriend?
    1. Yes
    2. No
    3. Have sweetheart/boy friend but never have sex with him

49. In the past year, have you ever had sex when your partner was intoxicated (under the influence of drug-on high or unconscious)?
    1. Yes
    2. No

50. In the past year, have you ever had sex when you were under the influence of drugs?
    1. Yes
    2. No
    3. Not remember

51. In the past year, have you ever been forced to have sex against your will?
    1. Yes
    2. No (If No Skip to Q53)

52. Last time you had sex against your will, who was the person who forced you to have sex with against your will?
    1. Parents/siblings
    2. Relatives
    3. Stranger
    4. Sweetheart/spouse
    5. Others (specify.....)

53. The last time you obtained a condom, where did you get it?
    1. Vending stall /store
    2. Pharmacy / drugstore
    3. Health facility
    4. Bar/guest house/hotel
    5. Friend
    6. Client
    7. Madam/pimp
    8. NGO
    9. Other (Specify.....)
    10. Never have acquired

54. Through what method have you received HIV/AIDS education and/or information in the past 3 months? (More than one answer allowed)
    0. Never get information/education
    1. TV
    2. Radio
    3. Newspaper
    4. Billboard/Poster/Booklet
    5. Lecture/Training
    6. Internet
    7. Parent/Family
    8. Friend
    9. Health centre
    10. School
    11. Others (Specify.....)

55. In this past year, have you experienced the following symptoms?

	Yes	No	DK	No answer
55-1. Cuts or sores in the genital area	1	2	8	9
55-2. Swelling in the genital area	1	2	8	9
55-3. Vaginal discharge with an unpleasant smell	1	2	8	9

IF NO any KIND of STI, SKIP TO QUESTION 58

56. Where did you first go for treatment the last time you had any an STI symptom?

1. Pharmacy
2. Private clinic
3. Public Hospital/STD clinic
4. Clinic NGO
5. Traditional doctor
6. Didn't get care (IF 6 SKIP TO QUESTION 58)
7. Other (specify.....)

57. Have you ever experienced with stigma or discrimination (defined as being excluded from group or being treated differently or looked down by other) when you sought service for your last STI above?

1. Yes
2. No

58. Do you think, what are the main barriers preventing female adolescent or young people to use services when they have health issues (STI, HIV, other diseases...)?

(More than one answer allowed)

0. Never used any health service
1. far from home
2. The service is not free
3. The quality of service is poor
4. Staff are not supportive
5. The place is not for adolescent or young adults
6. Other (specific.....)

59. Have you ever had an HIV test?

1. Yes
2. No (IF NO SKIP TO QUESTION 62)

60. Where did you have your last HIV test?

1. Private lab or clinic
2. Public hospital
3. VCCT/NGO
4. HIV test as a part of survey conducted by Government (HSS)
5. Other (Specify.....)

61. Last time you got tested did you receive the result of the test you took?
(I do not want to know your test result)
1. Yes
2. No

62. In the past year, what type of birth control did you use? (More than one answer allowed)
1. Never had sex
2. Condom
3. Pill
4. Inject
5. Intra-Uterus Devices (IUD)
6. Implant (use under the skin)
7. Female sterilization
8. Male sterilization
9. Withdrawal
10. Other, please specify.....)

63. Have you ever been pregnant?
1. Yes
2. No (SKIP TO QUESTION 66)

64. What was the outcome of your last pregnancy?
1. Abortion
2. Stillbirth
3. Live birth
4. Miscarriage

65. Where did you go for your last abortion?
0. Never had abortion
1. Private clinic
2. Public hospital/health center
3. NGO clinics
4. Traditional midwife
5. Never pregnant
6. Other (specify.....)

66. If young women want to have an abortion, where could she go?
(More than one answer allowed)

1. Don't know
2. Public hospital
3. Private clinics
4. Self induced abortion

5. Pharmacy
6. Traditional birth attendant
7. Other, (specify.....)

Interviewer: "Thank you very much for answering these questions. Let me repeat that your answers are totally confidential and there is no way anyone will learn which answers are from you. Here is a token of our appreciation" -- (give respondent a gift or something)]

MARYP Survey January 2010 © KHANA/2010

MOST AT RISK YOUNG PEOPLE SURVEY 2010 GUIDED QUESTIONS FOR FOCUS GROUP DISCUSSION FOR BOYS

PREPARATION

Before the start of the interview, the moderators should make sure that they have all the tools for the FGD. Those tools are; large sheet of paper, pencils, pens, highlighters, scissors, tape recorder, taps.

(The following is to be read by the interviewer to the respondent): "The Ministry of Youth Education & Sports-ICHA, in collaboration with UNICEF, WHO, UNFPA, UNESCO, FHI, PSI and KHANA, is conducting a survey among adolescent and young people in eight different provinces to learn more about their lifestyle and actions that protect them or that put them at risk for STIs, unwanted pregnancy or HIV. We will discuss some questions about knowledge and behaviors regarding sex and reproductive health. We would like to request your cooperation for about 180 minutes to discuss some questions.

- Your participation is voluntary; you can leave if you don't want to participate in this discussion.
- You may feel sad and happy in the session, and you can leave at any time.
- The whole conversation will be tape-recorded; however it will be completely confidential.
- If there is something very personal and difficult to say in the big group, please talk to the researcher after the session.
- If you want help with your worries after a session please talk to a researcher – they can help you find the right people to support you.

Your participation should be fun and is very important and will help service providers to understand more about young people like you and help them to provide health promotion programs and services for young people like you.

INTRODUCTION

(Moderator and note taker introduce themselves to the study participants before starting the FDG)
Would you like to tell the group something about yourself?
And what name do you want us to use for you?
I would like to do a short game on trust – to help us think about what we mean by confidential

TRUST

1. Ask participants to sit in a circle (facilitator in a circle too)
2. Ask the young people to think of a secret that they would not want to tell anyone. Ask them to write it down on a small piece of paper and fold it up and do not show it to anyone
3. Now ask the participants to pass their piece of paper to the person on their left
4. Ask each person how it feels to have your secret in someone else's hands (facilitator can record this on flip chart but only in a way all can understand (if literacy an issue this must be done with symbols)
5. Now ask each person how it feels to have someone's secret in their hands. (facilitator can record feelings…. as above)
6. Now ask participants to give the paper back to the owner. Once done all papers can be destroyed.
7. Ask participants

a. What does this tell us about confidentiality?
b. What kind of things might people share with us that we should keep confidential?
c. What rules should we have about confidentiality during this session?

Understanding the lives of young people like you:

Ask them to discuss young adults' lives. Facilitators help facilitate in this discussion:

8. What do you think about their way of life?
9. What makes them happy?
10. What do they want to happen?
11. How do they spend their day?
12. How do you think what makes young adults look cool, handsome or trendy?
13. What did they do when they gather?
14. What do they dream about?
15. Could you tell (what will they do when they were 30?) What are their expectations and dreams?
16. What is an older boy's dream?
17. What are they concerned about?
18. Is this the same for girls?

CAUSES AND CONSEQUENCES TREE: FACTORS RELATED TO ALCOHOL DRINKING

19. I would like to ask you about alcohol (if not come up in cartoon drawing)
20. On this tree (a prepared big mango tree with wide trunk and many roots and branches). Draw a symbol for alcohol in the trunk
21. Can you discuss together and on the roots – put symbols or drawings for all the reasons that lead young men to drink alcohol all the causes, and even causes of the causes! Can you think of any?

Once one or two reasons have been given,

22. Great and ……
23. On the branches can you draw all the consequences for young women of drinking alcohol? Can you think of any?

Once one or two reasons have been given, leave the group to discuss and work as a team – make sure every participant has a pen in their hand. When they are finished and call you back.

24. Ask them to explain about the tree
25. What are the main factors that make your friends and you to drink alcohol?
26. What about family?
27. Is this the same for girls?
28. In your community, are there any services that can help adolescents or young men who have a drinking problem?
29. What do you think about these services?
30. Is this the same for women and men?

FACTORS RELATED TO DRUG USE

31. Among your male friends, how many of them have used illicit drugs? Inject drugs?
32. What drugs are out there – can you name as many as you can?
33. Have you ever-used drugs or injected illicit drugs? If yes, could you tell me from the very beginning when you started using drug?
34. Why do adolescent males start using illicit drugs?

Add to tree in a different colour the reasons/causes and consequences of using illicit drug among male adolescent.

35. What are factors that can help adolescents who use drugs to quit? To stop drinking?
36. Is this the same for girls?
37. In your community, are there any services that can help adolescents or young men who are "drug dependent"?
38. What do you think about these services?
39. Is this the same for girls and boys?

CAUSE AND CONSEQUENCE CIRCLE: FACTORS RELATED TO SEX

I will you ask about sexual relationships with girls or boys

40. If boys your age have sex, what do they think about? What do they know about contraception? What do they use? Can you tell me more about contraception?
41. What about condoms? What have you heard boys your age say about them? What jokes do you know about them?
42. If a boy your age wants sex - where do they go? What do they think about?
43. If a boy/man your age feels attracted to another boy/man – where would he go to find out more about his feelings?
44. How do adolescents or young adults become a boyfriend/girlfriend? Where do these boys and girls find each other before becoming boyfriend/girlfriend?
45. What do you think if someone said that 'boyfriends/girlfriends should have sex to maintain their love relationship'?
46. On this paper I would like you (sex drawn in centre) to put all the reasons young men like you may decide to have sex and arrows into the circle
47. And all the consequences of sex with arrows pointing out of the circle.

Leave the group to complete and make sure all participants have a pen, when the group have finished ask them to explain their picture and ask any more questions to learn about how they make decisions related to sex.

IF NOT ALREADY ASKED

48. Are there times boys your age have sex for money or gifts?
49. Are there times boys your age pay for sex?
50. Ask about alcohol, other drugs and sex
51. About having sex to prevent being beaten up/sex and violence
52. About having sex so that they can have money to feed children
53. How many of your female friends have experienced unwanted pregnancy?
54. What happens if your (partner) gets pregnant and does not want the baby? What would boys/men your age do?
55. If a young person your age is pregnant, where they should go to get advice?

56. If a pregnant young woman wants to have an abortion, where should she go to get safe abortion?
57. Have you heard any feedback from those who used to have abortion in public clinics? Private? Traditional midwife? (In terms of capacity of the staff friendliness/respect and location)
58. Have you ever heard about sexually transmitted infection? (or ulcer in genital region)
59. Do any of your male friends have STI symptoms? Could you tell me from the start, how your male friends seek care for their disease? Where he gets information about the services? Was he happy with the service he received?
60. Have you ever been sought for treatment from STI clinic? What are the institutions that offer STI service? Were you satisfied with their service quality?
61. Have you ever been tested for HIV? Why? Why do male adolescents or young men have their blood tested for HIV?
62. Do you know where to test for HIV?
63. Are there any services to promote 'safe sex practice" for men?
64. If you ever used the service, do you like the service? What did you like most? And what didn't you like? (In terms of quality and attitude of the staff)
65. If you were the service provider, what service would you want most?
66. Do you have anything else to tell or discuss with me?

MOST AT RISK YOUNG PEOPLE SURVEY 2010 GUIDED QUESTIONS FOR FOCUS GROUP DISCUSSION FOR GIRLS

PREPARATION

Before the start of the interview, the moderators should make sure that they have all the tools for the FGD. Those tools are; large sheet of paper, pencils, pens, highlighters, scissors, tape recorder, taps.

(The following is to be read by the interviewer to the respondent): "The Ministry of Youth Education & Sports-ICHA, in collaboration with UNICEF and KHANA, is conducting a survey among adolescent and young people in eight different provinces to learn more about their lifestyle and actions that protect them or that put them at risk for STIs, unwanted pregnancy or HIV.

We will discuss some questions about knowledge and behaviors regarding sex and reproductive health. We would like to request your cooperation for about 180 minutes to discuss some questions.

- Your inclusion is voluntary, you can leave if you don't want to participate in this discussion.
- You may feel sad and happy in the session, and you can leave at any time.
- The whole conversation will be tape-recorded; however it will be completely confidential.
- If there is something very personal and difficult to say in the big group, please talk to the researcher after the session.
- If you want help with your worries after a session please talk to a researcher – they can help you find the right people to support you.

Your participation should be fun and is very important and will help service providers to understand more about young people like you and help them to provide health promotion programs and services for young people like you.

INTRODUCTION

(Moderator and note taker have to introduce themselves to the study participants before starting the FGD)
Would you like to tell the group something about yourself?
And what name do you want us to use for you?
I would like to do a short game about trust to understand what we mean by confidentiality

TRUST

1. Ask participants to sit in a circle (facilitator in a circle too)
2. Ask the young people to think of a secret that they would not want to tell anyone. Ask them to write it down on a small piece of paper and fold it up and not show it to anyone
3. Now ask the participants to pass their piece of paper to the person on their left
4. Ask each person how it feels to have your secret in someone else's hands (facilitator can record this on flip chart but only in a way all can understand - if literacy an issue this must be done with symbols)
5. Now ask each person how it feels to have some ones secret in their hands.
   (facilitator can record feelings….as above)
6. Now ask participants to give the paper back to the owner. Once done all papers can be destroyed.
7. Ask participants

a. What does this tell us about confidentiality?
b. What kind of things might people share with us that we should keep confidential?
c. What rules should we have about confidentiality during this session?

Understanding lives of young people like you

Ask them to discuss about the young adults lives. Facilitators help facilitate in this discussion:

8. What do you think about their way of life?
9. What makes them happy?
10. What do they want to happen?
11. How do they spend their day?
12. How do you think what make young people look cool/handsome? Trendy?
13. What do they do when they are gathering?
14. What do they dream about?
15. Could you tell (what they will do when they were 30?) What are their expectations and dreams?
16. What is the older girls's dream?
17. What are they concerned about?
18. Is this the same for boys?

Cause and consequence tree: Factors related to alcohol drinking.

19. I would like to ask you about alcohol (if it did not come up in the cartoon drawing)
20. On this tree (a prepared big mango tree with wide trunk and many roots and branches) Draw a symbol for alcohol in the trunk
21. Can you discuss together and on the roots – put symbols or drawings for all the reasons that lead young women to drink alcohol all the causes, and even causes of the causes! Can you think of any?

Once one or two reasons have been given,

22. Great, and ……
23. On the branches can you draw all the consequences for girls drinking alcohol? Can you think of any?

Once one or two reasons have been given, leave the group to discuss and work as a team – make sure every participant has a pen in their hand. When they are finished and call you back…ask about the symbols. If not on the tree then ask.

24. Can you please explain the tree to me?
25. What are factors that make your girl friends or you to drink alcohol?
26. What about family?
27. Is this the same for boys?
28. In your community, are there any services that can help adolescent or young gilrs who have drinking problem?
29. What do you think about these services?
30. Is this the same for girls and boys?

FACTORS RELATED TO DRUG USE

31. Among your girl friends, how many of them have used illicit drugs? Inject drugs?
32. What drugs are out there – can you name as many as you can?

33. Have you ever used drugs or injected illicit drugs? If yes, could you tell me from the very beginning when you started using drugs?
34. Why do adolescent females start using illicit drugs?

Add to tree in a different color the reasons/causes and consequences of using illicit drug among female adolescent.

35. What are factors that can help girls who use drugs to quit? To stop drinking?
36. Is this the same for boys?
37. In your community, are there any services that can help adolescents or young women who are "drug dependent"?
38. What do you think about these services?
39. Is this the same for women and men?

CAUSE AND CONSEQUENCE CIRCLE: FACTORS RELATED TO SEX

I will you ask about sexual relationships with girls or boys

40. Can you tell me about relationships with boys for girls your age?
41. If girls your age have sex, do you think they know and use contraception? Can you tell me more about contraception?
42. What about condoms? What have you heard girls your age say about them? What jokes do you know about them?
43. How do adolescents or young adults become boyfriends/girlfriends? Where do these boys and girls find each other before becoming boyfriends/girlfriends? (use map to show locations if possible)
44. What do you think if someone says that 'boyfriends/girlfriends should have sex to maintain their love relationship'?

On this paper I would like you (sex drawn in centre) to put all the reasons young women like you may decide to have sex and arrows into the circle and all the consequences of sex with arrows pointing out of the circle.

Leave the group to complete and make sure all participants have a pen, when the group have finished ask them to explain their picture and ask any more questions to learn about how they make decisions related to sex.

If not already asked

45. Are there times when girls your age have sex for money or gifts?
46. In which conditions do young adolescents pay for sex?
47. In which conditions do young adolescents use alcohol, illicit drugs, and have sex?
48. Ask about having sex to prevent from being beaten up/sex and violence
49. Ask about having sex so that they can have money to feed children
50. How many of your friends have experienced pregnancy?
51. If a young woman your age is pregnant, where should she go to get advice?
52. What role does the man/boy have in this situation?
53. If a pregnant young woman wants to have an abortion, where should she go to get a safe abortion?
54. Have you heard any feedback from those who used to have abortion in public clinics? Private? Traditional midwife? (In terms of capacity of the staff, friendliness/respect, and location)

55. Have you ever been tested for HIV? Why? Why do girls or young women have their blood tested for HIV?
56. Do you know where to test for HIV?
57. Have you ever heard about sexually transmitted infection (or ulcers in the genital region)?
58. Do any of your girl friends have STI symptoms? Could you tell me from the start, how your girl friends seek care for their infection? Where she got information about the services? Was she happy with the service she received?
59. What are the institutions that offer STI services? Were you satisfied with the service quality?
60. Are there any services to promote 'safe sex practice" for women?
61. If you ever used the service, did you like the service? What did you like the most? And what didn't you like? (In terms of quality and attitude of the staff)
62. If you were the service provider, what kind of service would you want the most?
63. Do you have anything else to tell or discuss with me?

© MARYP Survey, January 2010/KHANA/2010

MOST AT RISK YOUNG PEOPLE SURVEY 2010 GUIDED QUESTIONS FOR IN-DEPTH INTERVIEW

[Introduction: (The following is to be read by the interviewer to the respondent): "The Ministry of Education, Youth & Sports, chaired by Interdepartmental committee on HIV/AIDS in collaboration with UNICEF, WHO, UNFPA, UNESCO, FHI, PSI, and KHANA, is conducting a survey of adolescents and young people in eight different provinces to learn more about their risk to HIV infection and their knowledge about sexual and reproductive health and health seeking behavior regarding to sexual and reproductive services. We would like to request your cooperation for no more than 90 minutes to ask you questions. Some of these questions are personal. You are free to refuse to participate or to terminate the interview at any time. All answers are completely confidential. I do not know your name and there is no way that anyone can learn how you answered these questions. Please be totally truthful in your responses. Your participation is very important for the support of HIV prevention, care and support efforts for adolescents and young people.

INTRODUCTION

1. How old are you?
2. Where do you live? With whom are you staying?
3. How long have been you living at this place?
4. Are you currently at school? What grade are you in?
5. If not, what was your highest grade?
6. Do you work to earn a living? If yes, what is your job?

FACTORS ASSOCIATED WITH ALCOHOL DRINKING

7. How many close friends do you have? How do you find your friends?
8. What do you think about adolescent life nowadays? What makes adolescents happy? What (can be objects or achievement) is really important to adolescents or young adults today? Do you think, what are the items/objects/money that make an adolescent or young adult look cool? Trendy? Is this different for boys and girls? What is different? Why?
9. What do you think other adolescents think about a good education? Do you think this is different for boys and girls? If so, what is the difference and why?
10. What (activities) do you do when you meet with your male friends? Female friends? Where do you usually meet your male and female peers?
11. Do you know other young people who drink alcohol? Mainly boys or girls? Why do you think they drink alcohol?
12. Do you drink alcohol yourself? If so, how often? What kind of alcohol? Please tell how old you were when you started drinking? How did you get your first drink?
13. Do your parents drink alcohol? Or the people you live with? How much and what kind of alcohol do they drink?
14. Do you think beers and other alcoholic beverages advertisements promote adolescents and young adults to start drinking? If yes, why?
15. What is/are the factor/s leading to increasing use of alcohol among adolescents and young people? Why do adolescents and young people drink alcohol?
16. Among your friends, who is the heaviest drinker? Could you describe his/her personality? What is good and bad about drinking alcohol?
17. If your peers push you to drink with them, what do you do? Why?

FACTORS RELATED TO SEX

18. Some adolescents start having boyfriends/girlfriends, why do adolescents want to have boyfriends/girlfriends?
19. Tell me about your friends. How many of your classmates or schoolmates or other friends have boyfriends/girlfriends?
20. Do you have a boyfriend or girlfriend? If not, do you want to have one? Why? What is good or bad about having boyfriend/girlfriend? (Probe for sexual preference)
21. Could you tell about how adolescents or young adults become a boyfriend/girlfriend? Where do these boys and girls find each other before becoming boyfriend/girlfriend?
22. Some adolescents buy sex from sex workers, why? Do adolescents and young people use condoms or not when they go to sex workers ? Why or why not?
23. How many of your friends have sex with their boyfriend/girlfriend?
24. What do you think if someone said that "boyfriends/girlfriends should have sex to maintain their love relationship?"What are the other possible reasons for adolescent to decide to have sex with their sweetheart?
25. Have any of your friends have been forced to have sex against their wills? If yes, how did that happen? How about you?
26. What is good or bad about having sex with sweetheart?
27. Where do boys and girls go to have sex?
28. Have your friends ever told you what they have done with their boyfriends/girlfriends, especially in their sexual relations?
29. How do their 'love relationship' end?

FACTOR RELATED TO SEX FOR MSM (FOR MSM ONLY)

30. Some adolescent boys start having boyfriend, why do you think male adolescents want to have boyfriends?
31. Tell me about your male friends. How many of your classmates or schoolmates or other friends have boyfriends?
32. Do you have a boyfriend or girlfriend? If not, do you want to have one? Why? What is good or bad about having male or female sweetheart?
33. Could you tell me how young men become boyfriends? Where do they meet each other?
34. Some adolescents buy sex from sex workers, why? Do adolescents and young people use condoms or not when they go to sex workers ? Why or why not?
35. How many of your male friends have sex with their boyfriend/ girlfriend? What about your female friends?
36. What do you think if someone said that "boyfriends/girlfriends should have sex to maintain their love relationship?"What are the other possible reasons for adolescents to decide to have sex with their sweetheart?
37. What is good or bad about having sex with sweetheart?
38. Where do boys and their boyfriends go to have sex?
39. Have your male friends ever told you what they have done with their boyfriends or girlfriends, especially their sexual relations?
40. How their "love relationship" end?

FACTORS RELATED TO DRUG USE

41. Among your friends, how many have used illicit drugs? Injected drugs? Why do adolescents use drugs? How do they get started? Is it different for boys and girls?
42. Have you ever used drugs or inject illicit drugs? If yes, could you tell me from the very beginning when you started using drug? How did you get started?
43. What is bad and good about using illicit drugs?
44. Where do adolescents and young adults find places to buy drug? Where do they get their money?

FACTORS LEAD TO BEHAVIORAL CHANGE

45. What do you think of how to help them to quit illicit drug use? To stop drinking? To change their high-risk behavior?
46. In your community, are there any services that can help adolescents or young adults who are "drug dependent"? To help to solve drinking problems? To promote "safer sex practice"?

ACCESS AND BARRIERS TO HIV AND SEX AND REPRODUCTIVE HEALTH SERVICES

47. Have you heard about HIV and other sexually transmitted infections? Would you like to know more about them?
48. Do you know where to go for an HIV test? Have you ever been tested for HIV? Why? Why do other adolescents and young adults go for HIV testing?
49. If you have been tested for HIV , please tell me what are the steps when you visit a VCT center for HIV testing?
50. If you have been tested for an HIV, where did you go? How did you like the service? (in terms of quality and the attitude of the staff)
51. What are things that can help adolescents and young people to have their blood tested for HIV?
52. Have you ever heard of other sexually transmitted infections? (or ulcers in genital region)? Have you ever had an STI yourself?
53. Do any of your friends experience such symptoms? What do they do if they think they have a sexually transmitted infection? Where do they go for treatment? Why?
54. Have you ever been to an STI clinic for STI treatment? What are the institutions that offer this service? Were you satisfied with the quality of services provided at the time you visited? Did you have to pay?

UNWANTED PREGNANCY

55. Do you know young women under 24 years who are pregnant or have children?
56. Do you know how many of your friends are or have been pregnant in the past?
57. If a girl becomes pregnant, where should she go to get advice? What is the role of her boyfriend or husband?
58. If a pregnant girl wants to end the pregnancy and have an abortion, where should she go to get a safe abortion (abortion without having problems to health of the mother)?
59. Have you ever heard any feedback from those who have had abortions in public clinics? Private? Traditional midwife?

QUESTION ON LIFE STORY OF AN HIV POSITIVE ADOLESCENT:

60. Can you tell me how you came to know your HIV status?
61. Please tell me how you lived your life differently before and after knowing that you are HIV positive?
62. Did you disclose your HIV status to your family yet? If yes, could you describe how you disclosed it?

63. What are reactions you experienced when you disclosed your HIV status to your family? Your friends?
64. Could you describe your experiences (schooling, friends, and communities) of being an HIV positive? What stigma and discrimination have you experienced (if any)?
65. What might have been the cause of your HIV infection?
66. Do you receive OI/ART treatment? What do you think about those services you received? What can be improved?
67. What do you do to keep yourself healthy?
68. Since you are aware of your HIV status, do you use condom when you have sex with your partners? Why?

MOST AT RISK ADOLESCENT SURVEY 2009-2010 KEY INFORMANT INTERVIEW

[Introduction: (The following is to be read by the interviewer to the respondent): "The Ministry of Education, Youth & Sports, chaired by Interdepartmental committee on HIV/AIDS in collaboration with UNICEF, WHO, UNFPA, UNESCO, FHI, PSI, and KHANA, is conducting a survey of adolescents and young people in eight different provinces to learn more about their risk to HIV infection and their knowledge about sexual and reproductive health and health seeking behavior regarding to sexual and reproductive services. We would like to request your cooperation for no more than 30 minutes to ask you questions.

You are free to refuse to participate or to terminate the interview at any time. All answers will be recorded but are completely confidential. Please be totally truthful in your responses. Your participation is very important for health care providers to learn more about adolescent and young adult. The information from this survey will help the country to support HIV prevention, care and support efforts for adolescents and young people.

1. What is your organization name?
2. How long has your organization been established?
3. What are the goals/objectives of your organization?
4. Who benefits from your services?
5. Why did you choose adolescents as your target group?
6. Do your target groups included adolescents or young adult?
7. What services are provided by your organization? Could you describe the objectives of each service?
8. How do you deliver your services to ensure that it will reach your target population?
9. What is your observation regarding the use of health services among adolescents and young adult? Why?
10. What types of programs reduce risk of HIV among MARYP?
11. What measures can service providers take to encourage adolescents to use services?
12. What are driving risks of adolescents that result in their current situation?
13. Why do most at risk adolescents behave as they do?
14. What problems do most at risk young people currently face?
15. Are there any current policies regarding providing services to MARP?
16. Do you know any other NGOs or organizations that work, specifically with MARYP?
17. Do you cooperate in partnership with other NGOs/institution working with MARYP?
18. Do you have anything else to share with me?

© UNICEF/Bona Khoy/2010

"Young woman walking home in the early morning" **© UNICEF/Axelrod/2010**

"Rays of hope for young people in Cambodia"

IMPLEMENTED BY:

KHANA
អង្គការសម្ព័ន្ធភាពនៃប្រយុទ្ធនឹងជំងឺអេដស៍
Khmer HIV/AIDS NGO Alliance

WITH FINANCIAL SUPPORT FROM:

ប្រសិទ្ធ PRASIT

USAID
FROM THE AMERICAN PEOPLE

psi
Cambodia

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

UNESCO
United Nations
Educational, Scientific and
Cultural Organization

UNFPA

unicef

World Health
Organization

MOST AT RISK YOUNG PEOPLE SURVEY CAMBODIA 2010

Contact Details:

MINISTRY OF EDUCATION, YOUTH AND SPORTS
ICHAD TECHNICAL SECRETARIAT

169, Norodom Blvd, BKK 1, Khann Chamkarmorn, Phnom Penh
Email: shd@moeys.gov.kh
Fax: (855) 23 221 815