

The European Union's Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries programme For Cambodia

Rural Cambodian Youth Sexual Reproductive Health Project

Factors Associated with Rural Cambodian Youth Sexual Reproductive Health.
A 2009 Survey Report

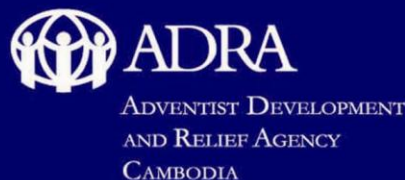
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Rural Cambodian Youth Sexual Reproductive Health Project
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Factors Associated with Rural Cambodian Youth Sexual Reproductive Health. A 2009 Survey Report

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Acronyms

AFRSH	Adolescent-Friendly Reproductive and Sexual Health Services
ADRA	Adventist Development and Relief Agency
CBTT	Community-Based Training Teams
EC	European Commission
HCMC	Health Center Management Committees
IEC	Information, education and communication
LLUSPH	Loma Linda University School of Public Health
MoED	Ministry of Education
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoWA	Ministry of Women's Affairs
NGO	Non-Governmental Organization
NHP	National Health Program
OD	Operational District
RACHA	Reproductive and Child Health Alliance
RCYSRH	Rural Cambodia Youth Sexual and Reproductive Health
SBTT	School-Based Training Teams
SRH	Sexual and Reproductive Health
WHO	World Health Organization
VHSG	Village Health Support Group
YSRH	Youth Sexual and Reproductive Health

Executive Summary

Purpose and description of the Study

ADRA Cambodia together with its implementing partner, Reproductive and Child Health Alliance (RACHA), implemented the Rural Cambodia Youth Sexual and Reproductive Health (RCYSRH) project in three operational districts (OD) - Baray-Santuk, Stoung, and Tbaeng Meanchey located in two provinces, Kampong Thom and Preah Vihear respectively. The RCYSRH project was designed to address the needs for:

1. increased knowledge and awareness,
2. improved access to information and appropriate health services and
3. community advocacy for sexual and reproductive health services for youth.

The present study explored the socio-cultural factors and their impact on access to health information and services, antecedents to risky sexual behaviors and key motivating factors for practicing safer sex. It also aimed to assess and identify factors associated with youth sexual and reproductive health behavior in Kampong Thom and Preah Vihear Provinces.

Quantitative study findings

Three hundred questionnaires were answered by 150 males and 150 females. Data collection was conducted over a two-week period beginning on March 26, 2009 and ending on April 7, 2009.

Sexual and Reproductive Health Knowledge

Both males and females agreed that 18 years of age was the ideal age for a girl to have sex for the first time while they agreed that 20 was the ideal age for males. However, a majority of them (boys and girls) agreed that they should have sex only after marriage.

Health-Seeking Behaviors & Access to Services

For all other health services, the health center remained the main source followed by private clinics, village shopkeepers, the pharmacy, and the referral hospitals. Reasons for seeking health care services were cited as medical screening, STI treatment, HIV testing, curative treatment services with more females than males, getting contraceptives, vaccinations and injury were cited by very small numbers.

Attitudes, Beliefs and Values; Social-Cultural Context

A majority planned to wait until marriage before having sex. The remaining indicated that they planned to wait until they got engaged, until they found someone they loved, until their partner was ready, until they were 19 years of age or whenever an opportunity arose. Few respondents indicated that they were ready to cause a pregnancy or to be pregnant. Reasons for wanting a pregnancy varied from having a baby to love, having a child's love, moving out of parents house, getting married, having a partner to love or wanting to be a father or mother.

Sexual Practices/Behavior & Influence of the Media

Some respondents identified going out late at night with friends as a high-risk behavior with more males than females doing so. More males identified alcohol use and drunkenness as a high-risk behavior and more females identified reading pornographic literature as a high-risk behavior rather than watching pornographic movies. More males than females identified drug use and gambling as high risk behaviors.

Conclusion

There was a great degree of knowledge about safe sexual practices and reproductive health among the participants in the two provinces. However participants showed varying degrees of understanding their own vulnerability to unsafe sexual practices.

Family relationships were rated very highly by the majority; evidence of the strong extended

family ties within the Khmer culture. Some cited the disruption of family ties and values as one of the causes of unsafe sexual practices among rural youth. More thorough and in-depth studies need to be carried out to further investigate factors that directly determine risk taking in sexual and reproductive health by Cambodian youth.

Introduction

Background

ADRA Cambodia together with its implementing partner, Reproductive and Child Health Alliance (RACHA), implemented the Rural Cambodia Youth Sexual and Reproductive Health (RCYSRH) project in three operational districts (OD) - Baray-Santuk, Stoung and Tbaeng Meanchey located in two provinces, Kampong Thom and Preah Vihear respectively. The direct beneficiaries of the project were 171,000 rural youth aged 10-24 years and indirectly affected the lives of an additional 331,000 people. This three-year program began in August 2006 and was funded by ADRA Germany, ADRA Norway and the European Commission under its Program Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries.

The RCYSRH project was designed to address the needs for:

1. increased knowledge and awareness,
2. improved access to information and appropriate health services and
3. community advocacy for sexual and reproductive health services for youth.

To meet these needs, the program objective worked towards:

1. Empowering provincial and district level employees of the Ministry of Health (MoH), Ministry of Women's Affairs (MoWA) and Ministry of Education, Youth and Sports (MoEYS),
2. The provision of training, coaching and mentoring of health centers' employees, referral hospitals and schools,
3. The establishment and provision of youth friendly services and information centers for in-school and out-of school youth, commune council members, health center staff and teachers
4. The formation of community-based training teams (CBTT) and school-based training teams (SBTT) for the provision of training, coaching and mentoring of youth peer educators, religious leaders, village health support groups (VHSG), and
5. The training of health center management committees (HCMC) to be community youth advocates. The master training curriculum was developed from selected information of currently available curricula and was adapted to the needs of the target groups.

The teachers' training focused on youth sexual and reproductive health (YSRH) concepts, youth characteristics, youth rights, life skills and counseling skills. After the training, teachers were expected to introduce the topics into the appropriate curricula. To reach out-of-school youths, the project contacted local authorities and identified youth who were active in the community and trained them as peer educators. These youth functioned as peer educator leaders who conducted outreach activities in their communities, sharing information with other young people.

The project established youth-friendly health services at each health center, referral hospitals as well as school-based youth corners. Youth-friendly services recognize that young people have special needs for information and services that differ from those of adults – for example a greater need for privacy and a need not to be judged by adults. Youth friendly services established separate rooms in some locations for information sharing and counseling where a peer educator or HC staff member is on hand to facilitate discussion. Complementary to the youth friendly services, youth corners have a library with reading materials, posters, games and information, education and communication (IEC) tools on sexual and reproductive health. A project-sponsored referral system links school youth corners with youth friendly services and

referral hospitals.

The project staff has participated in advocacy and policy at the national level, advocating for the need for an adolescent national policy and contributed to the development of national standard guidelines for adolescent-friendly reproductive and sexual health services (AFRSH). The project utilized research data and experience in field-level interventions in presenting technical papers and formative research reports to provide data that will inform and encourage policy development and guide future program implementation. Information gathered through this project will be used to inform and influence national YSRH policy development.

Modernization is a threat to the Cambodian family's protective values. Families in Cambodia are paternalistic with strong family ties. Each member of the family is expected to live within certain family values and their perceived protective mechanisms. These family values have been created by complex interactions of community, family and environment and are passed down from generation to generation. Community elders and more commonly the fathers and grandparents act as guardians and defenders of these values.

Rebellion against these values results in immediate discipline and at the extreme case, rejection by the family and loss of the family safety net. A highly-held family value/practice is not to discuss sexual topics with young people. NGOs which advocate for increased access to sexuality and reproductive health education have sometimes received stern opposition from heads of families and community leaders. During the project implementation some of the trained youth were forced by their parents to stop attending sexual and reproductive health education in their schools.

The challenge of modernization to these strongly held family values is that most information on sexual and reproductive health is now readily available through different media such as print, internet, television and radio. This allows youth to bypass parental or cultural control mechanisms. Some of the information in the media is not conducive to healthy youth sexual and reproductive health development. This has led some researchers to implicate the increase of poor quality sexual and reproductive health information to the rising early sexual debut and loss of cultural values among young people in Cambodia.

Cambodia has made considerable progress in its health indicators over the last decade, but continuing challenges include high maternal, neonatal, infant, and under-five mortality rates, low rates of births attended by skilled personnel, high unmet need for contraceptive services, high levels of anemia in women of reproductive age, and high STI and HIV transmission. Recently, the Ministry of Health (MoH) has acknowledged the importance of providing services for adolescents and the National Reproductive Health Program has developed national guidelines for adolescent friendly reproductive and sexual health (AFRSH) services. The purpose for the latest *National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010)* was "to ensure an effective and coordinated response to reproductive and sexual health needs in the country and to attain a better quality of life for all Cambodians by improving the reproductive and sexual health status of women, men, and adolescents through effective and appropriate health programs". The Ministry of Education, Youth and Sports (MoEdYS) has also recently started to introduce SRH education in schools, especially on HIV and AIDS and welcomes NGO partnerships in the implementation of in-school SRH education initiatives.

Cambodian school education on sexual and reproductive health is still in its infancy. The National Health Program (NHP) is working hard in developing a standardized national curriculum by collecting lessons learned and best practices in youth sexual and reproductive health education. The research findings will provide valuable information to the NHP as it develops the national curriculum.

Study Objective

This study explored the socio-cultural factors and their impact on access to health information and services, antecedents to risky sexual behaviors and motivating factors for practicing safer sex. The study also aimed to assess and identify factors associated with youth sexual and reproductive health behavior in Kampong Thom and Preah Vihear Provinces.

Study Limitations

Recall bias is typically found in any quantitative and qualitative study. This is compounded by the fact that participants tend to report more desirable behaviors even when there is no self identification on the questionnaires.

Although all the surveyors were trained and most of them were experienced in this kind of work, there is still the possibility of bias introduced by the interviewer whether intentionally or unintentionally. Unfortunately there is no way to correct this in such a short period of time allocated for the study.

The numbers recruited for the focus group discussions and key-informant interviews were not large enough to validate some of the findings in the quantitative study. This was beyond the control of the investigators as this was identified only after the data analysis phase. Also the questionnaire was not re-translated back into English to verify for loss of meaning and understanding of the questions due to time constraints during the intense field data collection period.

Methods

Quantitative Methods

A 75-item questionnaire was prepared and pretested. It was divided into the following seven sections:

1. Demographics
2. Demographics by province
3. Attitudes, beliefs and values
4. Social influences
5. Media influence
6. Alcohol use
7. Drug use

The sample population consisted of 300 participants aged 10 to 24 years from 300 households that comprised 30 sample clusters. Each sample cluster population consisted of 10 youth. In each of the participating villages 10 households were randomly selected.. A total of five males and five females from each village were selected. Upon arrival at each village, local leadership (village chief) was consulted and approval was obtained prior to interviewing. Gender sampling was random and was conducted through matched gender interviewer-interviewee criterion.

Qualitative Methods

Focus group and key informant interviews were used to validate the questionnaire findings. Structured and semi-structured questionnaires were designed to guide in the conduct of focus group discussions and in-depth interviews. The purpose of the focus group discussions was to

verify and confirm the findings in the quantitative study. A series of 14 questions were constructed and presented to each group for discussion. Group discussions were limited to 90 minutes in length.

Staff Training

A total of 15 field data collection staff and supervisors were recruited and trained by a consultant from Loma Linda University School of Public Health. A two-day workshop was held to train the staff in the administration of the questionnaires and in the conduct of focus group discussions (FGD). The questionnaires were field-tested before deployment. The focus group questions focused on community access of youth sexual and reproductive needs and concerns. For example, participants were asked, “Are there any adolescent pregnancies among the youth of your community who you know about?” Other topics were youth migration for work, youth education, and the effects of pornographic media products.

Data Collection

Data collection was conducted over a two-week period beginning on March 26, and ending on April 7, 2009. One member of each household who met the inclusion criteria was included in the survey. The completed questionnaires were collected by supervisors on the due date and submitted to the research consultant. After careful examination, each questionnaire was stored for entry. The editing and coding of each questionnaire was performed manually and submitted for entry. Manual processing of questionnaires verified status of completeness, correctness, and quality of the data entries. The research consultant performed manual editing and coding.

Confidentiality of Information

All survey participants voluntarily agreed to participate in the study by giving their informed verbal or signed consent after being fully briefed on the goals and objectives of the study. They were assured that any information provided will be confidential and not be released to anyone outside of the study. In addition, they were informed that they could withdraw from completing the questionnaires or from the focus group if they did not feel comfortable at any time and without reason.

Data Analysis

All questionnaires were assigned an identification number and were entered into a software database package application twice to verify correctness of entry. “Epiinfo” was used to verify data entry and to rectify inconsistencies. In order to correct for data entry inconsistencies “data compare” was used to identify data points which did not correspond to the first and second entries. In addition, “SAS 9.1” was used for tabulation of survey results. A single supervisor and four data entry personnel performed this after being trained over the course of two days on entry verification, completeness of entry, correction of entry errors, and coding. Following data entry, a preliminary report was generated. Sets of tables were included in this report and variance checks were performed on all variables included in the questionnaire. The range checks that were generated indicated the minimum and maximum of all variables. All tabulations reported were extracted after cleaning of data files.

Survey results

Quantitative Results

All eligible participants were interviewed individually and face-to-face. The end result of all interviewing yielded a 98.52% response rate to questions presented to all respondents.

Socio-demographic findings

Three hundred questionnaires were answered by 150 males and 150 females with a mean age of 17.07 years. Two-hundred and thirty participants were from Kampong Thom and seventy from Preah Vihear. The females were a little older than the males (17.94 years) compared to males (16.20 years). The majority 98.67% identified themselves as Buddhists and only 1.33% as Christians.

Eighty-six percent of the males lived with both parents compared to 82% of the females. Of the participants who did not live with both parents, 36% of the females lived by themselves compared to 15% of the males; the remaining lived with a boyfriend or girlfriend, or mother and/or other family members. In most families, both parents (32%) had an income as opposed to the father only in 26% and 18% the mother. Approximately, eight percent of the youth indicated that they had an income and that the parents controlled the income. Forty-one percent indicated that the income was not enough as compared to 53% who indicated that it was enough. To supplement family income, 63% indicated that they sought other employment, borrowed money (3.6%) or sold personal belongings (5.67%).

Over fifty-eight (58.53%) percent of the youth were students with more females in school (62.64%) than males (59.67%).

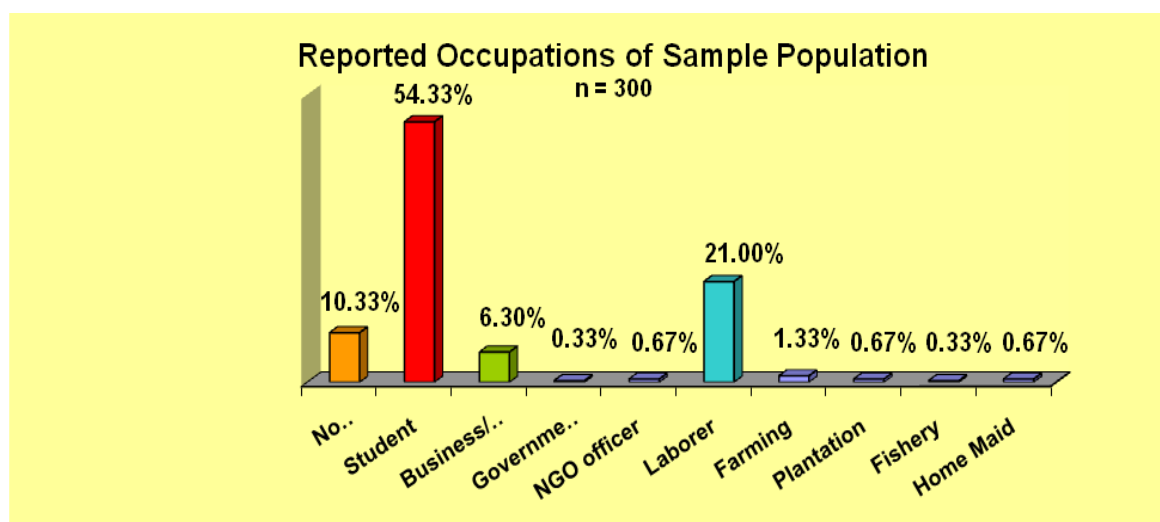


Figure 1.0 Reported Occupations

Twenty-nine percent of the males worked as laborers compared to approximately 13% of the females (see Figure 1.0). When asked about what they had done in the last month to earn some money 64% of the males and 8% of the females said they had done nothing, 16% of the males and 7% of the females sold some goods and others were farming, fishing or working on plantations. In response to whether they had been abused on the job, 25% of the females reported that they had been raped or forced to have sex (representing only 1 case of rape). Thirty-three percent of the males reported that they had been discriminated against or treated unfairly and 55% of the males reported that they had not been paid their salary. Eleven percent of males and 25% of females reported that they had been made to work overtime but not paid for it.

Twenty-one percent of both males and females reported that they had migrated to other areas to seek employment. Of the ones who migrated approximately 48% went to Phnom Penh City of

whom 29% were males and 68% were females. Others went to smaller towns in other provinces.

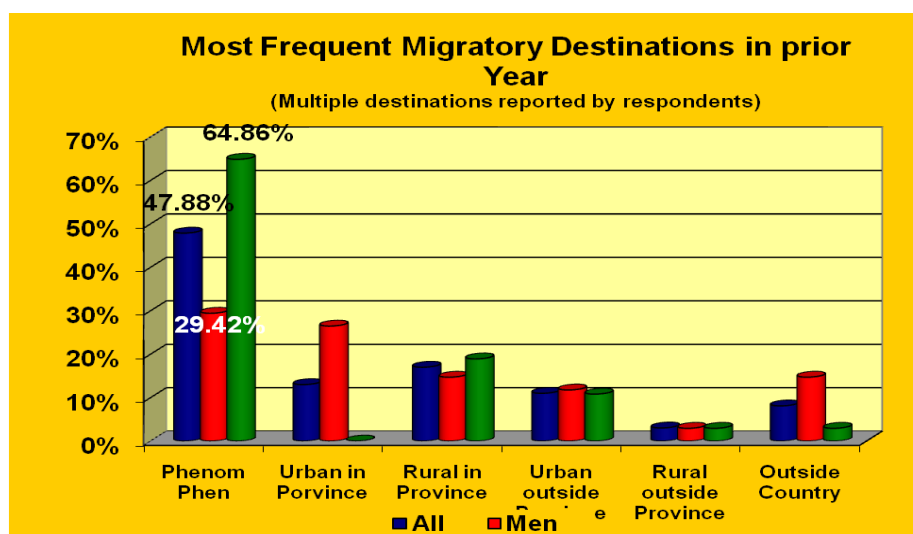


Figure 2.0 Reported Migratory Destinations

The majority of migrates stayed for more than a month (70%) with more females staying than males. Fifty-eight% of those who migrated worked as laborers; (78% males, 39% females), 26% worked in garment factories; (9% males and 42% females). The rest worked in restaurants, as taxi drivers or in hotels.

Twenty-nine percent reported being abused on the job; 31% males and 27% females. In this category no one reported being raped or forced to have sex. Most of them reported being discriminated against or not being paid full salaries for overtime or just not being paid at all.

Twenty-one percent reported ever having a boyfriend or girlfriend; (25% males and 19% females) with most of them having had their first boyfriend or girlfriend at approximately 18 years of age. 14% reported currently being in a relationship; 17% males and 11% females. Seventy-seven percent were committed to their relationship; 88% males and 61% females.

Attitudes, beliefs and values

Both males and females (n = 300) agreed that 18 years of age was the ideal age for a girl to have sex for the first time while they agreed that 20 was the ideal age for males. However, they agreed (94%) that females should have sex after marriage whereas they agreed (90%) that males should have sex after marriage. Fifteen percent of the participants (17% males and 13% females) did not expect to have sexual partners for the rest of their adolescent years (up to 24) compared to 79% who expected to have sexual partners (74% males and 82% females). A small number (3%) indicated that they expected to have 2 to 3 sexual partners in the next 12 months.

Seventy-nine percent planned to wait until marriage before having sex (69% males and 89% females). The remaining indicated that they planned to wait until they got engaged, until they found someone they loved, until their partner was ready, until they were 19 years of age or whenever an opportunity arose. Twenty-eight percent of the participants planned to get married; (21% males and 11% females). Approximately, 20% indicated that they were ready to cause a pregnancy or to be pregnant; (22% males and 16% females). Reasons for wanting a pregnancy varied from having a baby to love, having a child's love, moving out of parents house, getting married, having a partner to love or wanting to be a father or mother.

Of those who did not want to be pregnant, reasons given varied from being too young, continuing with studies, wanting to build a career, not able to afford children, not being mentally ready and

still living with parents.

Social influences

Even though informed consent had been obtained for the questionnaires, this section was based on the willingness of the respondent to answer questions honestly and correctly. This section began with a request for permission to ask more personal questions. Ninety-eight percent of the participants (n = 300) gave their consent again.

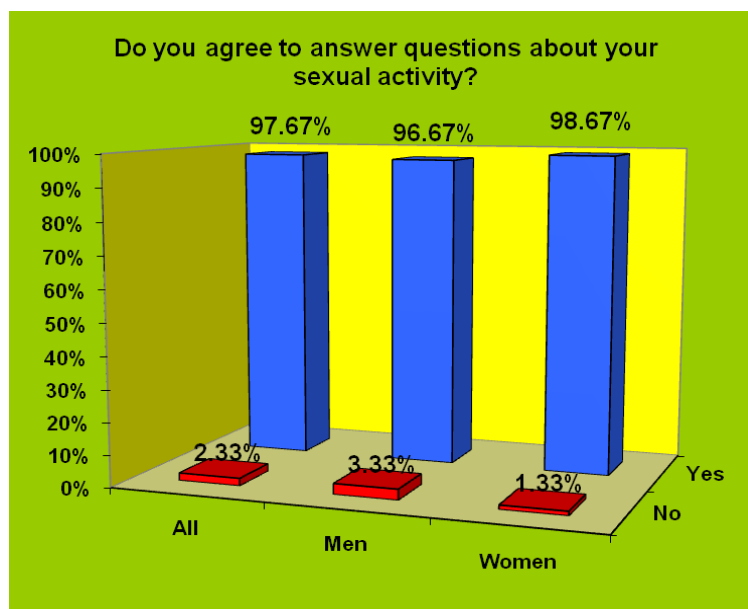


Figure 3.0 Reported responses to answer questions regarding sexual practices

17% reported ever having had sex and the numbers were equal for both males and females. 90% reported having had only one partner in the last six months; (80% males and 100% females). 20% of the males reported having more than one partner. Regular partners were boyfriends or girlfriends for 17% of the participants of whom 32% were males and 4% were females. 20% of the males had sexual encounters with commercial sex workers and the remaining had sex with their spouse. The median age at first sex was 18 for both males and females. In reply to the questions whether they wanted to have sex or if they were tricked, threatened or forced to have sex, 84% reported that they wanted to have sex; of whom 96% were males and 73% were females. The remaining respondents reported that it just happened and that they had not planned for it.

Of those who are married, 100% reported being happy with their marriages. An approximately equal number of both males and females (42%) reported facing family problems ranging from domestic violence 46%, alcohol abuse 27% and low income and poverty 24%. A small number (1.19%) reported drug use and having too many children.

More females (69%) reported being pressured into dropping out of school than males (31.58%). Almost an equal number of males and females reported being pressured into early marriage (6.25%) and others reported being discouraged or prevented from accessing reproductive health services (4.16%).

Twenty-four percent of the participants identified going out late at night with friends as a high-risk behavior with more males than females doing so (29% and 20%). More males identified alcohol use and drunkenness as a high-risk behavior (22% and 9%) and more females (55% and 14%) identified reading pornographic literature as a high-risk behavior rather than watching pornographic movies; (15% males and 5% females). More males than females identified drug use and gambling as high risk behaviors.

When asked if they participated in any of these risk behaviors without specifically naming one, 49% of them said they did of whom 62% were males and 35% females. Several reasons were given for doing so including “because my friends do it” 16% with more males (20%) than females (8%).

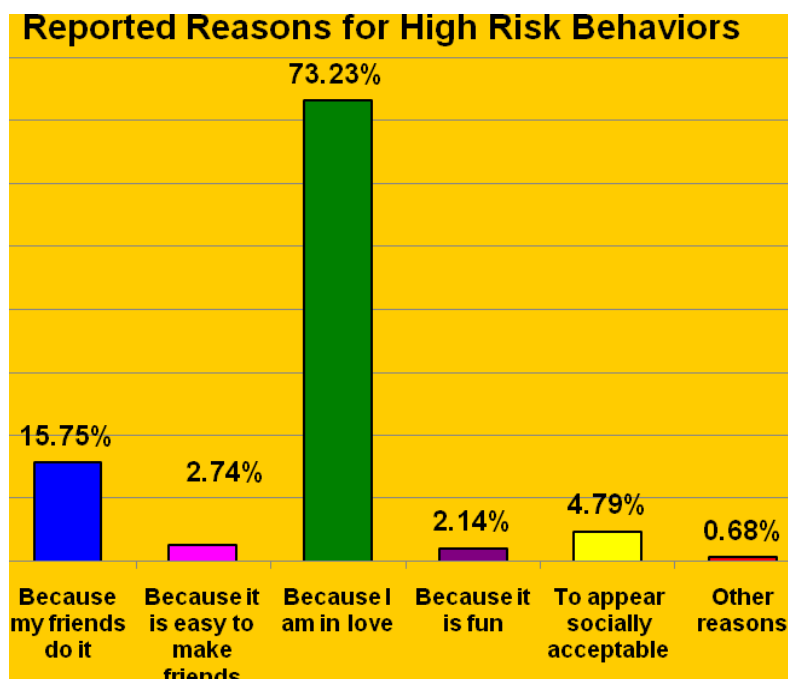


Figure 4.0 Reported reasons for high risk behaviors

An almost equal number of males and females gave “being in love” as the reason. It is interesting that females cited “being socially acceptable”.

For reproductive health services, 45% stated they would go to the health center if they had a problem with more females than males saying so (51% and 43%) whereas more females said they would go to a parent (21% and 12%). The rest said they would go to a referral hospital, a private clinic, and peer counselor, relative, friend and teacher even traditional healer.

For all other health services, the health center remained the main source (45%) followed by private clinics (19%), village shopkeeper (13%), the pharmacy 12% and the referral hospitals (8%). Reasons for seeking health care services were cited as medical check up 14%, STI treatment 5%, HIV testing 5%, curative treatment services 59% with more females (64%) than males 53%, getting contraceptives, vaccinations and injury were cited by very small numbers.

At the health center most of the were attended to by a nurse midwife (39%), followed by a doctor 17%, pharmacist 17% and village shop seller 16%. There were also some who went to see traditional healer although this number was very small. Overall the health care providers were rated highly (>80%) on friendliness, knowledge, interest in the client, qualifications, communication, respect for the client, politeness, provision of privacy and listening skills.

Media influence

The only question asked about media influence was if they watched or read pornographic movies or literature respectively. Twenty-six percent said they did with more males (42%) doing so than females (10%).

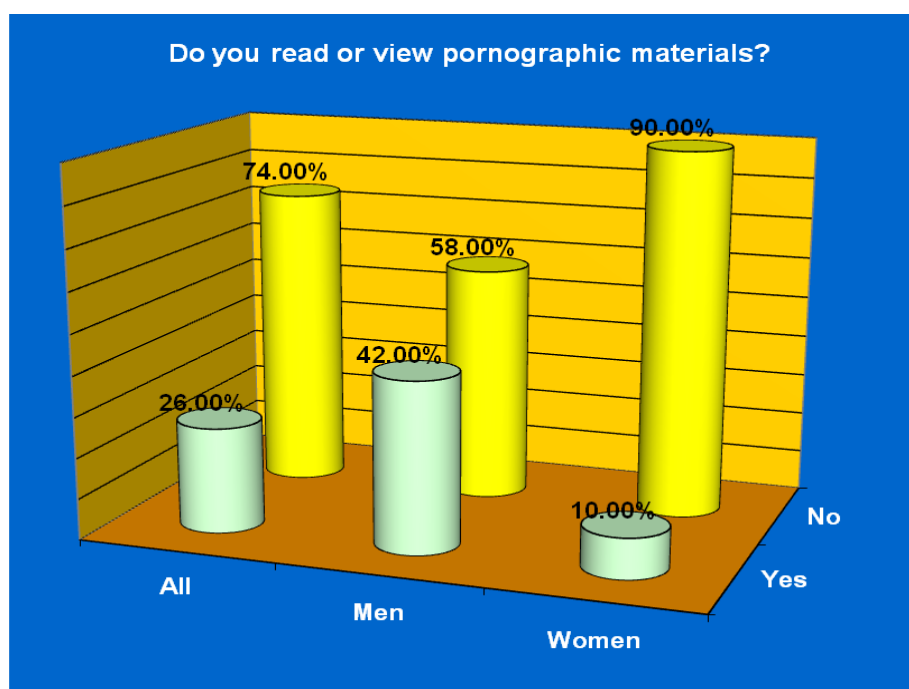


Figure 5.0 Exposure to pornographic products

Alcohol Use

More males (43%) consumed alcohol in the last month than did females (18%) and the number of times they drank varied from once (33%) to more than thirteen times (11%). More females 46% reported drinking once than males 28% whereas more males (55%) reported drinking 2 to 5 times than females (43%). It is interesting to note that more females got drunk at least once (66.7%) than males (35%) and more males got drunk 2 to 5 times (37% and 15% respectively). Only 6% of the males indicated that they had sex under the influence compared with less than 1% of females. Most of them had sex with their boyfriend or girlfriend, a partner or spouse. Forty percent reported no using condoms.

Drug Use

Six percent reported that they had friends who used drugs with more males reporting (11%) than females a little more than 1%. Only males 3% reported ever using drugs such as glue, yama and heroin. None of them reported having sex under the influence of drugs.

Qualitative results

The focus group discussions were conducted separately for the males and females. It was felt that more information would be obtained because each group would feel safer to talk. The following is a summary of the answers.

Social problems

The youths identified the following social problems in their communities, drug and alcohol use, poor life skills that lead youth into making bad decisions, peer pressure, poverty and low standard of living, unsafe sexual practices, youth confiding in their friends rather than their parents or other relatives. The ease of availability of pornographic literature and movies was cited as a major problem because of its influence on young people engaging in unsafe sex. They felt that youths were adopting a foreign culture and ignoring their own Khmer culture, which has resulted in increased incidence of rape and teenage pregnancies.

Running away from home to find a better life was cited as a frequent occurrence although most of these youths end up returning home after they failed to find a job, run out of money or having been trafficked into prostitution. Legitimate migration to find a job to support the family is not considered “running away”. It was reported that more males than females migrate because it is much easier for them to find jobs and because they are the main breadwinners for their families.

Reproductive health issues

The following were cited as major reproductive health problems faced by the youth, HIV and AIDS and STIs. The youth mentioned that they had studied about HIV and AIDS, STIs, drug use, migration, domestic violence, human trafficking, gender and peer education in their different secondary schools.

When asked whom do young people go to for counsel when they have sexual and reproductive health problems, the females said they go to their mothers first because they feel confident in them and their teachers would be the next. Most of the males felt that they could not discuss their problems particularly sexual and reproductive health issues with their parents especially their fathers because they did not feel free to do so. Teachers and friends were cited as sources of information and counsel. For their health care needs, both males and females said they would go to the health centers because they have good counseling skills and are confidential in dealing with youth reproductive health needs.

The females felt that they faced greater discrimination if they became pregnant out of wedlock or if it was known that they had contracted a sexually transmitted infection. This was considered shameful and bringing dishonor to the family.

More females dropped out of school because of pressure to help parents with domestic work. This is mostly true after grades six and seven. Both females and males felt that their community leaders supported youth programs as indicated by their providing meeting places for their health education activities in the community. This to a certain degree, indicates that there are some adults in leadership and influential positions, who recognize the youth sexual and reproductive health issues that must be addressed at the community level.

Discussion:

Sexual and reproductive health is a very sensitive subject even under the best of circumstances. Like many Asian countries, Cambodia, is to a large degree very conservative in this aspect. It is remarkable that rural communities were willing to participate in this program in spite of resistance in certain quarters.

Rural traditional cultures are being challenged by exposure to external media influences that threaten to disrupt the safety nets they provide to youth. The fact that the youth recognized exposure to pornographic materials as a risk factor for unsafe sexual practices is one piece of evidence for this. For most of the youth, friends rather than their parents are their main source of information regarding sexual and reproductive health matters although the women feel that they can speak with their mothers and the boys feel they cannot speak to their fathers. In the future parent-to-child communication is an area that needs to be strengthened in any program that attempts to address youth sexual and reproductive health. The teachers are also important but the child spends more time at home than they do in school and parents should serve as the best and safest sex educators for the child.

Although family relationships were rated very highly in the quantitative study, during the qualitative study, domestic violence and alcoholism were cited as one of the reasons why youth run away from home. This inevitably exposes them to risk taking as they are forced to make a living. Girls are more vulnerable as they can easily be trafficked into the sex trade or be sexually abused at their place of work.

Girls continue to face greater stigma and discrimination especially if they get pregnant out of wedlock and/or contract a sexually transmitted infection. The fact that girls are supposed to be virgins at marriage promotes directly or indirectly that boys are free to have sex whenever they can but that girls should save their virginity until their wedding day. This double standard relegates the girl child to a lower social status than her male counterpart.

The school drop-out rates for girls continue to be higher than those for boys because of family pressure to help with household chores or augment family income. The rural to urban migration for work, particularly to Phnom Penh is higher for girls than for boys because the garment factories, entertainment industry and services are located there. While some engage in genuine work for pay, others are lured into the sex trade and exposed to HIV and other STIs.

Health care services in general were rated very highly by the majority of the participants. Most said that they would go to the health centers for sexual and reproductive health care. This means that YSRH programs should continue to work with health care providers by training them to create youth friendly services in their facilities. In fact the Ministry of Education, Youth and Sports should work closely with the Ministry of Health to make sure that every facility has youth friendly services.

Overall there is a high level of knowledge of unsafe sexual practices and how to prevent oneself from contracting sexually transmitted infections among the youth who participated in this study. However, there are still some risky behaviors such as boys having sex with sex workers, using drugs and drinking alcohol, having multiple partners particularly the boys and not using condoms. Any YSRH program will need to approach this issue holistically by exploring in-depth the relationships between socio-economic status, education, rural and urban living, migration, health care services and youth sexual and reproductive health.

Recommendations:

Further studies are needed to assess the impact of behavior change communication approaches on youth sexual and reproductive health in the Khmer context. This needs to be supported by all key stakeholders such as the MoEYS, MoH and other policymakers in order for YSRH programs to be fully integrated in school curricula and health care facilities.

Future programs must include the strengthening of parent-to-child communication regarding sexual and reproductive health. This should go hand in hand with the integration of YSRH in school curricula in order to reduce resistance from parents and other community leaders. This will help mobilize support from parents, community leaders, religious leaders, school teachers and principals.

The traditional family structures need to be strengthened in order to provide a safe environment for youth in rural areas. The exposure to sexually explicit materials can be controlled by having community programs that enhance healthy sexual behavior. The establishment of youth corners and resource centers will serve this purpose but there needs to be participation by community leaders and families. Girls will need to be supported equally in order for them to stay in school so that they can achieve their full potential.

It is important for youth friendly services to be established in health care facilities for this is where most of the youth indicated they go for diagnosis and treatment of any illness including the sensitive sexual and reproductive health matters. Youth friendly personnel will be confidential and not be judgmental. This will increase demand for their services and benefit the communities as a whole but especially the youth.

Appendices

Table 1. Demographics

	All % N = 300	Men % N = 150	Women % N = 150
Age (mean) in Years	17.07	16.20	17.94
What is your religion?			
Buddhist	98.67	98.67	98.67
Christian	01.33	1.33	1.33
Muslim	-	-	-
Other	-	-	-
Refuse to answer	-	-	-
What is your martial status?			
Single	87.67	90.67	84.67
Married	11.33	08.00	14.67
Divorced	00.67	00.67	00.67
Widowed	00.33	00.67	-
Refuse to answer	-	-	-
What is your family size? How many people live in your household?			
2 – 3 people	09.67	08.67	10.67
4 – 6 people	58.67	60.00	57.33
7 – 9 people	26.33	26.00	26.67
10 or more people	05.33	05.33	05.33
Don't know or refuse to answer	-	-	-
Do you live with both your parents?			
Yes	84.33	86.00	82.00
No	15.67	13.33	16.00
If you do not live with your parents, with whom do you live with?			
I live by myself	26.67	15.00	36.00
I live with my friend	-	-	-
I live with my boy/girlfriend or partner	14.44	05.00	04.00
I live only with my mother	08.89	-	16.00
I live only with my father	-	-	-
I live with other family members	57.78	75.00	44.00
I live with others besides family members	02.22	05.00	-
Refuse to answer	-	-	-
Who in your family has income?			
Myself	07.67	10.67	04.67
Father	26.33	30.67	22.00
Mother	18.00	14.67	21.33
Parents	32.00	31.33	32.67
Sister/Brother	09.67	09.33	10.00
Other	02.67	03.33	02.00
Don't know	02.33	-	04.67
Refuse to answer	00.33	-	00.67
Refuse to answer	03.00	-	02.00
Do you think this income is enough?			
No, this income is not enough	41.00	52.67	39.33
Yes, the income is enough	53.00	46.67	59.33
Don't know	00.33	-	00.67
Refuse to answer	00.67	00.67	00.67
If not enough, what does the family do to supplement the income?			
My family does not supplement	23.74	21.52	26.67
We sell personal belongings	05.67	10.13	-
We seek other employment	63.31	62.03	65.00
Borrow somebody money	03.60	02.53	05.00
Other	00.72	01.27	-
Don't know	02.88	02.53	03.33
Refuse to answer	-	-	-
What is your current occupation?			

None	10.33	04.00	16.67
Student	54.33	51.33	57.33
Business/seller	06.33	04.67	08.00
Government officer	00.33	-	00.67
NGO officer	00.67	06.00	03.33
Laborer	21.00	29.33	12.67
Farming	01.33	01.33	01.33
Plantation	00.67	01.33	-
Fishery	00.33	00.67	-
Home maid	00.67	01.33	-
Motordup driver	-	-	-
Other	-	-	-
What have you done in the last month to earn money for yourself?			
Nothing	73.00	64.00	82.00
Home maid	04.33	02.67	06.00
Selling goods	11.67	16.00	07.33
Casual labor	04.33	05.33	03.33
Farming	03.67	06.00	01.33
Plantation	02.00	04.00	-
Fishery	00.33	00.67	-
Motordup driver	00.67	01.53	-
Other	-	-	-
Did you ever get oppressed/abused on your job?			
Yes	13.75	15.09	11.11
No	86.25	84.91	88.89
If yes, what were the problems?			
Raped	07.69	-	25.00
Forced to have sex	07.69	-	25.00
Discriminated/treated unfairly	30.77	33.33	25.00
Fraud the salary	38.46	55.56	-
Fraud the labor/overtime	15.38	11.11	25.00
Other	-	-	-
Who controls the money you earn?			
Myself	13.25	07.41	24.14
My brother or sister	08.43	07.41	10.34
My parent	67.47	76.37	62.07
My grandparent	02.41	01.85	03.45
Husband or wife	08.43	12.96	-
My boy/girlfriend	-	-	-
Other	-	-	-
Are you currently studying?			
Nothing	58.53	59.67	62.64
Home maid	41.47	45.33	37.58
If yes, at what level?			
Grade 1 - 2	42.29	36.59	47.31
Grade 3 - 6	34.86	35.37	34.41
Lower secondary (7 - 9)	22.29	26.83	18.28
Secondary (10 - 12)	00.57	01.22	-
Baccalaureate	-	-	-
Vocational training	-	-	-
Undergraduate	-	-	-
Graduate	-	-	-
Other	-	-	-
Have you ever attended school?			
Yes	98.40	100.00	96.43
No	01.60	-	03.57
What is the highest grade that you completed?			
Grade 1 - 2	05.79	05.88	05.66
Grade 3 - 6	55.37	54.41	56.60
Lower secondary (7 - 9)	29.25	29.41	30.19
Secondary (10 - 12)	07.44	07.35	07.55
Baccalaureate	00.83	01.47	-
Vocational training	-	-	-
Undergraduate	-	-	-
Graduate	-	-	-

Other	00.83	01.47	-
Have you ever migrated to another area to find work in the last 12 months?			
Yes	21.14	21.33	20.95
No	78.86	78.67	79.05
If you migrated, where did you go?			
Phnom Penh city	47.88	29.42	64.86
Urban in province	13.00	26.47	-
Rural in province	17.00	14.70	18.91
Urban outside in province	11.00	11.76	10.81
Rural outside province	03.02	02.94	02.94
Outside country	08.10	14.71	02.94
Other	-	-	-
How long did you stay each time?			
Come back home every evening	06.25	-	12.50
1 – 3 days	01.56	03.13	-
4 days to 1 week	07.81	12.50	03.13
2 – 3 weeks	09.38	09.38	09.38
One month	04.69	09.38	-
Over one month	70.31	65.63	75.00
Other	-	-	-
What work did you do?			
Worked in garment factory	26.15	09.38	42.42
Worked as a farmer	04.62	03.13	06.06
Worked as a laborer	58.46	78.13	39.39
Worked as a home maid	-	03.13	-
Worked as a restaurant worker	01.54	-	-
Worked as a hotel/guest house worker	03.08	-	06.06
Worked as a beer girl	-	-	-
Worked as a sex worker	-	-	-
Worked as karaoke worker	-	-	-
Scavenger/begger	-	-	-
Worked as a motor dup driver	01.54	03.13	-
Worked as taxi driver	03.08	03.13	03.03
Other	01.54	-	03.03
Did you ever get oppressed/abuse on the job?			
Yes	29.33	31.25	27.27
No	70.77	68.75	72.73
If yes, what are the problems?			
Raped	-	-	-
Forced to have sex	-	-	-
Discriminated/treated unfairly	45.00	10.00	20.00
Fraud the salary	35.00	50.00	20.00
Fraud the labor/overtime	50.00	40.00	60.00
Other	-	-	-
Have you ever had a boy/girlfriend or partner?			
Yes	21.67	24.67	18.67
No	78.33	75.33	81.33
If yes, how old were you when you first had boy/girlfriend or partner?			
Age (in years)	17.85	18.38	17.15
Don't remember	-	-	-
Do you currently have a boy/girlfriend or partner?			
Yes	14.00	16.67	11.33
No	86.00	83.33	88.67
How committed are you to your current boy/girlfriend or partner?			
Very committed/ want to marry	77.27	88.46	61.11
No committed/ no plan to marry	20.45	11.54	33.33
Other	02.27	-	05.56

Table 2. Demographics by Province and Village

	All % N = 300	Men % N = 150	Women % N = 150
Province			
Kampong Thom	230 (76.67%)	115 (38.33%)	115 (38.33%)

Preah Vihear	70 (23.33%)	35 (11.67%)	35 (11.67%)
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Table 3. Villages Surveyed

All N = 30	
Sras Banteay	Pom Pir
Pro Tong	Dong
Kruel	Sakream Cheung
Sarre Samalia Tbeng	Msar Krang
Treal	Pralay
Baray Toch	Sampouch
Beung	Gnoun Siem
Balang	Srash duk
Chaeung Daeung	Roveing Dike
Krava	Phnom Dike
KPTthmar	Chnoun
Tnount Chum	Kulean Cheang
Taing Krasang	Kork beng
La-ok	S'aang
Banteay Stong	Chum ksan

Table 4. Attitudes, Beliefs and Values

	All % N = 300	Men % N = 150	Women % N = 150
In your opinion, what is the ideal age for a girl to have sex for the first time?			
Median age in years	18	18	19
In your opinion, what is the ideal status for a girl to have sex for the first time?			
Before marriage	05.03	05.41	04.67
After marriage	94.30	93.92	94.67
Other	-	-	-
Don't know	00.67	00.68	00.67
In your opinion, what is the ideal age for a boy to have sex for the first time?			
Median age in years	20	20	21
In your opinion, what is the ideal status for a boy to have sex for the first time?			
Before marriage	09.36	11.33	07.38
After marriage	89.97	88.67	91.28
Other	-	-	-
Don't know	00.67	-	01.34
Which of the following attitudes best describes your expectations about sexual partners during the rest of your adolescent years?			
I don't expect to have a sexual partner	15.00	16.67	13.33
I expect to have a sexual partner	78.67	74.67	82.67
I expect to have 2 - 3 sexual partners, but one at a time	03.33	04.67	02.00
I expect to have several sexual partners at the same time	02.00	04.00	-
Other	-	-	-
Don't know	01.00	-	02.00
Which of the following attitudes best describes your plan about having sexual intercourse in the future?			
I plan to wait until marriage before having sex	79.00	69.33	88.67

I plan to wait until I am engaged before having sex	03.67	04.67	02.67
I plan to wait until I find someone I love before having sex	05.67	06.00	05.33
I plan to wait until I'm at least 19 before having sex	01.33	02.67	03.33
I plan to wait until I'm at least 17 before having sex	06.00	08.67	-
I plan to have sex as soon as possible	00.67	01.33	-
I plan to have sex whenever an opportunity comes along	01.00	02.00	-
Having sex isn't something you can plan, it just happens	01.67	03.33	-
I plan to have sex whenever my partner wants to have sex	01.00	02.00	-
Other	-	-	-
Don't know	-	-	-

Which of the following attitudes best describes your plan about going to see a reproductive health provider (private or public health professional) for information or advice?

I do not plan to see a provider at all	07.33	07.00	06.67
I may see a provider for some information	16.00	15.67	15.33
I may see a provider for services	08.64	16.33	24.00
I definitely plan to see a provider for information	20.67	20.33	20.00
I definitely plan to see a provider for services	17.33	11.67	06.00
I definitely plan to see a provider for services and information	30.00	28.67	27.33
Other	-	-	-
Don't know	-	00.33	00.67

Do you want to get married? (For single males and females 15-24 years of age)

Yes	27.78	20.65	10.53
No	72.22	78.80	88.16
Don't know	-	00.54	01.32

Do you feel you are ready to cause a pregnancy right now? (For single males and females 15-24 years of age)

Yes	19.67	22.43	15.79
No	79.78	77.57	82.89
Don't know	00.55	-	01.32

If yes to prior question, what are the reasons? (For single males and females 15-24 years of age)

Having a baby to love	17.07	18.87	13.79
Having a child's love	14.63	07.55	27.59
Moving out of my parent's house	03.65	03.77	03.45
Getting married early in life	03.67	03.77	03.45
Proving my fertility	-	-	-
Showing my maturity	-	-	-
Wanting to enjoy watching my child grow	09.76	09.43	10.34
Having a partner to love	03.68	01.89	06.98
Having security during my old age	20.73	22.64	17.24
Proving that I am a man/woman	01.22	01.89	-
I want to be a father/mother	12.20	15.09	07.90
I am able to stay on my own	03.59	05.66	-
I am able to earn money	06.10	09.43	-
It is in the nature of a woman to have child	03.70	-	10.34
Other	-	-	-
Don't know	-	-	-

If no to prior question, what are the reasons?

Still to young	29.08	29.41	26.57
Want to study further	19.58	16.67	22.38
Want to build a career	21.96	21.08	21.68
Cannot afford to have children	15.13	16.67	11.89
Not mentally ready yet	04.75	00.50	10.49
Still want to be free	04.75	08.41	04.90
Still live with my family or parents	04.75	09.88	02.10
Other	-	-	-
Don't know or refuse to answer	00.30	00.50	-

Table 5. Social Influences

	All % N = 300	Men % N = 150	Women % N = 150
If I ask you some questions about your personal life like sex, would you agree to answer my questions?			
Yes	97.67	96.67	98.67
No	02.33	03.33	01.33
Have you ever had sex?			
Yes	17.35	17.24	17.45
No	82.31	82.76	81.88
Refuse to answer	00.34	-	00.67
How many partners have you had sex with in the past 6 months?			
One	90.20	80.00	100.00
More than one	09.80	20.00	-
With whom have you have sex?			
Boy/girlfriend or partner	17.65	32.00	03.85
Sex worker	09.80	20.00	-
Husband or wife	72.55	48.00	96.15
Other	-	-	-
What age did you first have sex?			
Median Age in years	18	19	19
Don't remember	-	-	-
Refuse to answer	-	-	-
The first time you had sex, did you want to have sex, or did it happen or were you tricked, threatened, or forced?			
Wanted to have sex	84.31	96.00	73.08
Just happened not planned	15.69	04.00	26.92
Tricked	-	-	-
Threatened	-	-	-
Forced	-	-	-
Other	-	-	-
Don't know	-	-	-
Refuse to answer	-	-	-
If married, are you satisfied with your marriage?			
Yes	100.00	100.00	100.00
No	-	-	-
Don't know	-	-	-
Do you face any problems with your family?			
Yes	41.81	41.27	43.33
No	58.19	59.73	56.67

If yes, what problems?			
Gambling	-	-	-
Domestic violence	46.43	50.00	42.50
Alcohol abuse	26.79	32.95	20.00
Drug use	00.60	01.14	-
Low Income poverty	24.40	14.73	35.00
Have no child	-	-	-
Too many children	01.19	01.14	01.25
Often pregnant (poor birth spacing)	-	-	-
Other	00.60	-	01.25
Don't know	-	-	-
What pressures do you experience from your family?			
None	29.17	42.11	20.70
Family pressure to drop out of school early	54.67	31.58	68.79
Early marriage	06.25	05.26	06.90
Prevent or discourage access to RPH	04.17	05.26	03.45
Other	06.25	15.79	-
What high-risk behaviors do you friends practice?			
Going out late at night with friends	24.17	28.80	19.83
Alcohol use/drunkenness	16.73	21.88	08.45
Visiting brothels/sex workers	01.22	01.22	-
Drug use	04.05	06.80	-
Gambling	09.76	11.60	07.75
Watching pornographic movies	10.73	14.80	04.93
Reading pornographic literature	27.80	14.40	54.93
Other	02.44	-	02.44
Do you participate in these high-risk practices?			
Yes	48.49	61.74	35.33
No	50.17	37.58	62.67
Don't know or don't want to answer	00.33	00.67	-
Refuse to answer	01.00	-	02.00
If yes (to prior question), why?			
Because my friends do it	15.75	20.21	07.69
Because it is easy to make friends	02.74	03.19	01.92
Because I am in love	73.23	74.47	71.15
Because it is fun	02.14	02.13	03.85
To appear socially acceptable	04.79	-	13.46
Other	00.68	-	01.92
If you had a reproductive health problem or question, where would you go for help?			
Referral hospital	09.95	14.07	04.89
Health center	45.03	43.12	51.13
Private clinic	08.06	09.50	07.52
VHSG	01.35	01.22	01.50
Peer counselor	03.37	03.67	03.00
Youth center	00.84	00.61	01.13
Friend	07.59	09.17	05.64
Parent	15.85	11.93	20.68
Relative	03.20	03.06	03.38
Teacher	01.69	01.83	01.50

Traditional healer	00.51	-	01.13
Other	00.84	01.22	00.38
Don't know	01.01	00.31	01.88
Refuse to answer	00.17	00.31	-

Where would you go to receive reproductive health services?

No where	00.33	-	00.67
Health center	55.33	68.67	42.00
Referral Hospital	07.00	10.00	04.00
Private clinic	12.33	11.33	13.33
Traditional healer	00.67	-	01.33
Pharmacy	10.00	02.00	18.00
Village shop keeper	13.33	06.00	20.61
VHSG	01.00	02.00	-
Others	-	-	-
Don't remember	-	-	-
Don't know	-	-	-
Refuse to answer	-	-	-

Where did you go to receive health services in the past 6 months?

No where	-	-	-
Health center	45.39	58.33	32.89
Referral Hospital	08.19	11.11	05.37
Private clinic	19.11	15.28	22.82
Traditional healer	00.68	-	01.34
Pharmacy	11.60	04.17	18.79
Village shop keeper	12.97	08.33	17.45
VHSG	00.34	00.69	-
Others	-	-	-
Don't remember	01.71	02.08	1.34
Don't know	-	-	-
Refuse to answer	-	-	-

What were the reasons for seeking health care services in the past 6 months?

Medical checkup	14.42	15.21	13.57
STI treatment	05.05	07.83	02.01
HIV/AIDS testing	05.05	06.45	03.52
Curative treatment services	58.65	53.46	64.32
To get contraceptives	01.20	00.92	01.51
Vaccinations	07.93	10.14	05.53
Injury	03.84	04.15	03.52
Bring child to see doctor	01.68	-	03.52
Bring husband/wife to see doctor	00.72	00.46	01.01
Other	00.72	00.46	01.01
Don't remember	00.72	00.92	00.50

Who did you speak with or see at the health facility the last time?

Doctor	16.88	19.02	14.37
Nurse/midwife	39.31	39.21	39.08
Peer educator/counselor	08.44	13.17	02.87
Village shop seller	15.83	11.22	21.26
Pharmacist	16.88	14.63	19.54
Traditional healer	00.79	00.49	01.15

Other	00.53	00.98	-
Don't remember	01.32	00.98	01.72
Don't know	-	-	-

What was the attitude of the health care professional during your last visit to the health facility?
Knowledgeable

Yes	84.67	86.67	82.67
No	02.33	02.67	02.00
Refuse to answer	13.00	10.67	15.33

Friendly

Yes	84.33	84.67	84.00
No	10.33	11.33	09.33
Refuse to answer	05.33	04.00	06.67

Interested in you

Yes	87.00	83.33	90.67
No	06.67	09.33	04.00
Refuse to answer	06.33	07.33	05.33

Well-qualified

Yes	89.67	90.00	89.33
No	04.00	04.67	03.33
Refuse to answer	06.33	05.33	07.33

Good communicator

Yes	89.67	90.67	88.61
No	06.00	05.33	06.67
Refuse to answer	04.33	04.00	04.67

Respectful

Yes	85.67	90.00	81.33
No	05.33	06.00	4.67
Refuse to answer	09.00	04.00	14.00

Polite

Yes	89.33	91.33	87.33
No	03.67	04.67	02.67
Refuse to answer	07.00	04.00	10.00

Caring about your privacy

Yes	75.00	76.00	74.00
No	05.67	06.00	05.33
Refuse to answer	19.33	18.00	20.67

Good listener

Yes	89.00	95.33	82.67
No	-	-	-
Refuse to answer	11.00	04.67	17.33

Table 6. Media Influence

	All % N = 300	Men % N = 150	Women % N = 150
Do you watch or read any pornographic literature or movies?			
Yes	26.00	42.00	10.00
No	74.00	58.00	90.00

Table 7. Alcohol Use

	All% N = 300	Men % N = 150	Women % N = 150
Have you consumed any alcohol in the past month?			
Yes	30.67	43.33	18.00
No	69.33	56.67	82.00
Refuse to answer	-	-	-
In the last month, how many times did you drink alcohol?			
1 time	33.33	27.69	46.43
2 – 5 times	51.61	55.38	42.86
6 – 12 times	04.30	04.62	03.57
13 or more times	10.75	12.31	07.14
Don't know	-	-	-
Refuse to answer	-	-	-
How many times did you get drunk?			
1 time	44.57	35.38	66.67
2 – 5 times	30.43	36.92	14.81
6 or more times	04.35	06.15	07.41
Don't remember	04.35	03.08	11.11
Refuse to answer	16.30	18.46	07.41
The last time you drank alcohol, how many drinks did you have?			
1 drink	39.13	27.69	66.67
2 or more drinks	53.26	67.69	18.52
Don't remember	07.61	04.62	14.82
Refuse to answer	-	-	-
Did you have sex under the influence of alcohol?			
Yes	03.34	06.04	00.67
No	96.66	93.96	99.33
Don't remember	-	-	-
Refuse to answer	-	-	-
Who did you have sex with?			
My girl/boyfriend	20.00	22.22	-
My partner	30.00	33.33	-
My spouse	40.00	33.33	100.00
I can't remember	10.00	11.11	-
Don't know	-	-	-
Refuse to answer	-	-	-
Did you use a condom?			
Yes	60.00	66.67	-
No	40.00	33.33	100.00
My spouse	-	-	-
Don't remember	-	-	-
Don't know	-	-	-
Refuse to answer	-	-	-

Table 8. Drug Use

	All% N = 300	Men % N = 150	Women % N = 150
Have you consumed any alcohol in the past month?			
Yes	30.67	43.33	18.00
No	69.33	56.67	82.00
Refuse to answer	-	-	-
In the last month, how many times did you drink alcohol?			
1 time	33.33	27.69	46.43
2 – 5 times	51.61	55.38	42.86
6 – 12 times	04.30	04.62	03.57
13 or more times	10.75	12.31	07.14
Don't know	-	-	-
Refuse to answer	-	-	-
How many times did you get drunk?			
1 time	44.57	35.38	66.67
2 – 5 times	30.43	36.92	14.81
6 or more times	04.35	06.15	07.41
Don't remember	04.35	03.08	11.11
Refuse to answer	16.30	18.46	07.41
The last time you drank alcohol, how many drinks did you have?			
1 drink	39.13	27.69	66.67
2 or more drinks	53.26	67.69	18.52
Don't remember	07.61	04.62	14.82
Refuse to answer	-	-	-
Did you have sex under the influence of alcohol?			
Yes	03.34	06.04	00.67
No	96.66	93.96	99.33
Don't remember	-	-	-
Refuse to answer	-	-	-
Who did you have sex with?			
My girl/boyfriend	20.00	22.22	-
My partner	30.00	33.33	-
My spouse	40.00	33.33	100.00
I can't remember	10.00	11.11	-
Don't know	-	-	-
Refuse to answer	-	-	-
Did you use a condom?			
Yes	60.00	66.67	-
No	40.00	33.33	100.00
My spouse	-	-	-
Don't remember	-	-	-
Don't know	-	-	-
Refuse to answer	-	-	-