KINGDOM OF CAMBODIA

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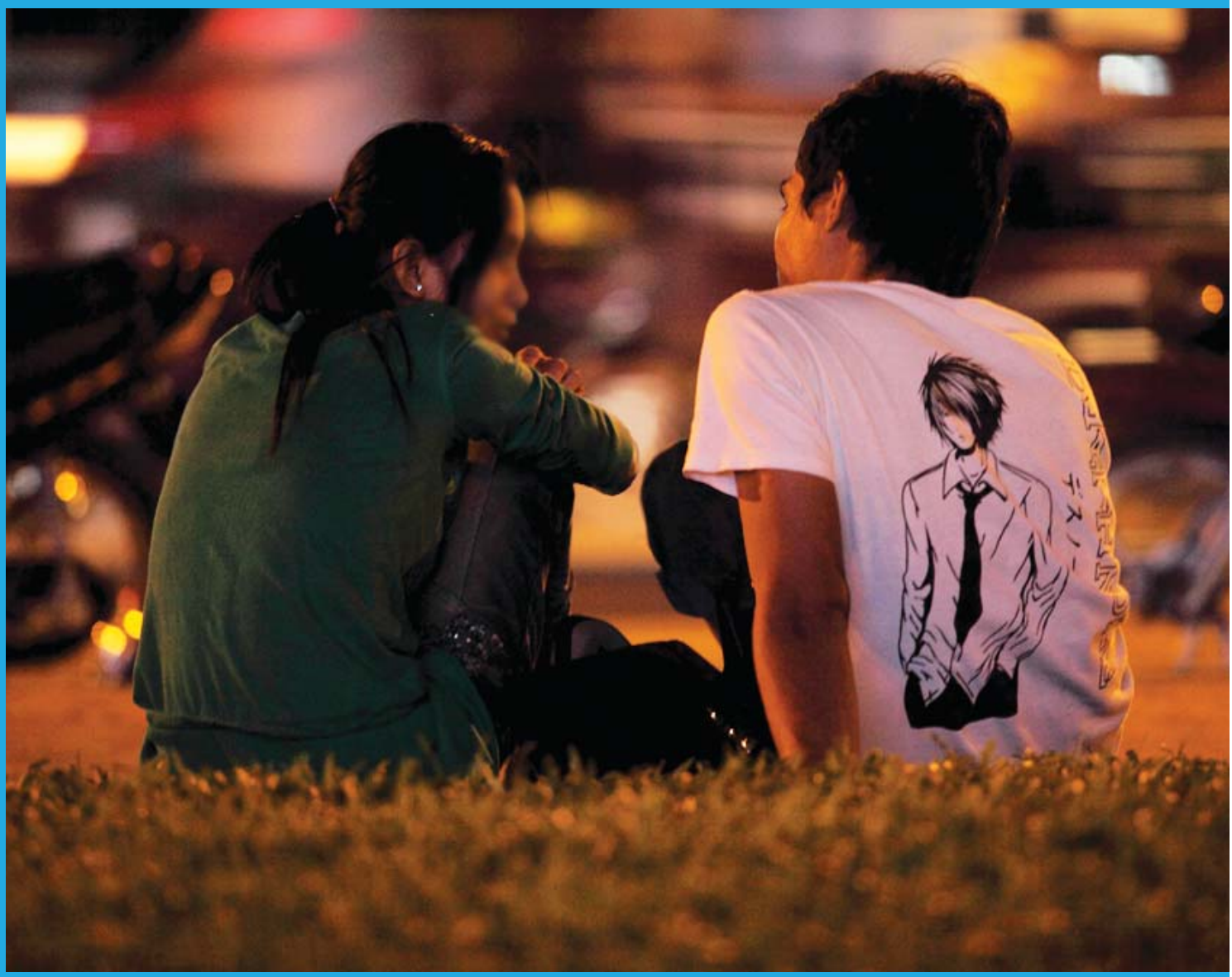
MINISTRY OF EDUCATION, YOUTH AND SPORTS

MOST AT RISK YOUNG PEOPLE

SURVEY CAMBODIA 2010



MOST AT RISK YOUNG PEOPLE SURVEY CAMBODIA 2010

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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.

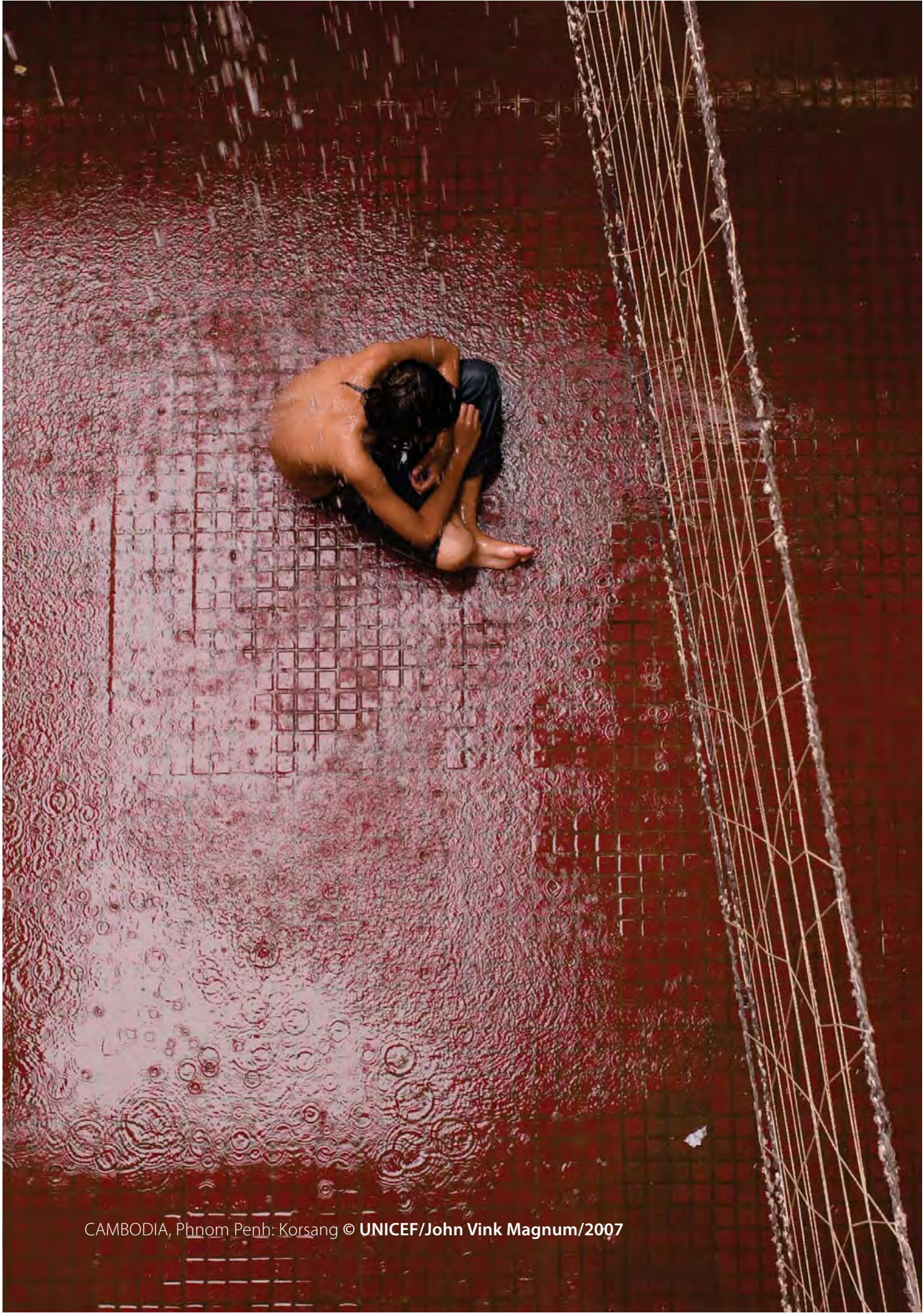
We would like to thank FHI, PSI, UNAIDS, UNESCO, UNFPA, UNICEF, WHO and The South East Asia and Pacific Technical Support Hub of KHANA (TS Hub) for providing financial and technical support for this study.

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.



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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:

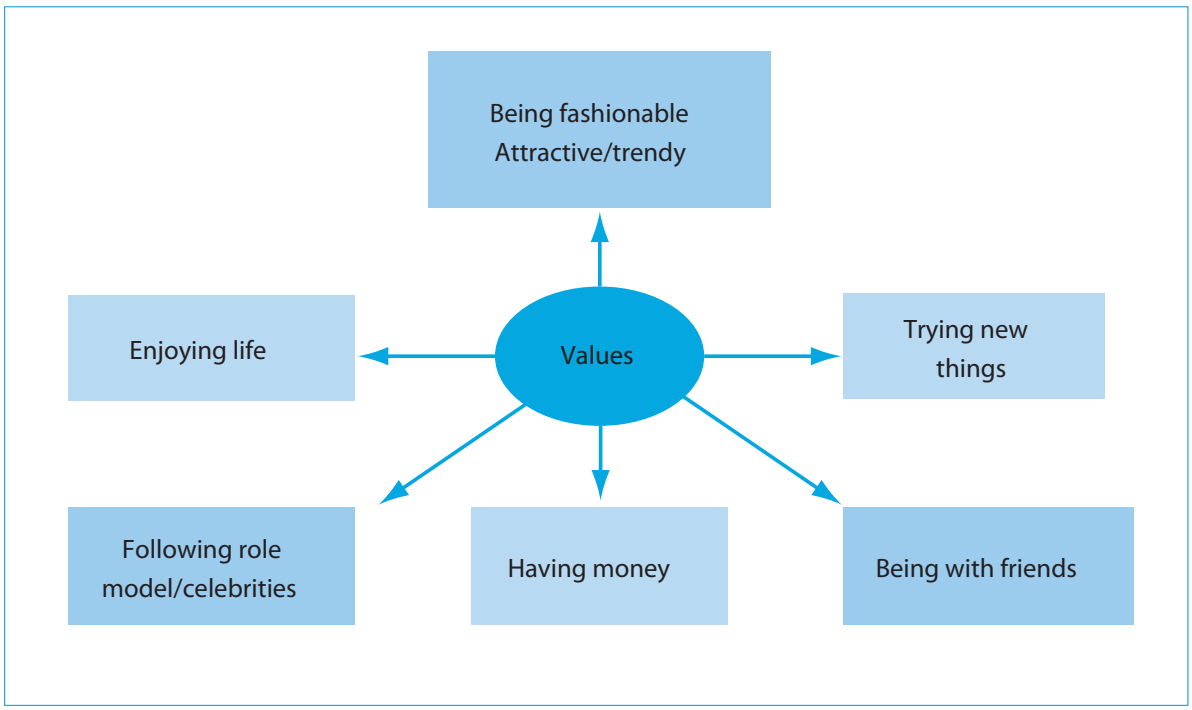
- The things MARYP valued most in their life.
- The concept of peer pressure.
- Similarities between males and females regarding life values.
- Perspectives on the social distinction between good and bad young people.

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

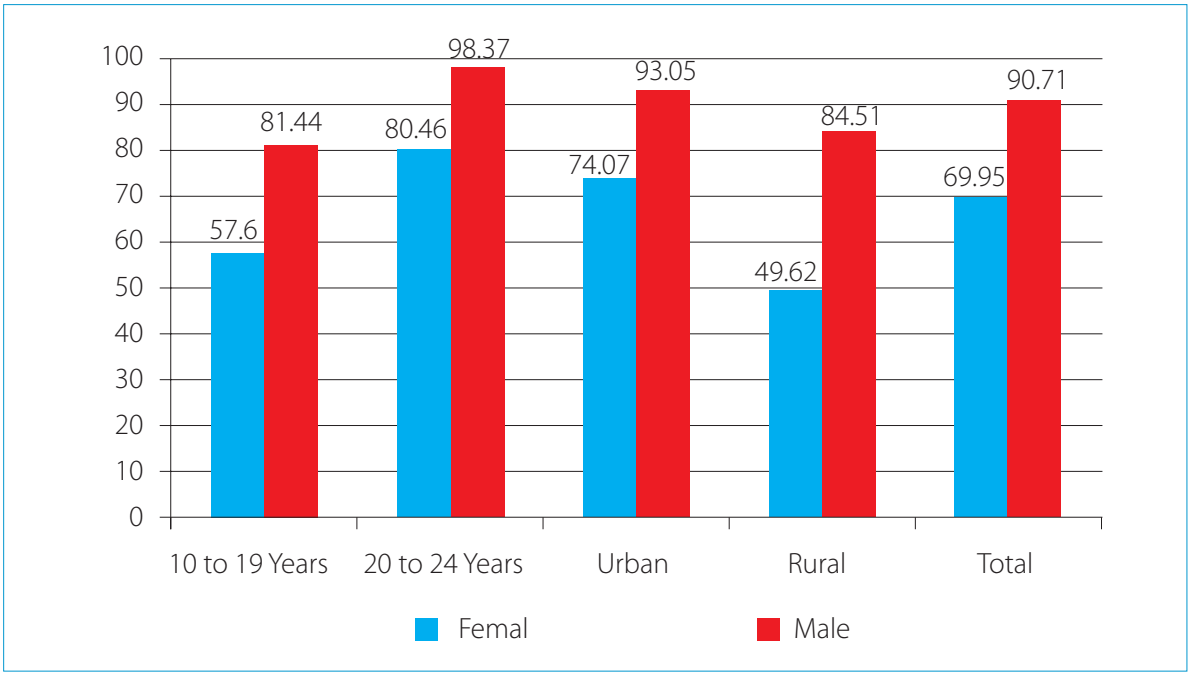
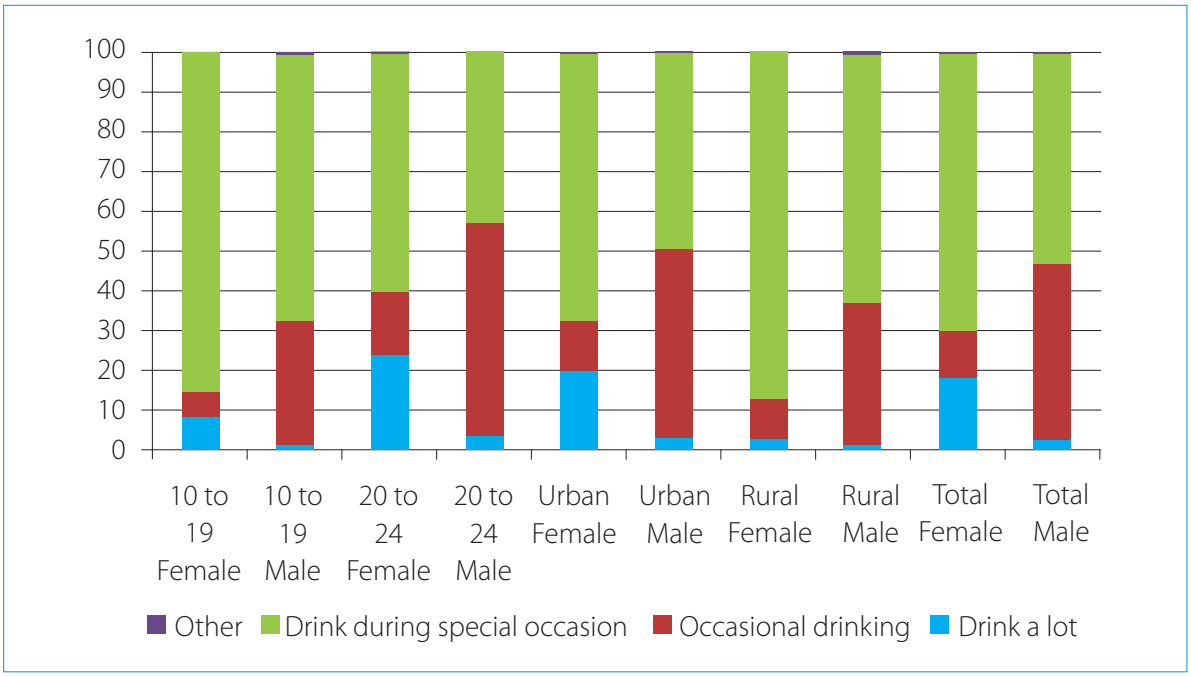


FIGURE 3 PERCENTAGE DISTRIBUTION OF SELF-RATED LEVEL OF ALCOHOL CONSUMED



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

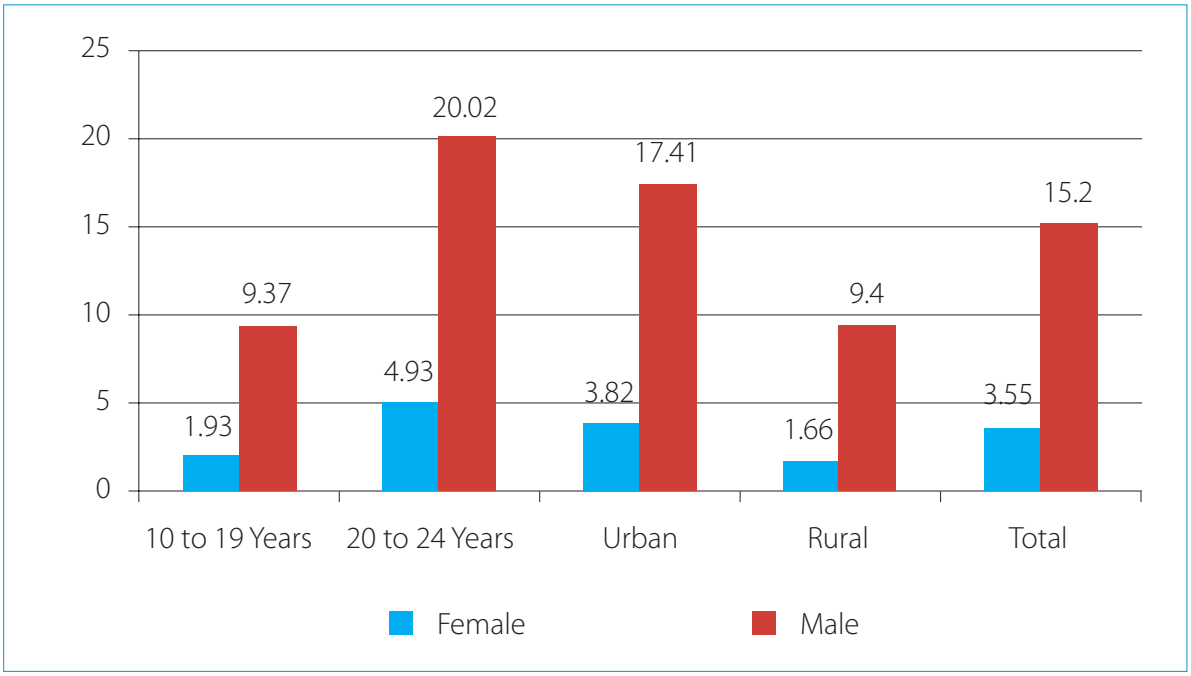
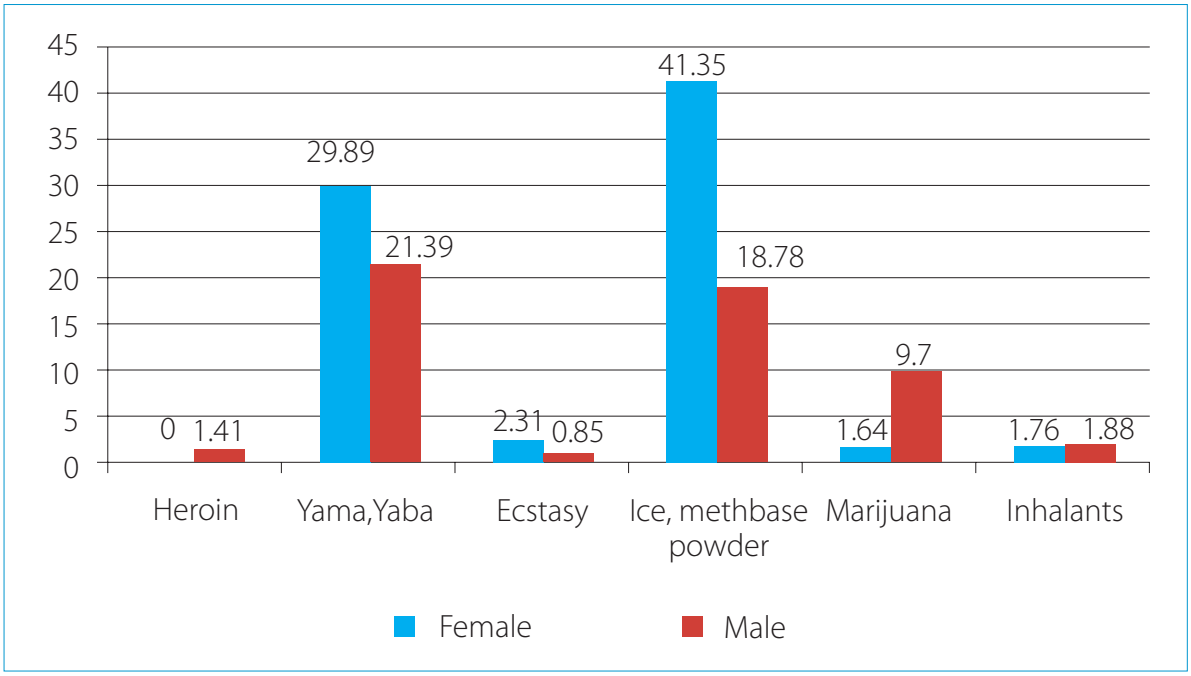


FIGURE 5 PERCENTAGE DISTRIBUTION OF THE TYPE OF DRUGS USED IN THE PAST SIX MONTHS



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

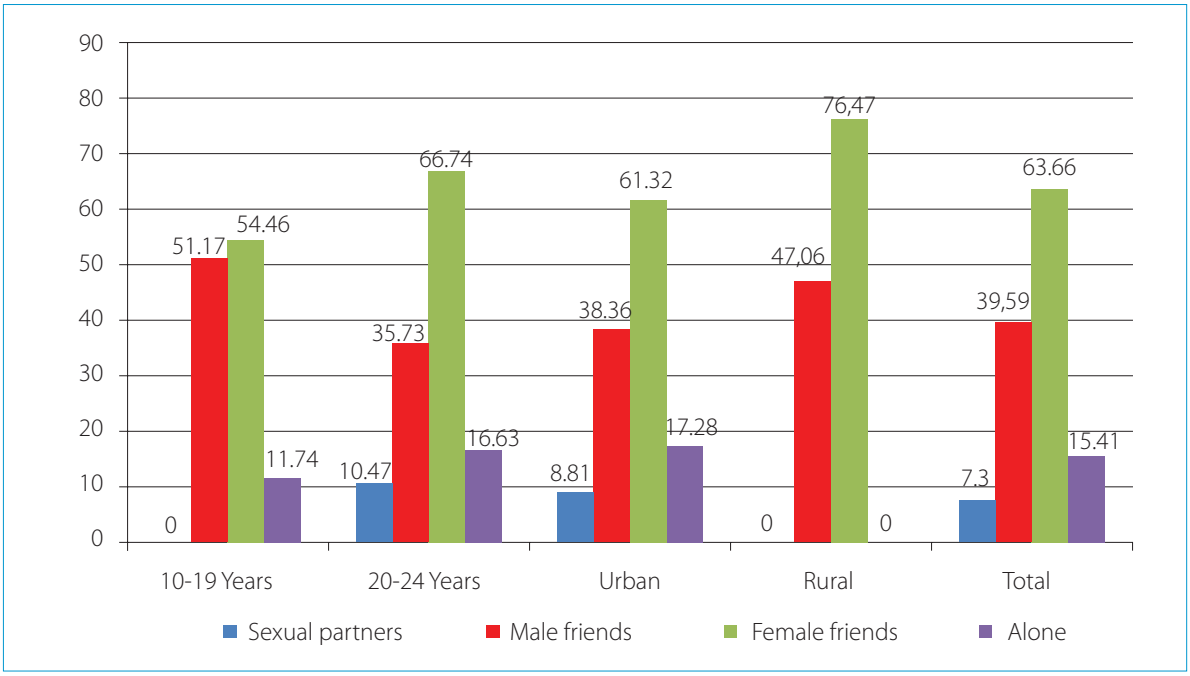
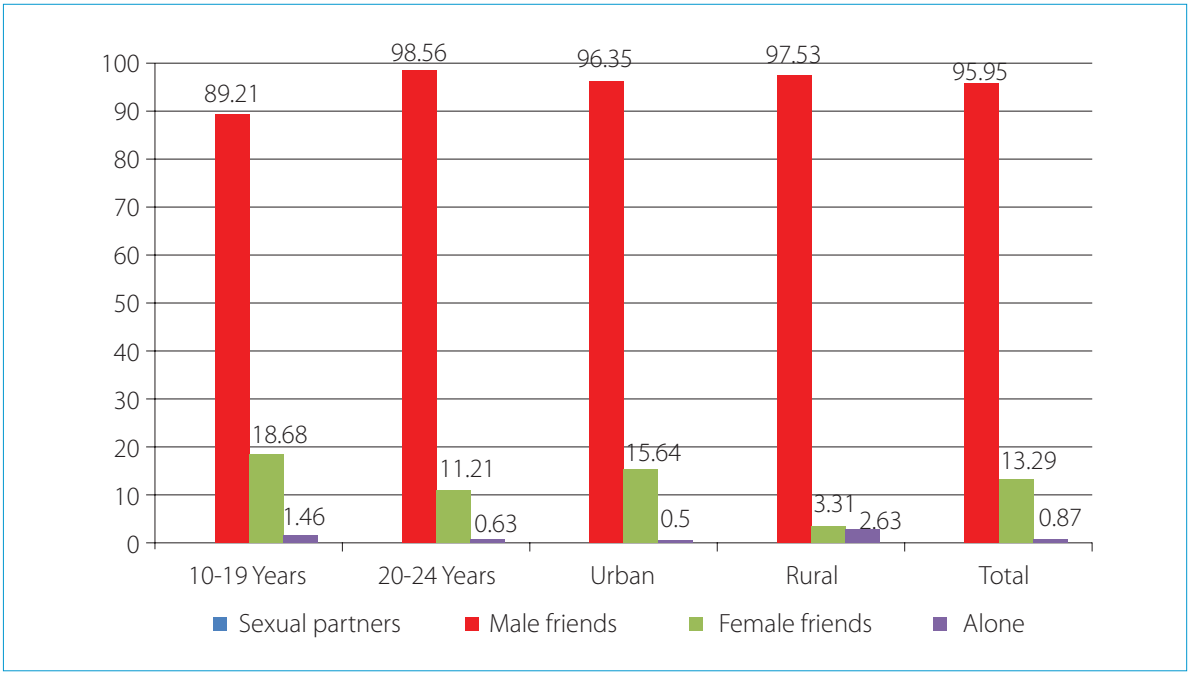


FIGURE 7 PERCENTAGE DISTRIBUTION OF THE LAST DRUG USE PARTNER AMONG MALE MARYP



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*

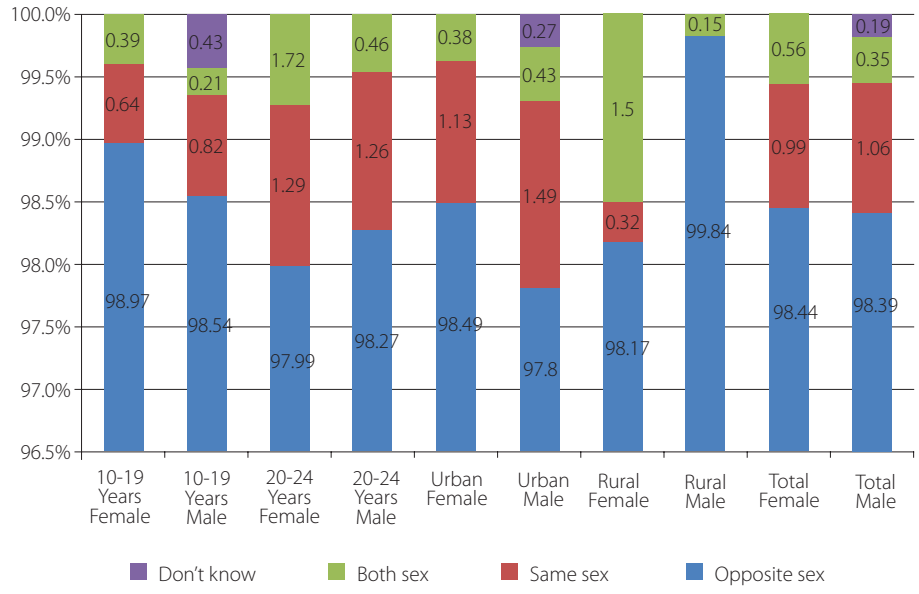
TABLE 8 SEXUAL BEHAVIOR OF FEMALE RESPONDENTS

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 %).

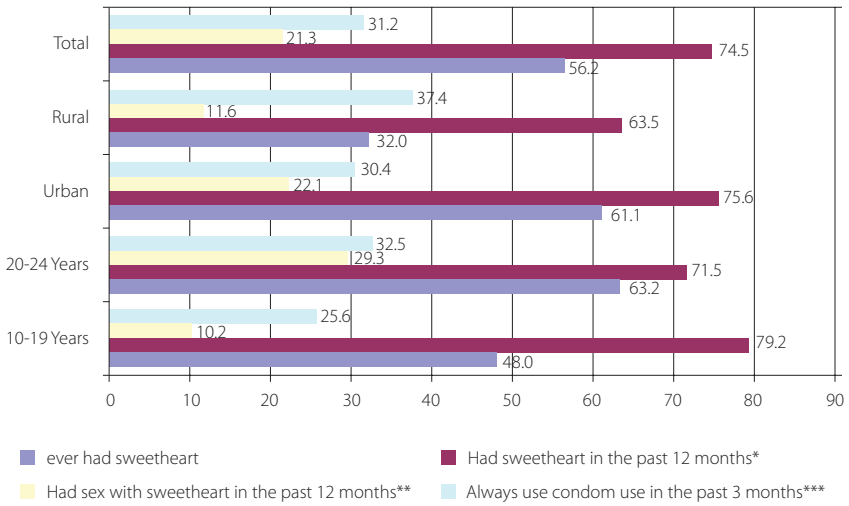
FIGURE 8 SEXUAL PREFERENCES AMONG MARYP



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.

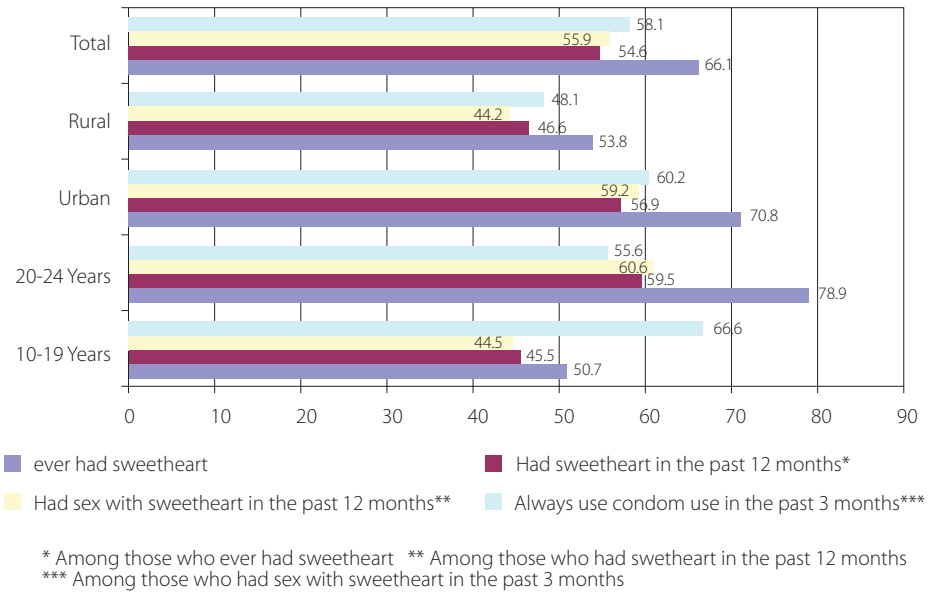
FIGURE 9 SEXUAL BEHAVIOR IN THE SWEETHEART RELATIONSHIP AMONG FEMALES



* 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)

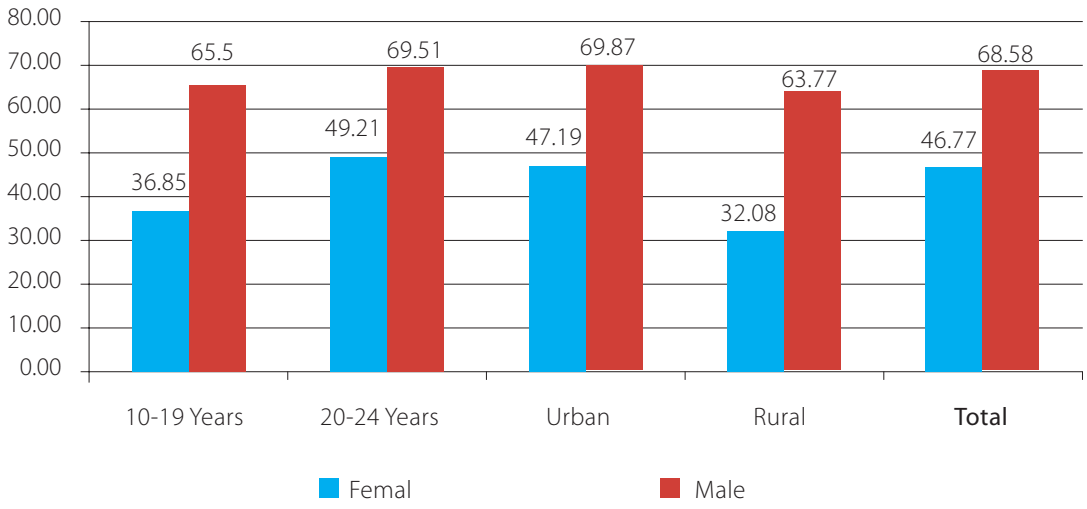
It is also possible that media such as TV and adult films can also influence MARYP when deciding to engage in sexual relations.

"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)

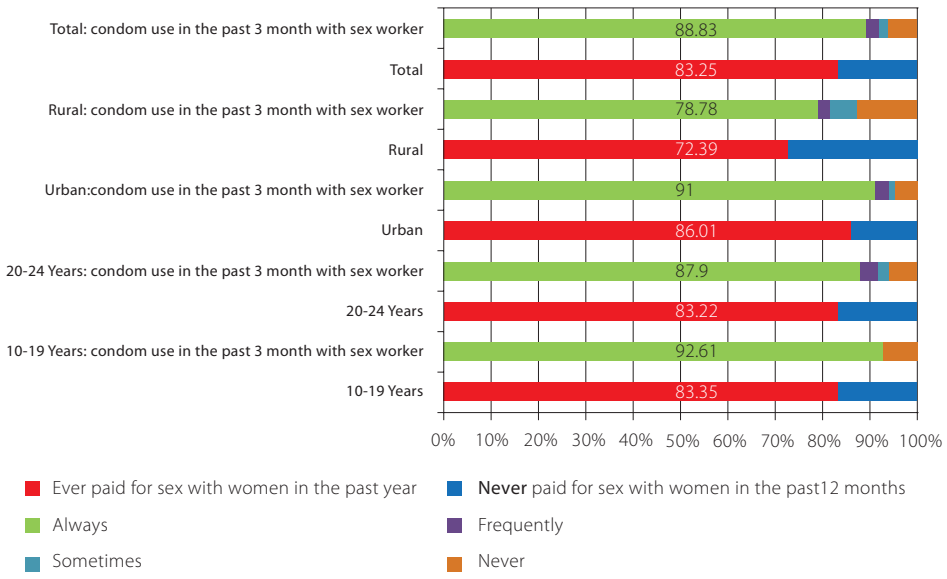
Male MARYP also reported that condoms reduce sexual pleasure, despite the fact that they know using condoms can prevent diseases.

"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.

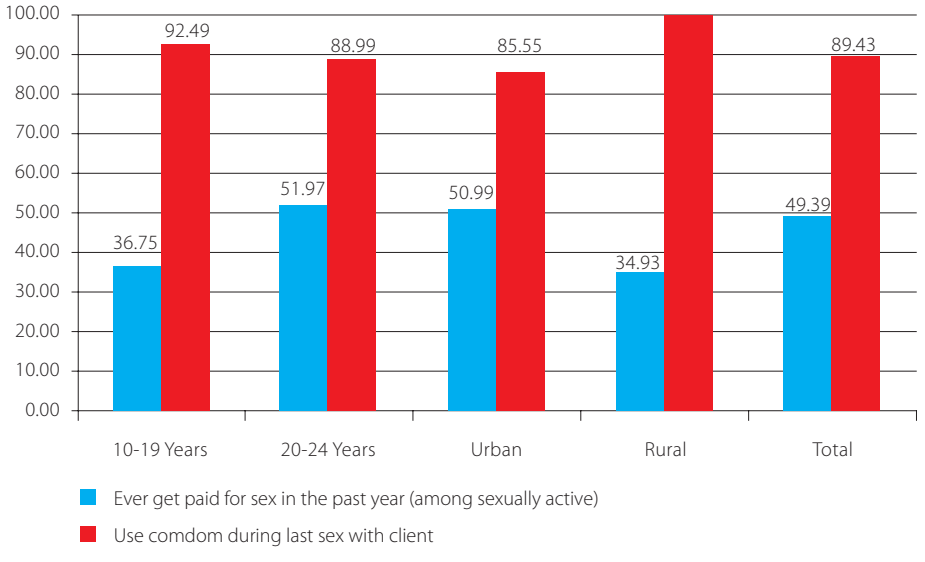
FIGURE 12 PERCENTAGE DISTRIBUTION OF MALES WHO BOUGHT SEX AND THEIR CONDOM USE IN THE LAST THREE MONTHS



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)

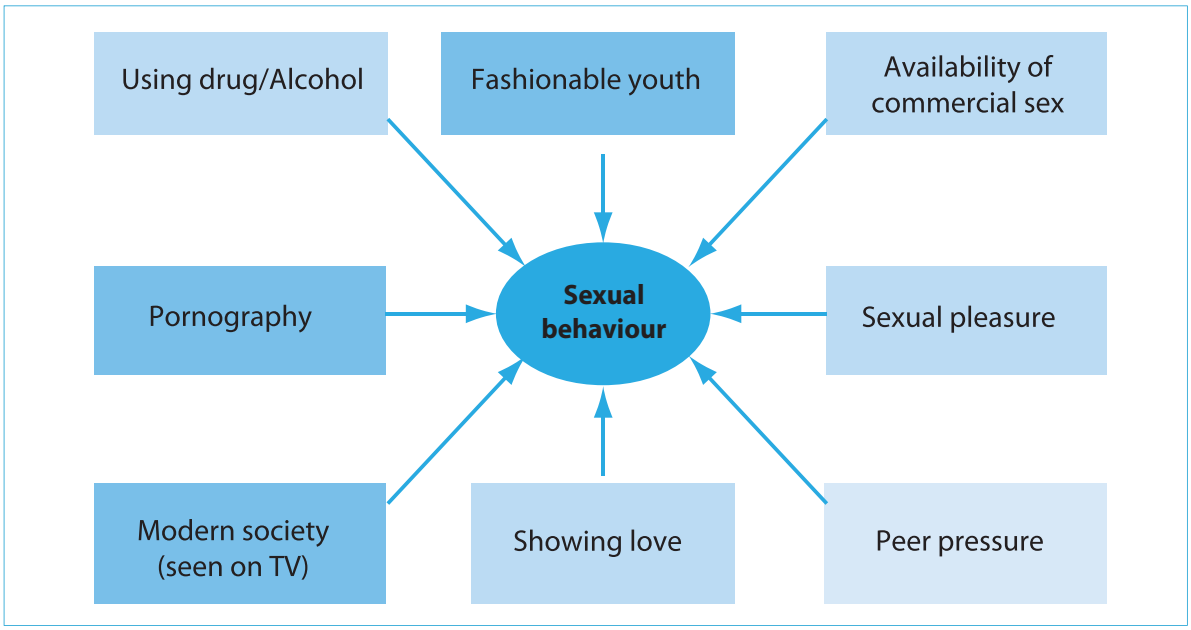
" some [young people] love their sweetheart so much , so when sweetheart offer drug, they accept" (female, 10-14 years)

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.

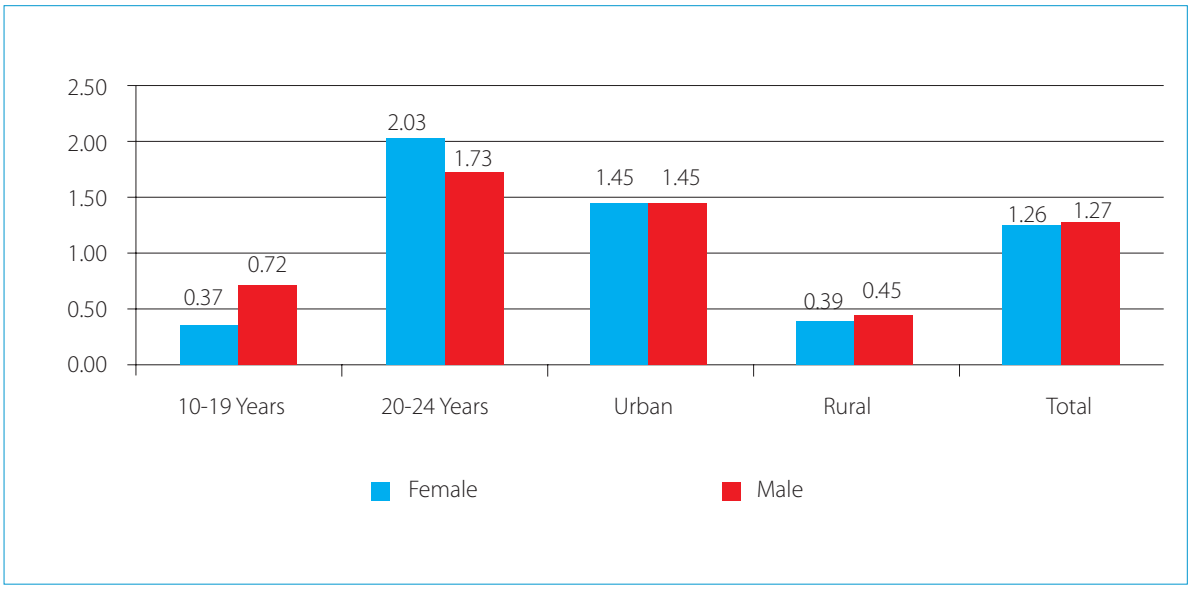
"when I don't have money to buy drug, [my boyfriend] ask me to have sex with him, I agree as long as I can have drug" (female, 10-14 years)

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

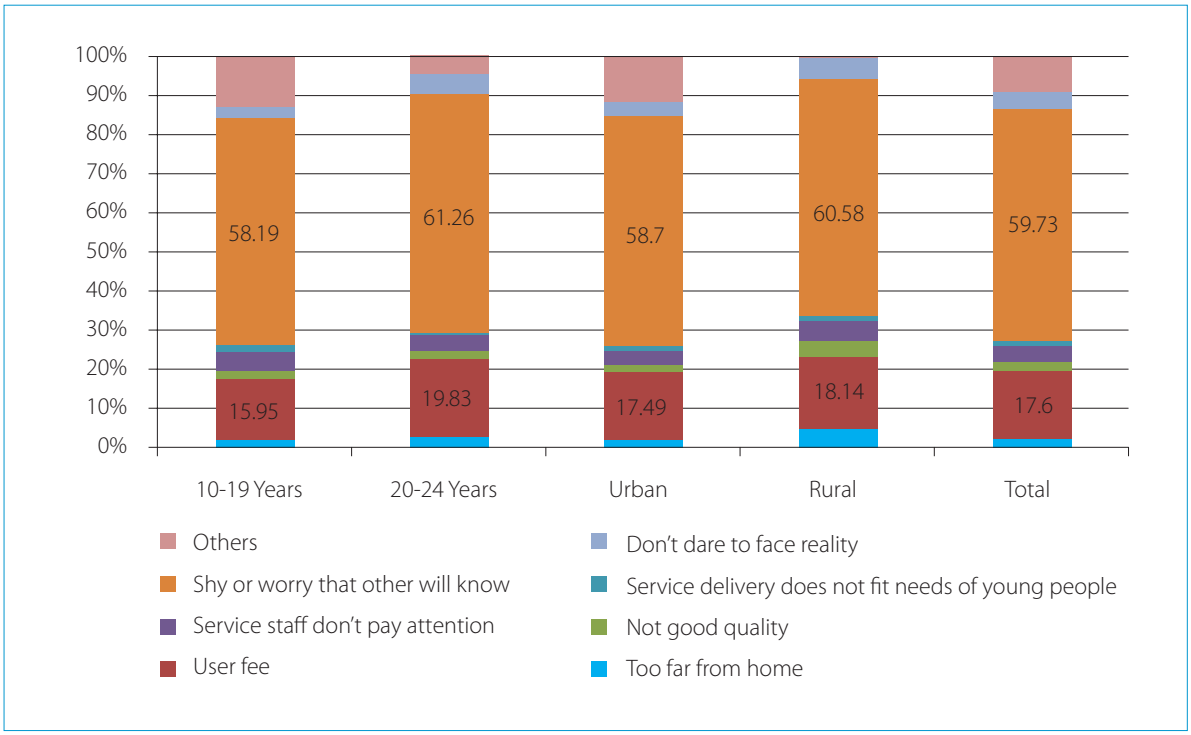


FIGURE 17 BARRIERS TO HEALTH SERVICES USAGE AMONG MALE MARYP

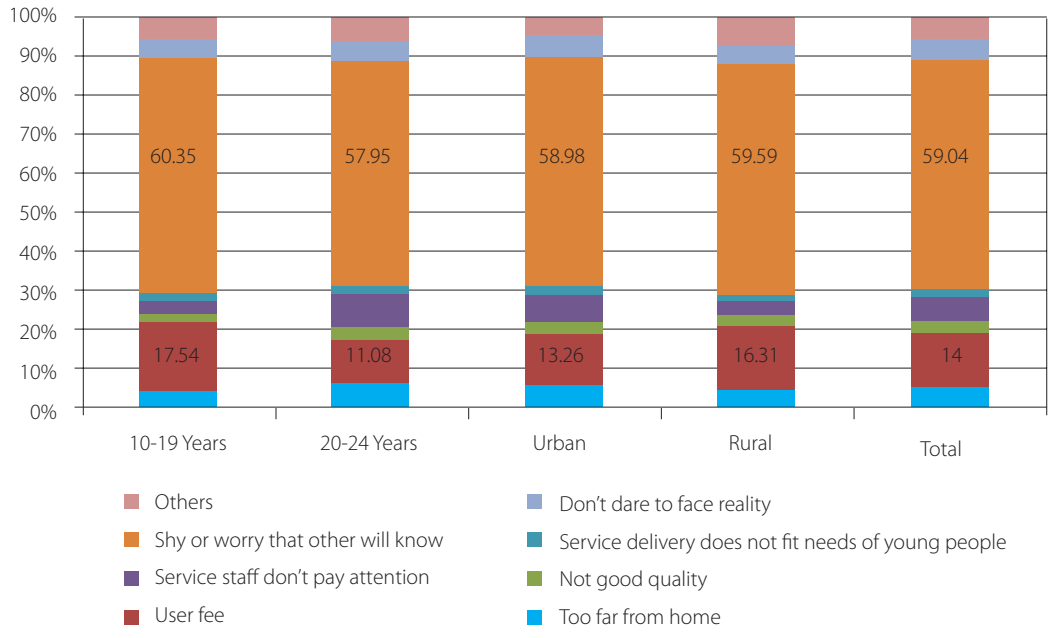


Table 13 sets out the reasons why MARYP were reluctant to use health services. The limited use of existing health services among MARYP was partially due to the lack of information about the services. The MARYP held a negative perception of public clinics citing the poor quality of services, low skills 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

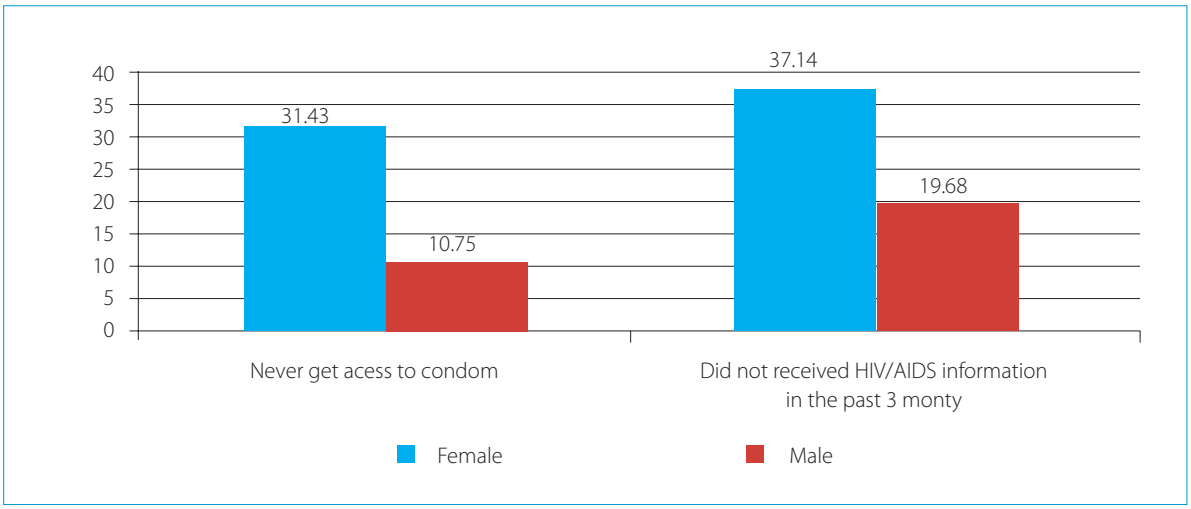
"at the VCCT, I want to have male health worker to provide service to male clients since male health worker may understand male issues better…with male health workers we can ask what we want to know [because] we are not shy" (male, 20-24 years)

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

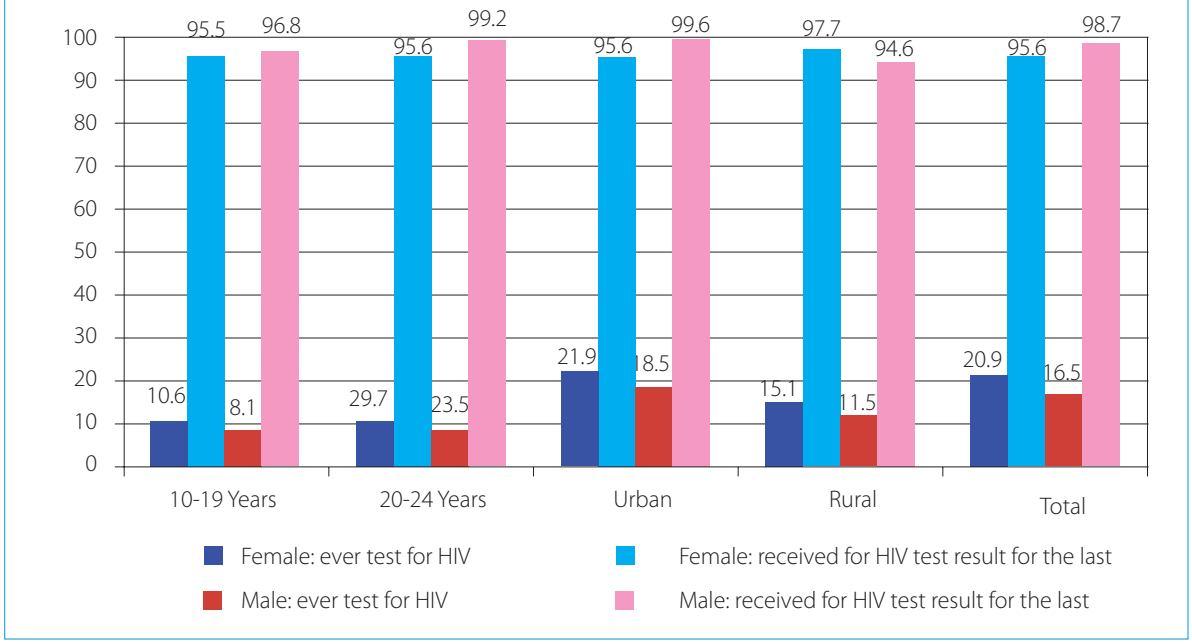
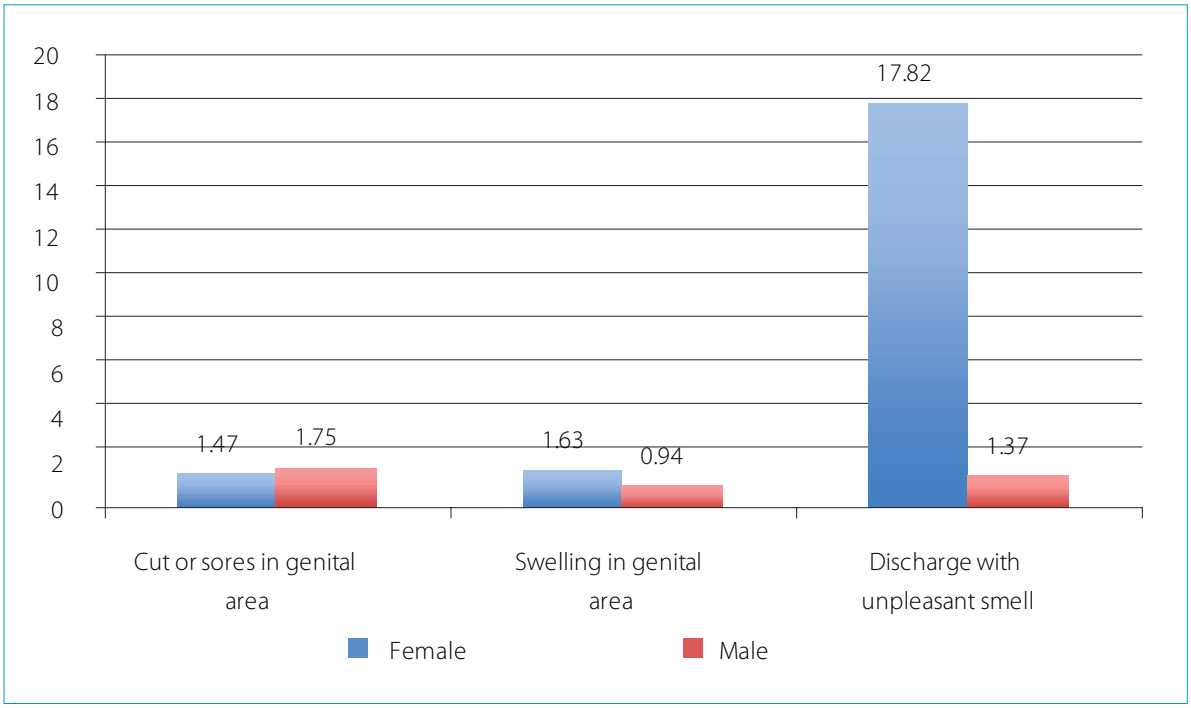
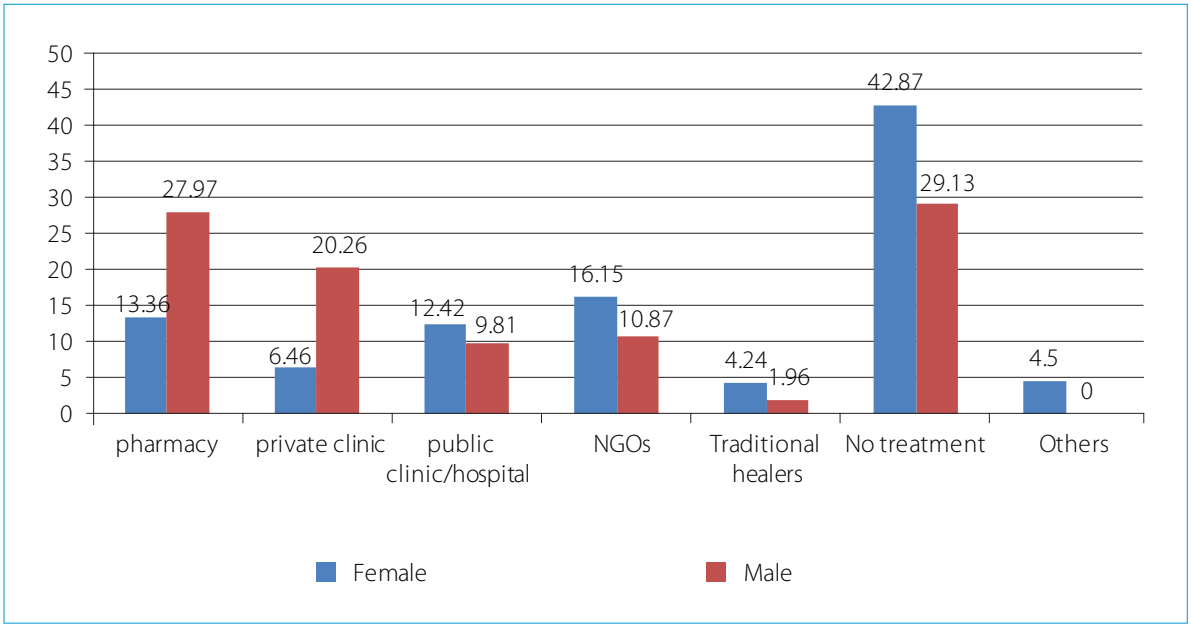


FIGURE 20 PERCENTAGE OF STI SYMPTOMS AMONG MARYP IN THE PAST 12 MONTHS



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

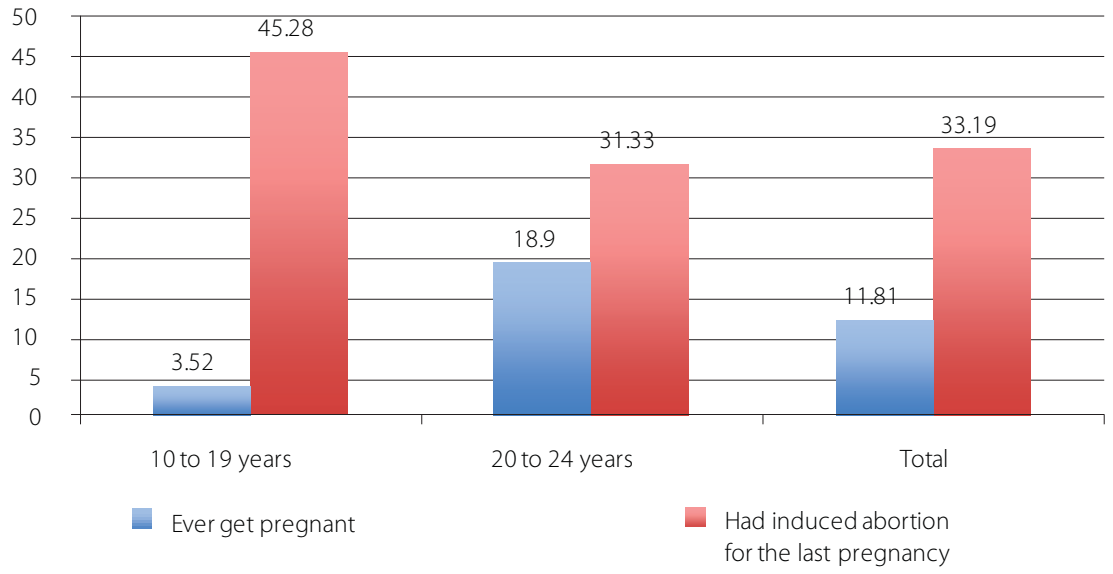
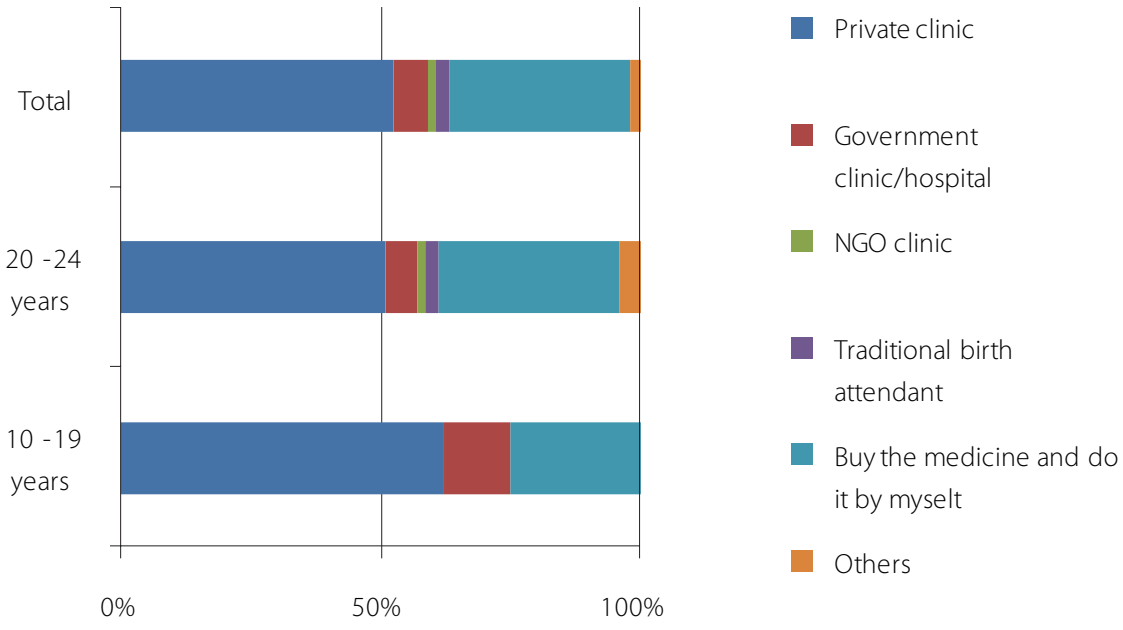


FIGURE 23 LOCATION OF THE LAST INDUCED ABORTION



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.

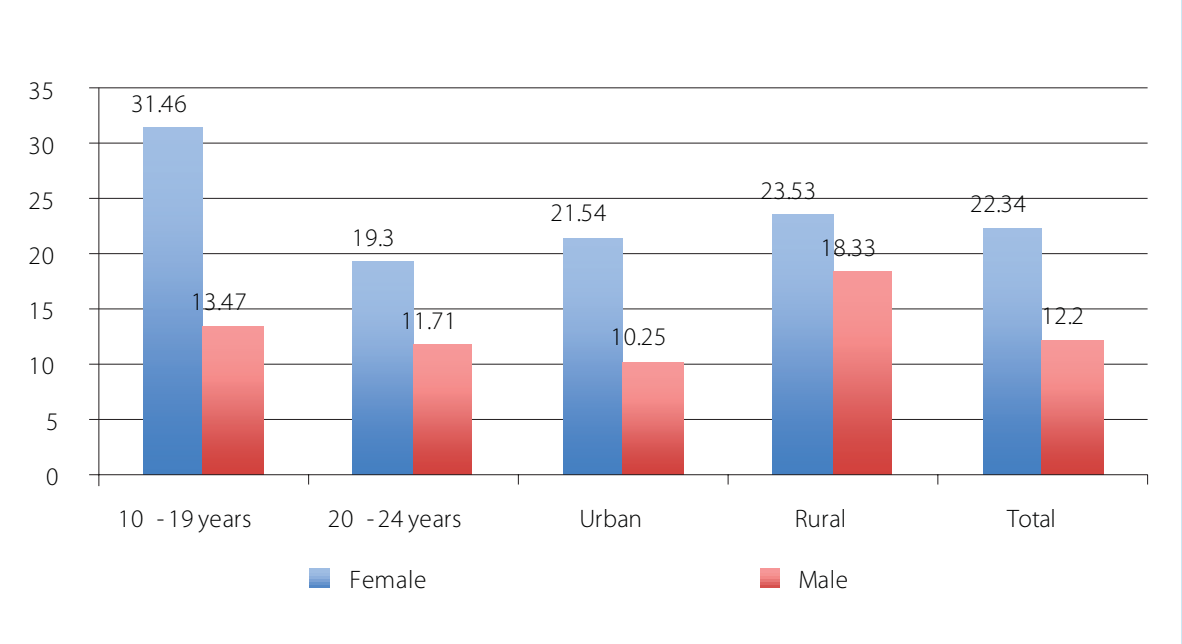
Among MARYP there was no reported knowledge of programs available to help them deal with drinking problems or that work towards delaying the initiation of alcohol drinking.

"[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).

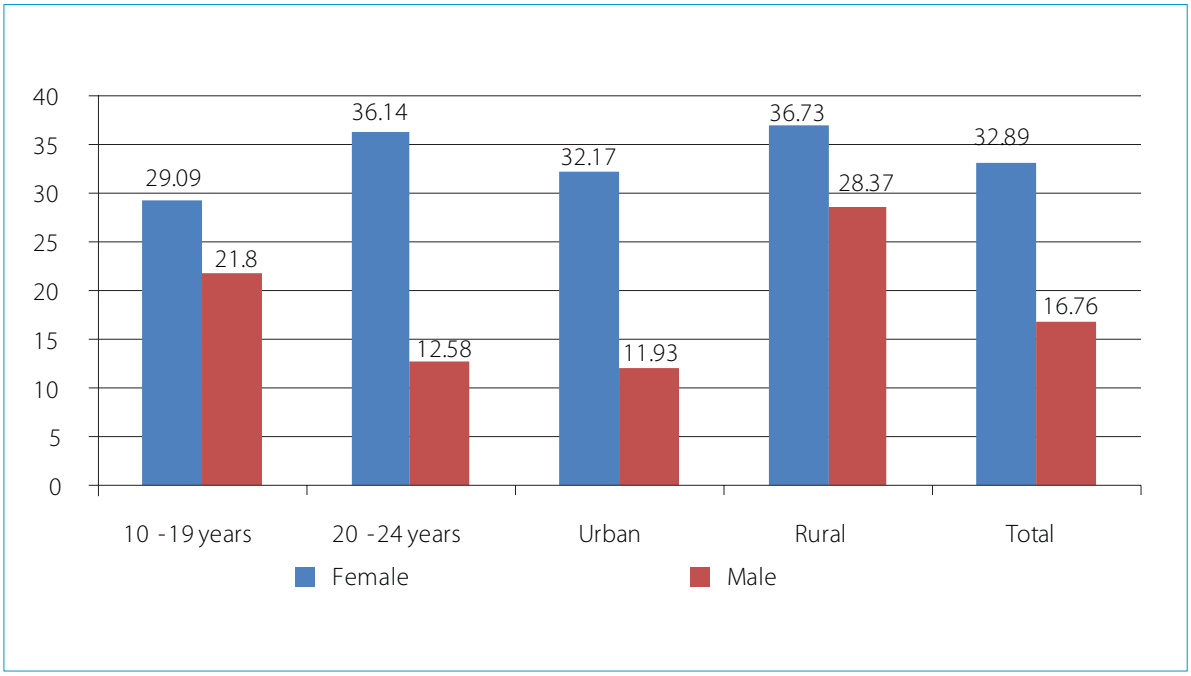
"I haven't heard on the news about rehabilitation center for female drug user" (female, 10-14 years)

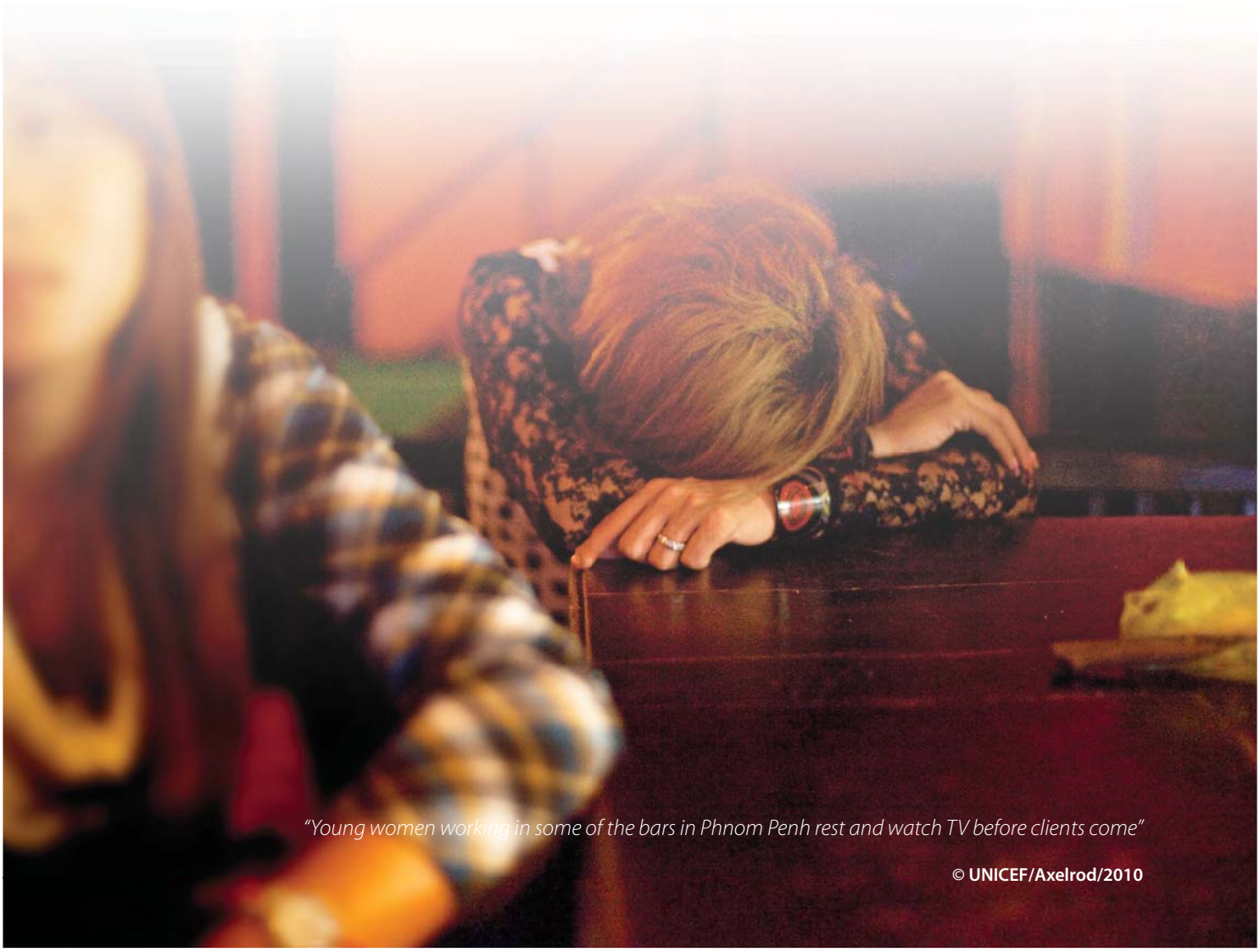
FIGURE 24 PERCENTAGE OF RESPONDENTS WHO NEVER RECEIVED ANY INFORMATION ON THE HARMFUL EFFECTS OF DRUG USE



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"

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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

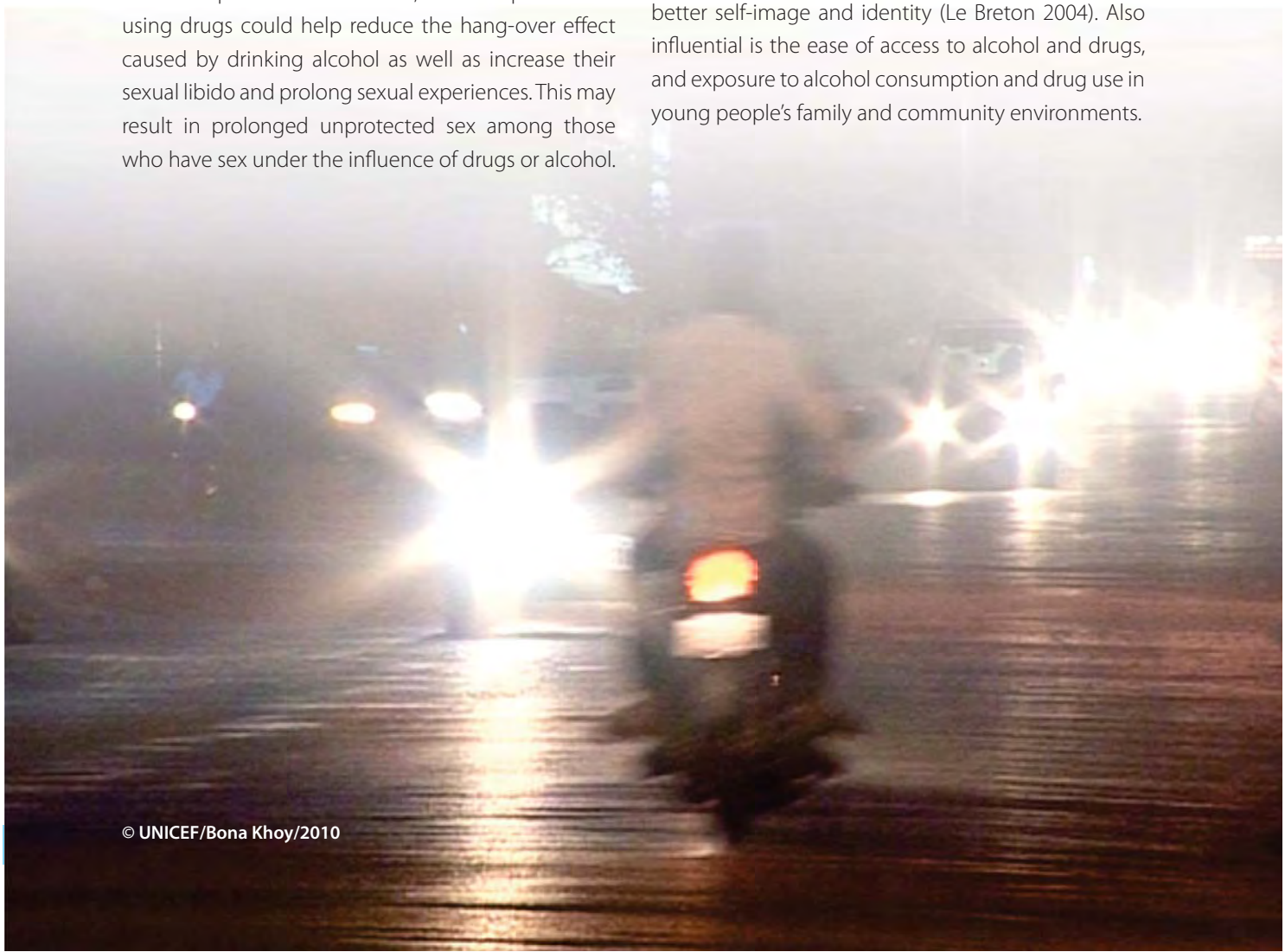
programming for MARYP. These should also include peer education programs which include life skills training and referral linkages to appropriate family planning services.

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.



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