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Sex & Rights

THE STATUS OF YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN SOUTHEAST ASIA

ISBN

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Glossary

AFR	Adolescent fertility rate
ASEAN	Association of South East Asian Nations
CCWC	Commune Committee for Women and Children
CSE	Comprehensive sexuality education
FGM	Female Genital Mutilation
FGDs	Focus group discussions
ICPD PoA	International Conference on Population and Development Programme of Action
IPV	Intimate partner violence
KAP	Knowledge, attitudes and practices
LYU ARH	Lao Youth Union Adolescent Reproductive Health
MMR	Maternal mortality ratio
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
RTIs	Reproductive tract infections
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
ToT	Training of trainers
WHRAP-SEA	Women's Health and Rights Advocacy Partnership-South East Asia
WHO	The World Health Organisation
YJP	Yayasan Jurnal Perempuan
YHDRA	Yunnan Health and Development Research Association

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Preface

In 2015, approximately 1.8 billion young people will be living in the Asia-Pacific region according to the UN.

This is a diverse and dynamic group of citizens who will be occupying the frontlines of our societies in the years to come in all sectors. Our governments and our societies need to be cognisant of ensuring their meaningful participation and their rights within all spectrums. Of particular interest is ensuring the health and rights of young people in all contexts especially their sexual and reproductive rights.

As a women's health and rights advocacy organisation, ARROW has invested in the development of young people's sexual and reproductive health and rights (SRHR) through its Women's Health and Rights Advocacy Partnership-South East Asia (WHRAP-SEA) project. Initiated in 2009 the project aims to mobilise young people especially young women to promote intergenerational leadership, movement building, as well as to address the challenges faced by young people in terms of restrictions placed on them when accessing information and services for sexual and reproductive health (SRH) from a rights based perspective. The project focuses on the issues of young people, HIV and education. It has enabled grassroots youth activists from marginalised communities in Burma, Cambodia, China, Indonesia, Lao PDR, the Philippines and Vietnam to advocate for young people's access to comprehensive sexuality education (CSE) to fully inform them of their rights and further mobilise groups to demand better access to youth friendly health services.

WHRAP-SEA's vision is to contribute to an improved quality of life, particularly in the area of SRHR for marginalised young people in South East Asia through civil society engagement for accountability in health governance. The WHRAP modality is divided into three components: 1) empowerment and mobilisation of the community to demand quality SRH services; 2) increased civil society participation and advocacy for quality SRH services at local, national, and regional levels; and 3) strengthening organisation and management of WHRAP-SEA.ARROW, as the regional partner, is investing in national partners' and youth-led organisations' capacity building on issues and processes, as well as emphasising organisational development as key strategies to strengthening partnerships.

WHRAP-SEA believes that evidence generation is an important strategy in shaping programs and policy which promote young people's SRHR. According to the UNFPA Asia Pacific Regional Office's assessment[1] on young people's SRHR initiatives, it is evident that there are gaps on data for such initiatives that is available in the South East Asia region compared to other sub regions. A key factor is the limited number of young people-led initiatives and programs in South East Asia which provides access to information to young people on their SRHR including sexual rights, sexual citizenship and sexuality.

[1] Freeman, J. (2009). Mapping regional and sub-regional and national youth networks across Asia: the state of youth networking for sexual and reproductive health across 21 Asian countries. Bangkok: UNFPA

The evidence generation aspect of this project aims to fill such gaps. Evidence from these studies and research conducted are being used to develop actions to support strategies for mobilization and advocacy at the local and national levels. Participatory community research was conducted in China, Indonesia, Lao PDR, the Philippines and Vietnam whilst partners in Cambodia and Burma documented responses of young people who accessed SRHR information and services. As an advocacy partnership, WHRAP-SEA wishes to highlights that innovative methods in collecting and analysing data on young people's SRHR should use appropriate methodologies to capture the complexity of the issues. The demographic data on young people's SRHR on its own will be meaningless if there is no effort made to elaborate the lived experiences of young people. In addition, trust building and ownership are essential aspects of such processes therefore most of the project staff, researchers, translators and volunteers were young people and activists that were familiar with the context and have faced similar challenges as the respondents of the studies.

This publication presents the key results of the six research studies in Cambodia, China, Indonesia, Lao PDR, Philippines and Vietnam as well as a landscape of the trends in young people's sexuality in South East Asia.

The following partners in WHRAP-SEA were instrumental in conducting the research and the advocacy. The study in Cambodia was conducted by the Reproductive Health Association of Cambodia (RHAC) where focus was given to two target areas; Siem Reap and Mondulkiri. In China the research was conducted by the Yunnan Health and Development Research Association (YHDRA) to assess marginalised ethnic young people's access to information on SRHR. These ethnic groups live on the border of Burma and China. In Indonesia the research was conducted by Yayasan Jurnal Perempuan (Women's Health Foundation) in the cities of Indramayu, Jakarta and Padang on young people's sexuality and the impact of religious extremism. In Lao PDR, the University of Health Science with the assistance of the Vientiane Youth Center commissioned a research on the Akha ethnic young people's sexuality. The Akha live on the border areas of Burma and Laos. In the Philippines, Likhaan commissioned a participatory research to assess the issues of unintended pregnancies among young women who live in the poor urban areas of Metro Manila. Lastly, in Vietnam, the Centre for Creative Innovation in Health and Population (CCIHP) conducted a baseline survey among young factory workers to understand issues in relation to their access to SRHR information and services.

Sivananthi Thanenthiran
Executive Director ARROW

I

Young People's Sexual and Reproductive Health and Rights in South East Asia- WHRAP-SEA Experience

Surveys in Asia and the Pacific have found that 36% of young females have accurate knowledge about HIV, which is still well below the 95% goal for young people's HIV knowledge unanimously endorsed by member states in the Declaration of Commitment on HIV/AIDS[1]. This data indicates young peoples' limited access to comprehensive information on sexuality in the region. Various international commitments signed by governments in the region speak about young people's right to be free from violence. It is therefore alarming to note that globally it is estimated that up to 48% of adolescent girls' first sexual activity was coerced[2].It is noted in a WHO Multi-country study that in the South East Asia sub-region younger women aged between 15-19 years of age are at a higher risk of experiencing intimate partner violence (IPV)[3].

South East Asia has a high number of reported cases of sexual violence. For example, 57% of first sexual experiences for young women and girls in the Philippines were unplanned or non-consensual[4]. Young girls and women in the region also experience numerous other forms of violence that negatively affect the realisation of their sexual rights, such as arranged, forced and child marriages as well as harmful traditional practices[5].

International agreements such as the International Conference on Population and Development Programme of Action (ICPD PoA) emphasise the need for governments to address young people's SRHR. The ICPD PoA specifically calls on governments to address adolescent SRH issues, especially those of young women and girls, which include sexually transmitted infections (STIs), unwanted pregnancies and unsafe abortion by promoting responsible and healthy reproductive behaviour. It also calls on them "to meet the special need of adolescent and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process, and access to education, health, counselling and high-quality reproductive health services"[6]. It is therefore essential to acknowledge that for the holistic realisation of SRHR for all includes the SRHR of young people.

Understanding the local context of each country and localities is important in giving meaning to the issues faced by young people especially young women in regards to their SRHR. Some specific insights into the context where our studies were conducted include the following:

[1]United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2009). International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers, and health educators retrieved July 10 , 2012, retrieved from UNESCO Website: http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

[2]World Health Organization (WHO). (2006). WHO Multi Country Study on Women's Health and Domestic Violence against Women. Retrieved November 21, 2012 from WHO website: http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

[3]Ibid

[4]Farhanah and Wijiastuti, K. (2011). Reaffirming Young People's Roles in Addressing Gender-Based Violence and Sexual and Reproductive Health and Rights. ARROWs for Change 17(2), 5-7. Kuala Lumpur: The Asian-Pacific Resource & Research Centre for Women (ARROW). www.arrow.org.my/publications/AFC/v17n2.pdf

[5]Ibid

[6]United Nations Population Fund (UNFPA). (2004). Para 7.44 (a).InProgramme of Action Adopted at the International Conference on Population and Development, Cairo, 55-13 September 1994 (p. 59). New York, USA: UNFPA

Cambodia: Out of the total population in Cambodia, 23.5% is in the age group of 15 to 24 years. Issues on young people's SRHR have received considerably more attention from the Cambodian government in recent years with the National Strategic Plan for SRH (2006 - 2010) and National Guidelines on SRH Services for Young People developed in 2007 being put in place to provide a comprehensive framework for the provision of young people's SRH priorities especially to access health services and sexuality education. Under the newly established Life Skills for HIV/AIDS Programme, SRHR has been identified as one of the issues that should be incorporated into the school curriculum.

Nevertheless, gaps between national strategies/policies and the implementation on the field remain an issue which requires immediate interventions. The adolescent birth rate in Cambodia almost remained stagnant between 1998 and 2005 with 52.3 per 1,000 live births. It showed, however, a slight reduction to 48 per 1,000 live births in 2010. HIV prevalence rate among young people has seen a steady increase over the years and 70% of young men (15-19 years old) were reported to be engaged in high-risk intercourse with low awareness on the risks of HIV and STDs.

In response to the reality, the Reproductive Health Association of Cambodia (RHAC) has initiated a project under the WHRAP – SEA partnership in Siem Reap and Mondulkiri provinces to improve young people's access to comprehensive sexuality education and services at the youth friendly clinics. During the implementation of the project, a set of stories from young people were also documented and collated as testimonies from the ground. The project identifies cultural norms, poverty, and low education level of the young people and their parents as the main barriers for young people in accessing reproductive health services. Interventions in these areas are further required to achieve a wider access to information and services for young people.

China: The Yunnan Province is located in China's south western frontier, with over 15 minority ethnic groups which are some of the most diverse groups in China. At present, these minority populations are distributed along the mountain areas of Laos, Burma and Vietnam border areas, as well as with other provinces in the border areas[7]. Due to its location, history and political economy, the minority populations have not had equal access to social development opportunities[8]. This has led to unequal distribution of education and economic resources. Additionally as gender inequalities have continued in these communities, early marriages and early pregnancies in these groups are common. The existing "sexual culture" is believed to lead to youth from minority communities to having fewer opportunities to receive CSE and related health services compared to the general population[9].

Indonesia: The issues of young people's SRHR is important as Indonesia's Health Profile data reveals that young people account for 31% of national population. Studies on young people's issues have been conducted by civil society organisations and universities which challenge the assumptions and views of the government. A study by the Gadjah Mada University indicated that young people do not become 'morally corrupt' with such information[10]. The study also indicated that information on sexuality given by the family alone is not sufficient or effective if it is not complimented with peer coaching or sharing sessions. More often restrictions to accessing information on young people's sexuality by their families result in young people being misinformed with fragmented inaccurate information from outside sources[11].

Lao PDR: As a small country in the heart of the greater Mekong area and classified as a least-developed country, Lao PDR has many challenges. Young people in Lao PDR face multiple challenges regarding their SRH such as sexual violence and the breakdown of relationships[12]. HIV-AIDS is also a major problem for young people[13]. Issues related to gender and ethnicity have been highlighted as government policies on land allocation and titling, shifting cultivation, and opium production increasingly affect the livelihoods and practices of ethnic minority groups[14]. In addition, ethnic minority societies in Lao PDR are dynamic and constantly changing. Rapid social change is especially evident in upland villages that are relocating closer to roads and markets,or are being amalgamated with other villages including other ethnic groups. A recent study of

[7]UN-Spain MDG Achievement Fund (2009). China Culture and Development Partnership Framework, Impact of Cultural Traditions to Maternal and Children's Healthcare.Spain.

[8] The Main Barrier on Economic and Social Development in Cross-Border Area of Yunnan.http://wenku.baidu.com/view/ff6c970c4a7302768e993999.html

[9]UN-Spain MDG Achievement Fund, China Culture and Development Partnership Framework, Impact of Cultural Traditions to Maternal and Children's Healthcare, 2009.

[10]Center for Population and Policy Studies. (2005).Seks dan Kehamilan Pranikah: Remaja Bali di DuaDunia., Indonesia: GadjahMada University,

[11]Ibid

[12]United Nations (2009) "The Millennium Development Goals Report 2009.Statistical Annex".United Nations.

[13]Ibid

[14]Ibid

relocated ethnic minority villages in Luang Namtha and Sekong provinces found numerous changes in cultural patterns, including the adoption of lowland-style housing, dress, marriage practices, and technologies. Traditional norms and practices are also changing as young people migrate to urban centres and to Thailand to work for part of the year.

The Philippines: Sex, sexuality and contraception are contentious topics in the Philippines. To illustrate, despite widespread support, the legislature has stalled for more than a decade a proposed national law on reproductive health (RH). The RH bill mandates government programmes and funding for contraception, sexuality and RH curriculum in schools and enhanced maternal mortality reduction. In the meantime, the adolescent fertility rate, already high to begin with, has risen. Among girls aged 15 to 19, the National Demographic and Health Survey (NDHS) recorded a rate of 54 live births per 1,000 in 2008, up from 50 in 1993 and 46 in 1998. Two proximate factors tracked by the NDHS contribute to the problem: 1) the growth in proportion of young people especially adolescents that are sexually active; and 2) the very low rates of modern contraceptive use among those young people especially adolescents, both married or unmarried. In the 2008 survey, 8.1 % of teens reported having sex in the past month, up from 5.8 % in 1993; and 7.4 percent were in a live-in relationship, up from 2.7% in 1993. In the same survey, 74 % of young people especially adolescents married or living-in were not using any form of contraception, yet only 17 % wanted a child within the next two years. Repeated NDHS surveys show what age young people and especially adolescents, pregnancy and motherhood generally starts and peaks. From less than 1 % at age 15, the proportion continually rises until age 19. From 1993 to 2008, at least 3 out of 4 young people especially adolescent girl who had started motherhood were from 18 to 19 years old.

Vietnam: Vietnam's national economy is largely supported by commerce and industries. Young people who work in factories and industries are mostly from rural areas with low educational qualifications. Data has been indicating that problems related to SRH such as unwanted pregnancies, prevalence of HIV-AIDS, increase in reported cases of IPV, sexual abuse, etc. are increasing among young people. In addition to this, the living conditions and facilities being provided to young factory workers, their backgrounds and limited exposure to information and knowledge on SRH, makes them even more vulnerable.

Context-beyond young people's SRHR

The promotion of young people's SRHR in the South East Asian context is directly and indirectly influenced by the geopolitical changes in the region. The Association of South East Asian Nations (ASEAN) has been mobilizing to increase civil society participation by developing a community ASEAN blueprint by 2015. Part of the blueprint is the investment on youth issues such as the role of young people in volunteerism, entrepreneurship and leadership building. Some exchange programmes have been organized by the ASEAN secretariat for ASEAN youth. Unfortunately, the issues of young people's rights especially SRHR have not been incorporated by the ASEAN secretariat and governments as a key issue in the sub region.

Elections in a number of countries have brought about positive change. In Cambodia, the recent elections have seen changes in the roles and structures of their local government. The changes imply strengthening the role of Commune Committee for Women and Children (CCWC) which is responsible for delivering a number of programmes on health of women and children at the community level. The 2012 bi-elections in Burma to elect representatives for 46 vacant parliamentary seats was seen by the world as a positive move on the part of the Burmese leadership. More positive attention was focused as the results of these elections were announced with an astounding victory for Daw Aung Suu Kyi and her party (National League for Democracy) who won 43 of 44 contested seats. How this will shape the country and its policies will have to be seen. However, our partner and other organisations working in the border areas have noticed an increase in the number of security check points along the border which has made it increasingly difficult to reach out to the most in-need communities in Burma.

Organisations working on the border areas have noticed a shift in donor priorities where funds are being transferred to programmes in country. Local NGOs inside the country have reported tighter controls of funds being transferred.

Landscaping young people's sexuality within the region: findings from national partner studies

Findings from national partner studies and research showcase a multitude of information on the state of young people's SRHR within their project sites. The common issue between partners was that young people's access to SRHR information and services is still restricted at the local and community level.

- **In Cambodia,** cultural norms, poverty and education are seen as important factors for young people to access reproductive health services and information. The existing cultural norms that restrict young people from talking about sexuality and reproductive health due to its sensitivity, financial constraints, and low level of understanding of the issues make it even more difficult for young people to reach out for assistance.Through the WHRAP-SEA project implementation, RHAC was able to provide a safe space for young people in Siam Reap and Mondulkiri to express and share their challenges and difficulties in dealing with their own personal SRHR issues and at the same time, to receive relevant information and health services. These stories were documented and collated as testimonies to be further used as evidence to advocate for better and affordable access to comprehensive sexuality education and youth-friendly services.

  The project also emphasised the importance of seeing the issues through a human rights perspective. The realisation of rights to education and knowledge on particularly sexuality and reproductive health is regarded as an essential part of improving young people's SRHR as lack of understanding and awareness on the issues have been identified as one of hindering factors in getting the correct information and proper health services. Government is playing an important role in this regard with continued efforts in creating policies and programmes, including interventions in the area of education and poverty alleviation to address the existing gaps, needed to be continuously done.

- **In China**, the findings of a study done in the Yunnan province highlight the results of a quantitative data analysis that shows significant discrepancy in access to information between young people in the urban setting compared to young people from minority ethnic groups that live in the rural areas. People of the Jing Po and De'ang ethnic minority groups were less informed, as they are considered a migrant population for which neither the Chinese government nor the Burmese government will take responsibility for. In addition, for young people who are younger than 18 years old, information is more restricted and they face discrimination in accessing information on their SRHR. Furthermore, the study shows that gender, age, nationality, level of education and marital status correlates with access to information on STIs.

  The study also showed that information on contraceptive methods was very limited with only 20% of the respondents were able to correctly identify the correct method for taking oral contraception. Regarding the correct usage of condoms, the respondents also faced challenges in accessing the accurate information especially on the dual function of condoms (HIV prevention and as a method of contraception). There was also a correlation between occupation, marital status and knowledge about the dual function of condoms. Among the respondents: farmers' knowledge was higher (37.14%); while the knowledge of migrant workers, students, unemployed and other youth was much lower. 92.86% of the students did not have knowledge of the dual function of condoms and none of the unemployed youth knew about that aspect either. The study indicated that 13.95% of married respondents

and 66.67% of cohabitants and unmarried youth had experienced unintended pregnancies. In the case of unintended pregnancies 75% of the unmarried youth chose (unsafe and safe) abortion.

Despite the limited knowledge of contraception, respondents had a better level of knowledge regarding HIV-AIDS, however they also believed myths around how the disease is spread. For instance 41% of the respondents believed that mosquito bites and having a 'Burmese wife' could cause HIV infections. Therefore, the level of knowledge is not correlated with the accuracy of the knowledge on HIV-AIDS.

The inaccurate and insufficient knowledge of contraception, STIs, HIV-AIDS, and abortion was worrying as among 100 youth respondents, 72 % have had at least one sexual experience. The average first sexual intercourse age was 19.05 years old, and the youngest was at 12 years old.

- **In Indonesia**, the study undertook the approach of a bio-psycho-social model of young people's sexuality. The model looks at the correlation between knowledge, attitude and behaviour of young people on their sexuality. Specific issues discussed included reproductive organs and their function, puberty, pornography, menstruation, dating, pregnancy, abortion, masturbation, sexual intercourse, STIs, and HIV-AIDS.

  Overall myths on sexuality support the statistical analysis that gender correlates with values and attitudes on SRHR in general, and access to information in particular. The quantitative and qualitative data shows that although young people are somewhat knowledgeable on their sexuality, however, the information is incomplete and incoherent. Knowledge of sexual intercourse, contraceptive methods, HIV-AIDS, pregnancy and (access to safe) abortion is very limited. From the qualitative data, barriers to accessing information on these issues included parental restriction as young people are considered too young to access such information.

  Specific analysis of qualitative data on dating behaviour among young people showed that the first instance of sexual activity can happen as early as elementary school. Despite some respondents expressing positive aspects when dating, such as increased motivation to go to school, most respondents shared that male partners within the dating relationship have more decision making power (and used force and/or threats) to decide when and how they had sexual activities.

- **In Lao PDR**, this is one of the first studies that examined the knowledge, attitudes and accessibility to SRH information and services among female Akha adolescents in the Luang Namtha province. It also updates the estimates of sexual activity in this population. The study revealed low knowledge of contraception, STIs, HIV-AIDS, with comparatively moderate knowledge on reproductive health. In addition, the findings also found a significant proportion of Akha girls engaged in premarital sex, early age at first sex, multiple sex partners, and low condom use. Given these factors female adolescents are at significant risk in contracting STIs, HIV-AIDS and limited ability in making informed SRHR related choices. One of the current practices among the Akha ethnic group was 'Breakthrough Vagina', when the young women and girls engage in sexual intercourse for the first time to welcome a guest that has come to their village. The age of the young women and girls who underwent such practice ranged from 11 to 17 years.

  About one third of respondents agreed that unmarried young women should not have sex and the rest felt that unmarried members of the opposite sex should not even form friendships. Forty-eight percent believed that young people who have premarital sex should be punished.

Regarding attitudes towards sexuality education, 95.4% and 93.6% of respondents believed that it is important for sex education to be taught in schools and among out-of-school youth respectively. A large majority of female respondents received some SRH information and the major source of SRH information was from project volunteers, friends, and schools. A negligible proportion reported discussing the matter with parents and health personnel.

One quarter of respondents were aware of contraception. The most common contraceptive methods that they had heard about were condoms and oral pills. Only half of the respondents discussed contraceptives with friends. There was a high rate of unprotected sexual activity among the respondents, with 90.4% of them indicating having had sex without any contraception. Overall, 88.8% of respondents had heard of HIV/AIDS. Adolescent girls aged 14-19 years old in this study had low level knowledge of HIV/AIDS. They have a lot of misperceptions of HIV/AIDS.

About two fifth of the respondents had sought care for genital symptoms in the last year and reported them at a range of different health facilities such as district hospitals and traditional healers as these were the most convenient and confidential. Reasons for not seeking medical care included normal to mild symptoms, shyness, mistrust of health facilities and lack of money. The majority of respondents (77.8%) reported that their houses are far away from the health facilities which provide SRH services.

- **In the Philippines**, the study done has showed that peer education sessions among teenage girls by trained community youth leaders can improve information and motivation factors relevant to pregnancy risk-reduction, i.e. abstinence and contraceptive use. Information factors include correcting misinformation about the safety of contraceptives, the effectiveness of folk methods, and pregnancy-free first sex. Motivation factors include attitudes and norms about youth in general and macro-level SRH policies, such as views on contraceptive use and promiscuity; on the rights of young people to access government-supplied contraceptives; and on contraceptive use by sexually active youths.

  The participants of this study were asked if they thought young people trained in sex education and contraception would be effective in teaching the same to their peers. At the pre-test, a slight majority (58%) thought that peer educators would be effective. During the post-test this proportion increased to 82%. These results indicate that peer SRHR education was largely not a barrier to receptivity in this study. One should note however that 12 % of the post-test group remained unconvinced about the effectiveness of peer educators.

  However, these peer education sessions were weak in improving motivation factors that involve personal and interpersonal relationships, such as attitudes on pressure to have sex by one's boyfriend; the need to marry one's first sexual partner; and talking about sex issues with friends. The sessions were also weak in improving minimal personal plans about the timing of sex, marriage and having children which served as the only measures of behavioural skills.

  The peer education sessions as currently done will be more effective with younger teens, generally those without boyfriends, who need relatively uncomplicated behaviours to do or maintain pregnancy risk-reduction. Older teens or those with boyfriends need better results in two areas: motivation factors involving personal and interpersonal relationships, and behavioural skills.

- **In Vietnam**, the findings of the study showed that young workers in factories have many concerns and queries about SRHR related issues like menstruation, abortion, reproductive tract infections (RTIs), STIs, love relationships, etc. It also reflected the reality among the group that the negotiation skills of female workers is very low, resulting in a low bargaining position in front of their male partners.

Recommendations: What we need to change

WHRAP-SEA partners and ARROW in bringing forward the results of this study on young people's SRHR call for policies and programmes for young people's issues need to be designed and implemented by keeping the context and the realities faced by young people in mind. Various actions to mobilise young people, peer educators, teachers, parents, factory workers, and ethnic leaders need to be carried out. WHRAP-SEA has defined seven key elements of CSE as: gender, SRH and HIV, sexual citizenship rights, pleasure, freedom from violence, diversity and relationships. Based on the agreed elements, the WHRAP-SEA partners have created their curriculum on CSE with the incorporation of specific needs that are related to the context of young people at their project sites. The results from their experiences which have been showcased at various interventions at the national, regional and global levels include:

- In Indonesia, the local government of Indramayu in West Java has begun to replicate a programme for young people's SRHR that focuses on young women's sexuality and access to youth friendly services together with supporting youth leadership.

- Community-based study on young women's unintended pregnancies in poor urban communities of Metro Manila has been a catalyst for rallying young people and women activists to advocate for the enactment of the Reproductive Health Bill in the Philippines.

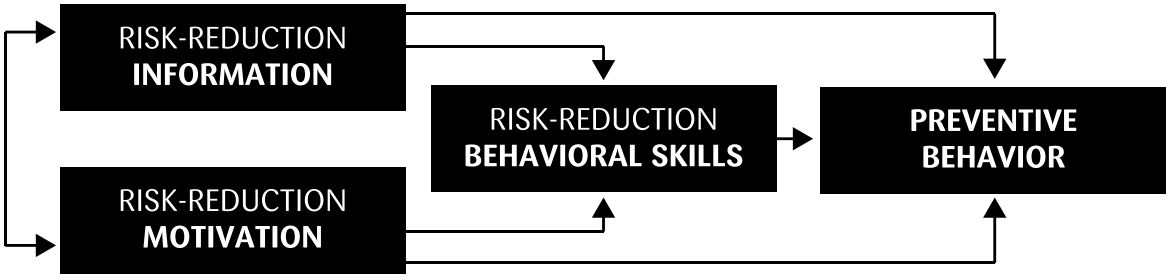
- Finally, factory workers' unions in Hanoi, Vietnam have now included sessions on providing SRHR information to young factory workers in four factories. The unions working together with the factory management have agreed not to dock the wages of the young factory workers who attend such sessions.

Based on the experiences on the ground and insights provided by these studies, some recommendations in regards to the promotion of young people's SRHR include:

- Young people's sexuality should be framed in an affirmative way in order to address the myths around it which restrict the realisation of young people's, especially young women and girls,' sexuality. A bio-psycho-social model can be used to further elaborate various factors that are relevant to young people's sexuality.

- The complex interlinked contexts in South East Asia need to be taken into consideration for young people's programme and policy development. These include an increase in mobile populations where migrants rights are not safeguarded, increase in cultural and religious extremisms which have a severe impact on gender and sexuality, curtailing of the rights of minority groups, etc.

- In providing information on young people's sexuality, every issue should be addressed in a non-judgmental way. It is also important to ensure that the information is standardised, accurate and comprehensive. Abstinence only information is not helpful in addressing the issues of young people's sexuality. In addition, tailor made adaptations based on the context such as language diversity and literacy level should be taken into consideration. In doing so an information-motivation-behavioural skill model should be utilized to develop CSE curriculum for young people.



- The relevant dimension in the acknowledgement of young people's SRHR such as discourse on sexuality, sexual orientation, gender identity and pleasure need to be integrated within the discussion theme to cover the issues in a comprehensive manner.

- There should be multiple ways to provide information to young people on their SRHR and the role of peers, especially peer educators should be recognised.

- Parents need to understand young people's needs and give room for young people to explore their sexuality. Restricting information on sexuality will cause more harm than good. Trust building between parents and children is a necessity, furthermore the relationship between parents and children should be based on the realisation of young people's SRHR.

- Movement building to advance young people-led organization needs to be done. This will contribute to the improvement of advocacy efforts in demanding for the government to be actively responsible in implementing the national policy and budget such as what happen in Cambodia through the Commune Council for Women and Children.

- Ultimately, governments should be accountable in providing access to information in regards to young people's sexuality in a comprehensive manner. Partnerships with CSOs are important in creating a curriculum, as well as ensuring youth friendly health services are available to follow up the information dissemination. Referral systems that do not focus on age and parental consent are important.

II

Ensuring Access to Youth Friendly Health Services and Comprehensive Sexuality Education in Siem Reap and Mondulkiri, Cambodia

Reproductive Health Association of Cambodia (RHAC)

Abstract

It is estimated that 23.5% of the Cambodian population is in the15 - 24 age group[1]. Reflecting this reality, the existing National Strategic Plan for Sexual and Reproductive Health (SRH) in Cambodia (2006-2010) provides a comprehensive framework for provision of young people's SRH priorities, especially access to health services and sexuality education, as well as to engage in annual planning and mobilization of the necessary resources for effective action. Further, the National Guidelines on SRH Services for Young People was developed in 2007and provides clear instruction on how to scale up young people's access to health center services in local communities. Nevertheless, there are still gaps found between national strategies/policies and the implementation in the field.

Reproductive Health Association of Cambodia (RHAC), since 2010, has participated in a project for young people's sexual and reproductive health and rights (SRHR) called the Women's Health and Rights Advocacy Partnership in South East Asia (WHRAP-SEA). The project has been implemented in Siem Reap and Mondulkiri provinces with the agenda to provide better access for young people to youth-friendly clinics and comprehensive sexuality education. Through the project, it has become evident that the lack of accessibility to SRH services correlated with cultural norms, poverty, and education level of young people and their parents. In addition, issues on the realization of rights often appears as the aspect of sexual and reproductive rights and education rights that are closely related to better access to information and services for young people. During the projects' implementation, a set of stories from young people was also documented and collated, representing testimonies and real voices from the ground.

Context

The Cambodian population has increased by 1.95 million over the last decade, from 11.4 million in 1998 to 13.4 million in 2008[2] (the total population is 13,388,910, of which 48.5% are males and 51.5% are females)[3, 4]. Results of the 2010 Cambodian Demographic and Health Survey (CDHS) confirmed that 61% of the population is in the 15 - 64 age group, and nearly 5% are over 65 years of age. About half of the population is under the age of 24, as a result of the baby boom in the 1980s[5].

[1] National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[2] Ibid.

[3] National Institute of Statistics, Ministry of Planning Phnom Penh, Cambodia (August 2008).General Population Consensus of Cambodia 2008.

[4] National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[5] Ibid.

Sex education is currently part of the curriculum and is strongly supported by the government of Cambodia. In 2005, the Ministry of Education, Youth and Sport (MOEYS), through its Inter-departmental Committee on HIV/AIDS and Drug (ICHAD), expanded its SRH activities in schools through a newly adopted Life Skills for SRH curriculum. Initially, the MOEYS had developed a policy for HIV/AIDS and Sexually Transmitted Diseases (STDs) education in primary and secondary schools (grades 5 to 12). However due to various gaps identified in the programme, ICHAD decided to develop a new and improved Life Skills for HIV/AIDS Programme with support from the Department for International Development (DFID) and United Nations Children's Funds (UNICEF). The new programme incorporated SRHR issues into the school curriculum. Owing to the new programme, discussions about sex and sexual health has become easier among Cambodian families.

In addition to the curriculum, the National Strategy for SRH in Cambodia (2006-2010) also provides a comprehensive framework which calls for the advocacy of SRH priorities, as well as engagement with CSOs, especially those who are working for adolescent SRHR such as RHAC, KHANA, and Inthanou, as well as provincial health departments in annual planning and necessary mobilisation of resources for effective action and implementation. Alongside the National Strategy, the National Guideline on SRH Services for Young People was developed in 2007 to serve as reference for young people in local communities to access health centers and services.

Nevertheless, there are still existing gaps between national strategies/policies and field implementation, especially on the finalisation of the sexuality education curriculum for young people, as well as the accessibility of youth-friendly health services among youth. Despite the recognition of the rights of young people in accessing reproductive health information and the wide acknowledgement of services in the population policy that support the national strategy on SRH, there has not been much attention given to the issues at the community level[6]. There is, in general, a lack of mass understanding of SRHR information and services, especially in its linkages with the improvement of health and socio-economic development[7].

Many young people, particularly young men, are engaging in high-risk sexual behavior with little knowledge of the associated risks[8]. The adolescent birth rate in Cambodia was almost stagnant at approximately 52.3 per 1,000 live births between 1998 and 2005, and in 2010, it had moderately reduced to 48 per 1,000 live births[9]. The percentage of adolescent women who have begun childbearing increases with age, ranging from 0.4% among 15 year olds to 25.5% among 19 year olds. Additionally, modern contraceptive use among young women aged 15 -19 is still low; furthermore, a decrease was observed between 2005 and 2010, from 2.5% to 1.9%. The unmet need for family planning is also high among this age group; it was estimated to be approximately 15.3% in 2010[10].

The HIV prevalence rate among young people aged 15 to 24 has increased from 0.20% in 2000 to 0.41% and 0.49% in 2005 and 2006, respectively. The HIV prevalence rate in 2005 was even higher for young women between 15 and 24 years old, which was estimated to reach 0.3%; for young men in this age group, it was estimated to be 0.1[11]. 70% of young men aged15 to19 were reported to engage in high-risk intercourse (compared to 1.2% of young women in the same age bracket) with very low levels of awareness on the risk of HIV contraction and transmission[12].

In addition, the Law on the Prevention and HIV Control article 19 indicates that HIV testing for young people under 18 years old cannot be performed without the written consent from a legal guardian. In conditions where the written consent cannot be obtained from the guardian, the HIV test can still be performed with the informed consent from the young person concerned, although this can be problematic for most of the health clinics[13,14]. Young people in Cambodia are still facing barriers in accessing and using health services and facilities, particularly those that are related to sexual and reproductive health (SRH), including sexual transmitted infection (STIs) such as HIV/AIDS[15].The needs of young people, regardless of their marital status, for SRH services are yet to be widely acknowledged, given the cultural and political sensitivities among communities, especially with regards to the sexual engagement before marriage for women[16].

[6] National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[11] National Institute of Public Health and National Institute of Statistic (December, 2006). Cambodian Demographic and Health Survey (CDHS) 2005. Measure DHS: Maryland, USA.

[12] Ministry of Women Affair (April, 2008). A Fair Share for Women: Cambodia Gender Assessment. UNDP: Cambodia.

[13] Unknown (2002).Cambodia Law on the Prevention and Control of HIV/AIDS.AIDS Data Hub: USA.

[14] IPPF ESEAOR, UNFPA, GCWA, Young Positive (2007).Research Dossier: HIV prevention for girls and young women Cambodia. IPPF Central Office: UK.

[15] Ibid.

[16] Ibid.

RHAC's Initiative on Young People's SRHR

There has been a long debate on the negative effects of the growing tourism industry, including commercial sex and women's sexual exploitation, which can lead to a higher possibility of HIV/AIDS spread. The WHRAP-SEA project was initiated in Siem Reap in early 2010 as a response to the restricted access of young people to health clinics in this area and its nature as one of the most visited tourist destination in Cambodia. This could also account for the large number of people with high risk of contracting HIV and other STIs, such as young entertainers, men who have sex with men, and sex workers. The HIV and STI prevalence rate among the entertainment establishment-based sex workers (direct sex workers) in various sites in Siem Reap in 2006 was 20.4% and 20.2%[17], respectively, which were considerably high compared to the rates at other provinces.

Moreover, the Cambodian Demographic and Health Survey (CDHS) data in 2010 shows that the Mondulkiri province recorded the highest birth rate per woman (4.5) and one of the lowest median age during first birth (21.4 years)[18] compared to other provinces in Cambodia, which points to the need of widely accessible SRH information and services in the province. The understanding of men and women on prevention and transmission of HIV/AIDS in Mondulkiri was also among the lowest[19]. Further, the majority of the population in Mondulkiri consists of ethnic groups, where traditional customs that are harmful to women's sexuality and reproductive health, such as early marriage, are still widely practiced. Taking into account these important factors, Siem Reap and Mondulkiri were selected as the main target areas for the WHRAP-SEA project.

Since the start of the project, RHAC has hosted a series of advocacy activities which includes provincial open forums and capacity building activities for the local authorities on sexual rights (SR) of young people. The RHAC project staff organized various dialogue forums to provide the opportunity for young people to discuss with local authorities and health service providers, including the operational district directors and school directors, the promotion of young people's SRH and its implementation. Ultimately, the forums aimed to develop relevant action plans for all stakeholders to resolve SRHR issues among young people.

In addition to the dialogue forums, Sunday Group Discussions were conducted among Commune Committee for Women and Children (CCWC), Health Service Providers and young people to discuss issues experienced by young people. Engagement of the CCWC is very crucial as this body is the smallest local government structure that has the authority over the local community budget allocation and local policy making. These discussions enabled allocation of local community budgets to address the needs of young people in their communities. As a follow up to the forums, members of CCWC were given training on young people's SRHR issues to promote awareness, understanding and support in order to raise their involvement in addressing youth health issues in their communities.

An additional outcome from these forums was the collection of testimonies and experiences from young people in accessing health services and comprehensive sexuality education. The stories featured information and services for young people in Cambodia, including topics on the Cambodian marriage law, sexual orientation and gender identities.

To further promote the access of youth friendly services for young people in a conducive environment, at least three music concerts were held in the local communities. Local authorities joined the concert to show their support and acknowledgement of young people's SRHR. The concerts were intended to raise awareness and understanding of both government health center staff and local authorities to ensure that the quality of youth-friendly services delivery are in compliance with the national guidelines, especially to reassure that youth clients receive services without discrimination. These key messages were featured during the concerts.

The project also extended its reach to involve mass media as well. The National TV station broadcasted to its public audience in Cambodia the main activities of the project which included highlights of the dialogue forums, social events and music concerts.

[17] HIV and AIDS Data Hub for Asia-Pacific: Evidence to Action (2010). Sex Work & HIV in Cambodia. August 2010.

[18] National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[19] Ibid.

As a check and balance mechanism for reviewing progress of the project activities, a quarterly meeting with CCWC, Health Service Providers and young people who have been involved in the activities were conducted. The quarterly meetings were intended to uncover and understand the challenges in implementation of the project and to come up with recommendations to address these in the next quarter.

Lack of Access to Youth-Friendly Health and Information Services in Siem Reap and Mondulkiri- Some Findings

At least 30 testimonies from young people with or without access to youth-friendly health clinics and information were collected from the project sites. The stories were collected and analysed to further understand the factors that enabled and restricted young people's access to services and information. RHAC then utilised this analysis to develop key advocacy messages to advance young people's SRHR through accessible youth friendly health services and implementation of comprehensive sexuality education. With these initiatives in place, RHAC envisions that the issues of young people's SRHR can be raised in open forums of local and national stakeholders to improve young people's SRH and access for better health care. Some of the issues that were associated with the access of health services and comprehensive sexuality education include:

1. Lack of accessibility to reproductive health services due to (cultural) norms, poverty, and education level of the young people and their parents.
2. Realisation of young people's rights especially their SRHR, in the context of provision of health services and comprehensive sexuality education that are accessible for young people.

1. Accessibility to Reproductive Health Services

a. (Cultural) Norms

According to the testimonies collected from young people in Siem Reap and Mondulkiri, access to health care services is among the main challenges in realising young people's SRHR, especially for young women in the remote areas of Cambodia. The knowledge and information on reproductive health (RH) are limited -or even restricted- for young women[20]. The current cultural practices in Cambodia restrict discussion on 'sensitive issues', such as SRHR, within the family and societal context. It adds to the barriers for young women to access RH services at health facilities, both public and private owned, as they feel embarrassed or shy to consult on their sexuality and reproductive health issues with other people, including the counselors[21]. Below are some of the stories collected in the project:

"Ms. Hea Sarorng, 18 years old, because of her shyness, she never discussed her sexual and reproductive health with her sister or parents. Even when she missed her menstruation cycle for almost a year, she never sought treatment or discussion with RH counselors at the health center".

"Because of the norms in society, it is not only illiterate youth who find it difficult to access health consultancy, but literate young people also find themselves unable to express freely about his/her reproductive health issues with friends or family. This happened to Ms. Chhayyung, age 20. In grade 12, her menstruation cycle was not regular. However, as a young female, shyness and pressure from cultural norms prevented her from discussing reproductive health issues with her mother or her friends, until RHAC's WHRAP-SEA staff reached her and provided her with counseling on the risks of this problem, as well as information on youth-friendly services and young people's rights. It is only after that was she convinced to go to the health center near her house".

[20] IPPF ESEAOR, UNFPA, GCWA, Young Positive (2007).Research Dossier: HIV prevention for girls and young women Cambodia. IPPF Central Office: UK.

[21] Ibid.

"Having sexual intercourse before marriage is taboo in Cambodia, but at the same time, Cambodian young people are heavily influenced by the western culture in which free sex is commonly accepted. In Cambodia, having sexual intercourse when a person is still at school is not appropriate. Ms. Sophal, grade 12, had sex with her partner. She found out later that she had some problems with her reproductive health, but she did not have the courage to discuss this issue openly with other people because she concerned that people will insult her".

b. Access to Financial Resources and Poverty Issues

Cambodia still remains as one of the poorest and the least developed countries in Asia. It is estimated that approximately 28% of the total population in the country lives below the poverty line[22], with a poverty rate of 19.8% in 2011[23]. Poverty has been identified as one of the factors that contribute to the limited access of its people to health services[24].

Apart from paying direct costs for health services, they also need to allocate resources for other associated costs such as the costs for transportation to health centers and hospitals, and expenses on food[25].The average health care costs, inclusive of transport, for first treatment in public health facilities are reported to reach as high as $35.45.The cost varies across provinces; in Siem Reap and Mondulkiri the average cost is approximately $24.43 and $33.20 respectively. It is also worth noting that the total health care cost rises with the patient's age, from $9.04 for children 0 - 9 years old, to $42.28 for people aged 20 - 39[26]. For a country with over a quarter of its population still living under PPP $1[27], this could be problematic. As a result, instead of visiting the health facilities, people prefer to go to Khmer traditional healers in their villages, which are less costly. The following stories of young people that were collected in the project explicitly show their difficulties in accessing health services due to financial constraints:

"Ms. Kheoun Sinat, 22 years old, is a farmer. She dropped out of school at grade 5 due to her poor living conditions. Sinat has been suffering from some RH issues for many years. She could not afford access to the health center. Instead she turned to a traditional healer for treatment".

"Ms. Sek Veasna, currently 19 years old, has 8 siblings in her family. Because of poverty and debts that her family had to pay, she dropped out of school and immigrated to Thailand to find a job, where she got married at the age of 16. After she got married, she always complained of having vaginal discharge and feeling itchy. She did not seek treatment because she could not afford to pay for transportation, health care services, and food, etc. She never disclosed this problem, not even to her husband".

"Ms. Sinath, 22 years old, has been living with her old grandmother since she was born because both her parents had passed away. She decided to stop going to school when she was in grade 5 and became the breadwinner for the family. She always felt sick. She did not have a regular menstrual cycle and sometimes she even missed it for a few months. She earned income day by day by doing farm work, which makes it difficult for her to pay for health treatment at the clinic or hospital. After getting information from WHRAP-SEA's project about youth health services at the health center, she started attending the center which is located near her house".

Responding to this, RHAC, under the WHRAP-SEA project, has been proactive in providing information on youth-friendly services that are accessible and affordable at the health centers. This is to make sure that young people who experienced similar issues are equipped with the right understanding and correct information on sexuality and reproductive health. By the end of 2012 (from April to December 2012), the project had reached 3,317 young people who live in poverty and did not have access to youth-friendly SRHR services in 24 villages in Mondulkiri. From statistical data, it was also revealed that more young people had access to target health centers (HCs) where staff have been trained on SRH youth-friendly services (a total of 1,133 youth clients). In addition, during the implementation period, the SRHR activities were

[22]National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[23]UNDP Country Profile: Cambodia. Available from http://www.kh.undp.org/cambodia/en/home.html.

[24]Van Damme W, Van Leemput L, Por I, Hardeman W, Meessen B (2004). Out-of-pocket health expenditure and debt in poor households: evidence from Cambodia. US National Library of Medicine National Institutes of Health : USA.

[25]Ibid.

[26]National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[27]ASEAN Secretariat (April 2012). ASEAN Community in Figures 2011 (ACIF 2011). Jakarta, Indonesia.

incorporated into the Commune Investment Plan (CIP) of the respective catchment communes; this included sexuality and reproductive health – youth friendly services (SRH – YFS) under the Annual Operation Plan (AOP) of the Provincial Health Department (PHD)

c. Level of Education

According to the Cambodian Demographic and Health Survey (CDHS) in 2010, 48% of females and 46% of males in the household population of Cambodia have had some primary schooling. It was further estimated that 37% of this male population and only 25% of the female population attended secondary or higher schooling. Approximately three out of five men and women aged 15 -19 years in Cambodia and 57% and 48% of the male and female population, respectively, aged 20 - 24 years have attended secondary school. As estimated, a higher percentage of men and women in urban areas attend secondary schools compared to those who live in rural areas. Data on educational attainment across provinces in Cambodia varies. The outliers are Mondulkiri and Rattanakiri provinces, where 27% males and 44% of female population have never been to school[28]. The following shows how education is an important element in young people's sexual behavior in Cambodia:

"Mr. Chheum Sopheak is an out-of-school youth and a farmer. One day, he was drunk and found himself sleeping with a beer promotion girl in a guesthouse. He suspected himself of having been transmitted with HIV or other STDs. He could not convince himself to do the voluntary confidential counseling and testing (VCCT) for HIV/AIDS. After getting clear information from WRHAP-SEA project staff, he decided to get the VCCT test done."

"Ms. Heasarong, 18 years old, never attended school. She is poor at basic knowledge on personal hygiene during menstruation. Sometimes she became seriously ill and her menstruation was never on a regular basis. Her mother also was illiterate and did not know how to help her. However she tried to seek for information on how to treat her health from her neighbors. WHRAP-SEA staff managed to meet with her and introduce her to the youth-friendly services to get more information on reproductive health at the health center".

[28]National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA.

[29]Ministry of Education, Youth and Sports (MOEYS) of Cambodia. Available from: http://www.moeys.gov.kh/en.

[30]National Institute of Statistic and Ministry of Health of Cambodia (September, 2011). Cambodian Demographic and Health Survey (CDHS) 2010. Measure DHS: Maryland, USA

2. Utilization of Human Rights Principles

a. Right to Education

In Cambodia, formal education starts from pre-school (3 years) and continues to primary school (6 years), lower secondary school (3 years), and upper secondary school (3 years), after which there is tertiary education (4-7 years). The new constitution sets nine years of compulsory education from primary school to secondary school for all its citizens. Non-formal education is also available as an alternative tool primarily to provide children, youth, adults, poor people and those with disabilities who have not been able to pursue formal schooling, with basic education and lifelong learning, as well as access to life skills. The government of Cambodia through its Education Strategic Plan (ESP) 2009-2013 has been expanding its efforts to realize the National Education For All (EFA) Plan by 2015[29].

Alongside wealth, education affects fertility. Women with secondary or higher education have fewer children than women with no education. The poorest women have more than twice as many children as the wealthiest. Further, women with secondary and higher education begin childbearing at a later age than those who do not attend school and those who complete only a primary education. Unmet need for family planning is also especially high among women in the lowest wealth quintile and among women with a primary education or no schooling[30]. This shows how education and understanding of SRH are actually interrelated and affect each other. By viewing education as a human right that needs to be acquired by each individual, we have taken one step ahead in promoting understanding and awareness of young people on SRH.

Following are some of the experiences collated in the project on the impact of education level of young people and their family member on the awareness on reproductive health issues:

"Ms. Tann Maluon, 23 years old, stopped studying in school at grade 7. She then got married when she was 18. Because of her poor knowledge on reproductive health, she has been having problems with her fertility, and serious issues in relation to her sexual and reproductive health."

"Because of her poor living condition, Ms. Sophon, 19 years old, stopped her studies at grade 5, and turned to help her parents to earn their income by farming. At this age, she has not had her menstruation yet. Her parents ignored her health problem. Her parents never cared about her education and her health situation. Ms. Sophon hesitated to discuss this health issue with other people because she felt ashamed being a young girl talking about this issue. Until now she had not discussed this issue with any doctor yet".

b. Right to SRHR Knowledge

Lack of knowledge about assistant schemes, beliefs and socio-cultural practices are among the barriers to access health care and services[31]. Acquiring comprehensive knowledge about SRHR-related services and care is an important step towards gaining better access to and utilization of high quality RH treatment and services in a timely and effective manner. Young people who have adequate information and knowledge about RH have a better chance of avoiding risky sexual behavior.

[31]WHO, Ministry of Health Cambodia (2012). Health Service Delivery Profile: Cambodia. WHO: Cambodia.

"Ms. Peuychealing, 16 years old, grew up in a poor family. She has no mother to inform her about her reproductive health and hygiene. As a result, she developed vaginal discharge and felt itchy. She hid this problem for a few years as her father and other family members were strict in this regards. She finally met RHAC's WRHAP-SEA staff who explained to her about the impact of this problem, provided information on young people's rights to SRHR knowledge, and recommended her to get youth-friendly services at health centers. It was after that that she became more aware of her health problem and began seeking treatment at the health center".

"Ms. Top Savy, 20 years old, did not have her menstruation. She tried telling her mother about this issue; however, her mother ignored her and did not bring her to clinics or hospitals to get any treatment. Her mother thought it was normal for women and that it was not necessary to spend money on health".

Conclusion and Recommendations

In the South-East Asian region, Cambodia remains a least developing country with a high proportion of young people (almost 60% of the population is aged below 30). Despite its economic growth post the 2009 global economic crisis, its young people are facing social development challenges, particularly in the context of health and education. Many young people in the project areas of Siem Reap and Mondulkiri are confronted with obstacles in accessing limited youth-friendly health services. Several factors have been identified to have contributed to these barriers including culturally-restrictive norms, poverty, and low level of education of young people and their parents, especially among minorities.

While policies and guidelines have been put in place to address the issues, resources and efforts still need to be incorporated in order to maximise its implementations for the greater interests of the people. Specifically on the SRHR issues, the 2007 National Guideline for SRH youth-friendly services and the existing structure of Commune Committee for Women and Children (CCWC) need to be fully implemented by the relevant government institutions and authorities, and they have to be accountable to provide free and equitable access to youth-friendly health services and comprehensive sexuality education for young people.

Key recommendations for further follow-up include:

- Involvement of local stakeholders, such as CCWC, is crucial in making the project initiatives more impactful and sustainable. This would allow the community to have ownership of the agenda of advancing young people's SRHR and to allocate local budget to conduct follow up activities.
- Programmes and policies on SRHR in future need to be oriented to address the gaps. Young women in the project areas of Siem Reap and Mondulkiri are disproportionally more restricted in terms of having access to health services and information.
- Implementation of the 2007 National Guideline for SRH needs to be scaled up to fully advance young people's SRHR. CSOs, communities, youth-led organizations and young people themselves need to be proactive in making an appeal for the government in addressing young people's access to health services and information through this guideline.
- Movement building to advance youth-led organisations needs to be increased. This will contribute to the improvement of advocacy efforts in demanding for the government to be actively responsible in implementing the 2007 National Guideline on SRH as well as the relevant CCWC local policy and budget.
- The effort to advance young people's SRHR needs to be integrated with poverty alleviation programme by the government and CSOs as it contributes greatly to the access for services and information on SRHR among young people in Siem Reap and Mondulkiri.

III

China- Advocating Sexual Health and Capabilities Building on HIV-AIDS Response Among Ethnic Youth in Yunnan Border Areas

Yunnan Health and Development Research Association (YHDRA)

Abstract

This paper outlines the findings of a Knowledge, Attitudes and Practices (KAP) study with the ethnic minority youth community in the Yunnan province of China. Using a mixed methodology approach, one hundred youth respondents wereinterviewed through a survey questionnaire. The purpose of the study was to learn about youth sexual health knowledge and awareness as well as perceptions about safe sex and protective ability with a specific focus on HIV-AIDS. The findings from the survey were supplemented and triangulated through qualitative interviews with a small subset of youth and focus group discussions with key informants. Data suggests that there are significant misperceptions about HIV-AIDS transmission among young people. This includes perceptions that HIV-AIDS is transmitted by mosquitoes; only drug users can get HIV-AIDS; as well as ethnocentric assumptions that HIV-AIDS is spread by 'Burmese wives' not local people. Additionally it is important to note that 61% of respondents from the survey could not list any of the symptoms of STIs. Transmission from sex workers is also a source of concern as participants reported low condom usage. There was also limited knowledge on condom dual protection utility. Almost 93% of students interviewed did not know about dual protection and none of the unemployed youth knew about this function of the condom either. Although awareness about abortion services was high, qualitative interviews revealed that unmarried youth who live with their parents tend not to access public services due to fear of stigma. The findings of this study point to the need for a tailored intervention for improving knowledge and protection skills for young people living in these communities in the Yunnan province of China.

Context

Yunnan Province is located in China's south-western frontier, which is home to over 15minority ethnic groups, some of the most diverse groups in China.[1] At present, these minority populations are distributed along the mountainareas of Laos, Burma and Vietnam, as well as with other provinces bordering the area.Due to the location, history and political economy of Yunnan, the minority populations have not had equal access to social development opportunities.[2] This has led to an unequal distribution of education and economic resources. Additionally as gender inequalities have continued in these communities'; early marriages and early pregnancies in these groups are common. The existing "sexual culture", is believed to lead to youth from minority communities having less opportunity to receive comprehensive sexuality education and related health services compared to the general population.[3]

Objectives of the Study

YHDRA designed this study to learn about the basic sexual health knowledge and awareness and protective ability of youth from minority communities in the border areas of Yunnan province as well as to learn about the knowledge, attitude and understanding of HIV-AIDS of youth from these minority communities.

[1]Huang, Z. (2009).Ethnical Minority Research in Yunnan, School of Humanities, Yunnan University, China.

[2]'The Main Barrier on Economic and Social Development in Cross-Border Area of Yunnan' found at http://wenku.baidu.com/view/ff6c970c4a7302768e993999.html

[3]N-Spain MDG Achievement Fund.(2009). China Culture and Development Partnership Framework, Impact of Cultural Traditions to Maternal and Children's Healthcare. Spain.

Methodology

This is a mixed methods study using both qualitative and quantitative techniques. A structured survey questionnaire investigation was used as the primary form of data collection supplemented with individual in-depth interviews and focus group discussions.

i. Structured Questionnaire
The structured questionnaire survey involved 100 youth respondents aged 14-30 years. According to the definition of the WHO, the age of youth is from 14 to 25 years old. The project had planned to interview the respondents in this age range. However, the project team learnt that the local respondents defined the youth age from 14 to 30 and as such people in this age group were invited to events organised by the youth groups. In order to respect the local customs and traditions, the study expanded the age group to 14-30. All the interviewees are selected from Mangnong, Leigong, Guangpa and Yinshan in Huyu Town of RuiLi and more than 80% of the youth in the four villages were involved in the survey except for those that work in other places. Interviewees include the respondents who are in school and out of school.

ii. Individual In-Depth Interviews
Ten youth were selected as a sub set from the questionnaire respondents purposively to participate in in-depth interviews. This group included five males and five females. The interviews focused on the youth's understanding and attitudes towards sex, HIV- AIDS, condoms, drugs, the relationship between drugs and AIDS, youth sexual health knowledge, their sources of information and their needs. In-depth interviews were conducted with 14-30 years old youth respondents from Jingpo and De'ang ethnic minority communities.

iii. Focus Group Discussion
Six to eight key informants were invited to take part in a focus group discussion. They included teachers, village leaders, a family planning publicist, a head of household, a leader of the women association. The purpose of the discussion was to learn more about the communities, the economy, the condition and quality of community health services; the condition and quality of local youth's sexual health education, and their expectation of the intervention following the baseline. Demographic and health related quantitative data about the local community were collected through the discussion.

Profile of Study Area

For the purposes of this cross-sectional survey, the villages of Mangnong, Leigong, Guangpa and Yinshan in the Huyu Village Party Committee of Huyu Town in the city of RuiLi, Yunnan Province were selected. Huyu is a town in the city of RuiLi where the Dehong Jingpo ethic groups reside. The population of Huyu is 7,387 with the Jingpo as the main minority group (about 2/3 of the population), the Han constitute 27%, with the remaining 8% consist of other ethnic groups such as the Bai, Miao, Dai, Lisu, De'ang and A'chang, etc.[4]

It is an autonomous district in Yunnan Province and about 204 square kilometres.. Its north-western border is on the opposite of the Burma Mu BawangalongNanwan River. It has about 30,000 acres of cultivated land, mainly located on the mountain stream and small basin. The town is governed by four village party committees of Huyu, Nongxian, Leinong and Banling, with 28 village groups. The main industry of Huyu is agriculture with sugarcane, rice and corn as the main commercial crops.[5]

In 2008, the recorded drug taking population in Huyu was at 465 people and the current drug taking population has reduced to 140(about 2% of the village population). By the end of 2009, there were 177 persons who were recorded as being HIV positive. Since then 73 have passed away and 104 have survived.[6] According to the statistics of RuiLi, the STI prevalence in this area is rising quickly.

[4] Brief of Huyu Township, http://zh.wikipedia.org/zh/.

[5] http://baike.baidu.com/view/55927.htm

[6] Report of HIV/AIDS Epidemic Situation in 2009, submitted by HIV Prevention Office of RuiLi City, Yunnan, China

Demographic Profile of Respondents

The study group involved 100 youth aged 14-30 years. Among them were 29 youth from Mangnong Village, 13 from Leigong Village, 27 from Guangpa Village, and 31 from Yinshan Village. The group was composed of 58 males and 42 females. The average age was 22.75 years. The majority of respondents were from Jingpo and De'ang minority ethnic groups (80) and 20 were of Han origin[7].Most had received secondary education (66.33%) and four were enrolled in university (4.08%). Forty three (43) informants were registered for marriage, 47 were unmarried, and the other 10 were living with their partners. Most respondents were farmers (70%), 14 respondents were students, and 9 work in another other city (they were visiting family during the survey).

Findings

Knowledge of Sexual Health

- **Knowledge of sexual transmitted infections (STIs)**
  Among the 100 youth respondents, 13 had never heard ofSTIs, and none could list all common symptoms. Only 39 mentioned that they could list some symptoms, and the remaining 61 did not know any symptoms at all. Variables were analysed by the study team (gender, age, nationality, education and marital status) and found youth at different ages have different cognition of STIs, and the difference is meaningful P<0.05). We found that those younger than 18 were generally less informed. And there was no distinct difference between different gender, ethnicity, educational status and marital status in terms of their cognition of STIs and their symptoms.

	n	%
Heard about STIs		
Yes	87	87
No	13	13
Symptoms of STIs	39	
Stomachache	7	8.05
Abnormal secretion from genitals	12	13.79
Smelly secretion	10	11.49
Thermalgia when urinating	5	5.75
Ulcer/pain in genitals	22	25.29
Lump on inguinal region	4	4.6
Pruritus	17	19.54
Others	4	4.6

- **Knowledge of emergency contraceptive pill**
  Among all the respondents, only half of them (about 56) had heard aboutthe emergency contraceptive pill and 11 could tell when it needs to be taken. Gender was not a differentiating factor when knowledge about the pill was concerned.

- **Knowledge about HIV-AIDS**
  Although all the respondents had heard about HIV-AIDS, 16%still thought HIV-AIDS could be transmitted through a mosquito bite, 14% thought and 12% did not know if cleaning genitals after sexual acts could prevent HIV-AIDS. Forty one percent (41%) thought that respondents who look healthy would not be infected by HIV. Some also thought that HIV-AIDS can be prevented by reducing food intake. Qualitative data triangulated the finding that many youth had some knowledge about HIV-AIDS infection, but they were not quite clear about STIs and

[7]Han people are the majority population in China with over 90% of population (1.3 billion) in Li, L. (2010). History of Han Group in China, Science Press, China.

symptom of HIV-AIDS. And many respondents were not clear what the relationship between HIV-AIDS and STIs is.

One participant stated:

HIV-AIDS is kind of infected disease, it can be prevented but not be cured. It has been publicised a lot, HIV-AIDS can be prevented as long as respondents don't have sex, use the condom, and don't touch the drug user. But I want to know about STIs, what the symptoms are, and also want to know some health knowledge.

Another participant stated:

Drug users are infected by AIDS, everyone is scared, and dare not use drugs any more. The anti-drug and AIDS prevention department has come to publicise this.

Mangnong Village is the demonstration site of anti-drug and AIDS prevention in RuiLi. From 2005, two types of propaganda and three times interviews with awards about AIDS knowledge have been conducted in responsible of National Tax Bureau. So respondents had some cognition about three transmission ways of AIDS, but knew nothing about the others.

- **Awareness about Condom Usage**

Based on the survey data, 98% of the respondents had heard about condoms for men however 70% did not know about its dual protection function. There is a co-relation between education level and awareness about dual protection as92.3% of youth who have had primary education and 46 secondary educated youth did not know about the dual function of condoms. The proportion of high school and university youth who did not know about the prevention and contraceptive effects of condoms was 56.25% and 50.00% respectively. The lower the education levels the less knowledge about the dual function of condoms they had.

There was also a correlation between occupation, marital status and knowledgeabout thedual function of condoms. Among the respondents, farmers' knowledge was higher (37.14%). Knowledge of migrant workers, students, unemployed and other youth was much lower. Students (92.86%) and 78.72% of the unmarried youth did not know as well as none of the unemployed youth knew about dual function aspect of condoms either. Of married respondents, 41.86% knew the disease prevention and contraception effect of the condom, but only 2 of thecohabitants knew about this.

Many respondents were not clear about the correct way to use condoms. For example, one third of the study population did not know whether vaseline can be used as a lubricant for a condom. The assumption by the study group was that since the condom is usually used by men they would have better knowledge. However after analysing the survey data, it was found that knowledge of condoms by men was not better than women.

Attitude and Practices regarding Protective Sexual Behaviour

- **Sexual experience**

Of the 100 youth respondents, 72 % have had at least one sexual experience. This included 39 males and 33 females. The average first sexual intercourse age was 19.05, and the youngest was 12.

- **Contraception use**

Among the youth who had sexual experiences, 17 had never used contraception. Among those that had, 40 had used a condom, and most of them were unmarried. Some of the married women had used an intrauterine device or ligation.

Female 27 years-old unmarried Jingpo stated:

There are more than 90 women of childbearing age in our village. Ten women took short-acting contraceptive drug, 10 women had a ligation done, and most put intrauterine contraceptive ring. If they did not put intrauterine device or take contraceptive pills, they would use condom, about 20 respondents used it.

The unmarried respondents almost use the condom, they feel embarrassed to ask for it, I did not know whether they bought the condom or not. I would send condoms to cohabitants when I saw them. Among the respondents who would not like to use a condom, six said discomfort was a factor(8.82%), two expressed no reason.

Female, 27 yeas-old, unmarried, Jingpo stated:

I use the condom, almost every time, my husband had complained about its uncomfortable, then we used the contraceptive membrane.

Female, 21yeas old, unmarried, Jingpo stated:

The youth don't like to use condom when having sex, it is said that men don't like it, but I dare not ask the reason.

Female, 24 yeas old, unmarried, Jingpo stated:

I lived together with my boyfriend, sometimes we use condom, sometimes we use the contraceptive membrane, but I don't like using condom. . .. . .

Female, 20 years old, live together but unmarried, Jingpo stated:

My boyfriend and I both work in Jingcheng Hotel in RuiLi, we planned to get marry next year. We don't use condom, because he is very kind to me, I am his only girlfriend

In regards to where to get a condom, all respondents only knew one place, and about half of them (47 respondents) mentioned it can be gotten from the family planning service station, and other ways include hospital and family planning propagandist, etc... There were not many respondents would go to apharmacy or store to buy the condom.

Married respondents preferred to get condoms from family planning service stations or propagandists, and the unmarried respondents preferred to buy it from apharmacy or store for adults. There were 15 respondents who did not know where to get a condom from at all.

- Unintended pregnancies and abortion

  Of the total respondents, 53 had either themselves or their partners experienced pregnancy, and all the married respondents had a pregnancy experience. Of this group 60% lived together, and four were unmarried youth. For 13.95% of married respondents and 66.67% of cohabitants and half of unmarried youth the pregnancies were unintended. Abortion was opted for by 11.63% married youth, 66.67% cohabitants and 75.00% unmarried youth. All the differences above are noteworthy. Many youth said they can go to the hospital or the family planning service station to have the abortion. However qualitative data revealed that actually some youth lived with their partners and chose not to go to the hospital to seek an abortion. Additionally 10.64% of unmarried youth did not know where to get an abortion.

Female, 24 years old, unmarried, Jingpo stated:

When I was a student, my parents did not allow me to go out with boys. Then, I worked, my parents knew I was already an adult, this is inevitable, so even I lived with my boyfriend the parents did not say anything. In current society, everyone doesn't consider virginity very important anymore; there is no one so pure.

I already lived together with my boyfriend, sometimes we used condom, sometimes we used contraception membrane, I don't like to use condom, he said it doesn't matter, sometimes I felt pain when we used condom.

Sometimes I calculate the safe period, my menses is not regular, sometimes 3 days, and sometimes 5 days, I don't quite understand the safe period, I have taken emergency contraceptive pills before

but I cannot take it frequently when we live together now. I had been pregnant before, I went to the hospital, the time wasn't coherent, and the doctor told me maybe it stopped growing, I aborted it in a private clinic. The public hospital is too tough, and too many respondents there, the doctors normally don't have too much time to explain to you, so I don't like to go there.

- **The risk HIV-AIDSof infection**
  Eighty percent (80%) of the respondents thought it was impossible for them to get infected by HIV-AIDS and only six respondents indicated they may be infected by HIV-AIDS in the past year. The reason why they thought they would not beinfected is that they did not have sex outside the home. Most unmarried youth thought there was no risk of HIV-AIDS if they practiced abstinence. Ten married or cohabitated youth stated that they trusted their partner as they were loyal to them. Eight respondents though that they will not be infected as long as never touch people living with HIV. Only six respondents thought they may be infected HIV-AIDS, and there were 8% of youth who did not know whether they were at risk of being infected.

Male, 31 years old, married, DeAng stated:

I did not ask why they take ephedrine. I have no idea if they find sex workers, but they can't afford this, I heard the price was 30 Yuan for one time, spending one night was 100 Yuan. They did not like to use condom, because it was not comfortable.

I haven't gone out. I was not willing to. I haven't lived with my wife for two or three years. I also have the desire of (sex), sometimes I called her, then I went to see her, we lived together for two or three days. We sometimes use condom, sometimes we don't use it. She had a baby and fixed the contraception device. . . Now she works as a cashier in a pub, from 21 o'clock to 2, 3 in the mid-night. She is in that kind of environment and we don't live together, I don't know if she has another man. I would like to ask her to take VCT, otherwise she will blameme if she transmits the disease.

Female, 27 years old, unmarried but cohabiting, Jingpo stated:

I think we won't be infected by HIV-AIDS. I don't find another man, my husband doesn't find other person either. We both don't take drugs, so we won't be infected by the disease. The men here don't like to play outside. Before they went to the dance hall to play, now it is publicized that you can get HIV-AIDS there, they are scared, so they don't go there anymore.

Male, 20 years old, unmarried, Jingpo stated:

I have had sex, but I won't be infected by HIV-AIDS, because every time I use two condoms.

Qualitative data indicated that the local men (as opposed to those who were immigrants from Burma)normally are the ones to take initiative/role in using the condom, many men even knew there was risk but they weren't willing to use it. Most of the Burmese youth wholived in China married local villagers. These women are called "Burmese wives". Normally they are very young and know little about sexual and reproductive health. The local respondents always blame "Burmese wives" as the reason for HIV-AIDS transmission. They thought only the "Burmese wives" would have the HIV-AIDS virus since they were married to outsiders.For example one woman 24 years old, unmarried, Jingpo stated:

There is no Chinese girl who will marry Burmese. Only Burmese wives married with local respondents are here. Our village (Mangnong Village) had ten Burmese wives. But the women leader came to told us that don't touch the Burmese wives, they had HIV-AIDS. All the Burmese wives need to have the test and the drug user were forced to test. We haven't found there were infected Burmese wives in our village

Female, 27 years old, unmarried but cohabit, Jingpo stated:

As I know, there were 11 people infected in our village, and 7 died so only 4 survived. Among the 11 people, 6 were infected through drug, some were infected by drug taking husbands. Only one person was Burmese wife. She found the infection result when having pregnancy check.

I think we need to defend the Burmese wives mos. I heard (in Burma) many people use drugs, and they were promiscuous in sex. And the publicists asked us not to touch these Burmese wives.

Female, Jingpo, 37 years old, team leader of women stated:

As I know, there was one person who uses drug above 30 years old, two people died of HIV-AIDS, and now there are two infected, I've no idea about the others. Three HIV-AIDS orphans get the subsidy every month and the school also gives them subsidy.

The villagers perceived that as long as they do not marry or have relationships with "Burmese wives" they can prevent themselves from getting infected. In actuality, HIV-AIDS research for cross border marriage in the neighbouring village shows that the HIV-AIDS infection ratio of Burmese wives is 2.0% (19 respondents - n=933) whereas the HIV-AIDS infection ratio of Chinese husbands is 1.4% (11 respondents- n=769).Using statistical analysis it is clear that, there is not a big difference between these two $P>0.05$)[8]. So it was a misconception that "Burmese wives" were the source of HIV-AIDS infections.

- **Sex work and HIV transmission**

  After in-depth interviews with some youth and some local non-governmental organisations, project officials revealed that the composition of sex workers in the Burma border area varies. During the busy season, some estimated that the number could be over a thousand. The price of Burmese sex workers is cheaper than Chinese sex workers. Their main clientele are Chinese labourers with low pay and youth outside school, none of who use condoms. Respondents stated that based on their knowledge Burmese sex workers were not willing to accept the relevant tests and they lack of correct understanding of their health condition which increases the risk of HIV-AIDS transmission and infection.

Centre for Disease Control and Prevention of RuiLi City stated:

There are 500 Chinese and 100 Burmese sex workers in RuiLi with the HIV-AIDS infection ratio at 1.6% and 12.5% respectively. In the busy season, there can be more than 1000 sex workers in the city.

The Burmese sex workers are very cheap, 5-20 Yuan/time. These sex workers cannot negotiate condom use if a higher price is paid. The Chinese sex workers charge 50-100 Yuan/time.

The men from Burma and China come here to find the sex workers. The sex workers here are from all over China: Sichuan, Guizhou, and Harbin etc. Some Chinese men would go there to find the sex workers.

A Female, NGO project official stated:

Some of the Burmese sex workers came here by themselves with their experience; some were brought here by the "mother" after signing a contract with their parents. Some of the parents do not know what they do here. The boss gave the parents some money, and took them here after signing a three-month contract. So in the three months, these bosses asked them to service the clients as many as they can, and earn the money back.

Some Chinese sex workers don't use the condom. They don't use it with their boyfriends. The Burmese sex workers cannot use the condom, especially the first time of sex. They won't refuse the first client each day because they are afraid the business is not good in that day if they refuse the first client. Now the "mother" also encourages the sex workers to use the condoms.

The Chinese who have sex with the Burmese sex workers are labourers or the youth out of school. They have a common feature which is low pay which is hard earned but they give this money to sex workers. They just want to have fun (without the condom).

The Burmese sex workers don't like taking off trousers most in front of others, they feel it's not respected, so it's hard to take test for them.

There are also some sex workers who stand on the streets and some clients come there as they don't know where to find these sex workers.

[8] Peng, J., Tan, S., Jiang, T. and Zhang, K. (2010). Study of social relationship among cross-border marriages. Medicine and Society, Vol, 7.

Other Findings

- **Traditional culture's restraints on sexual relationships**
  The population in the Huyu Village is mainly of the Jingpo, De'ang and Han ethnicity and they have difference in terms of sexual culture among the various ethnic groups. Qualitative data revealed that there is conscious difference between the majority Han and the other ethnic groups. For instance, the unmarried youth have freedom to choose the partners, but they demand each other to be loyal. And there are some special ceremonies, to normalize the relationship, like the "Chang Pin Tong" ceremony of the Jingpo engagement. The relationship is fixed after the engagement, and cannot be changed. If the wife's side changes, she must return double the marital gift and if the husband's side changes, the house will be taken down. The Jingpo consider sexual acts outside of marriage a bad thing and the side (husband or wife) which changes its mind will be required to serve a punishment in the village and must organise a dinner for the village.

- **Minority youth' education level**
  According to the traditions of the Jingpo, normally youth will marry and have a baby when they are 17 or 18 yearsold. Some respondents stated that the Jingpo do not find formal education of value and consider it a financial burden. So the education level of the local youth is low.

Female, 24 years old, unmarried, Jingpo stated:
Before there were some people came to the village to distribute IEC materials but no one read it. Many people (older than 40 years old) were illiterate and so put the pamphlets aside. I think maybe it can work if they engage them in an art activity. It is a big burden for the countrymen to go to school (finish the high school) as their families cannot afford this. We cannot get a job after graduation and(getting a job) depends on personal relationships, and we don't have the relationship, so many families think it no use to go to school.

- **The organised local youth community**
  According to the interviews, there is a local special youth organisation and there are relevant male and female young people who take responsibility to organise events in the community. This youth organisation has the potential to be an important support and strength in the communities to implement relevant project activities and publicise them.

Female older than 70 years Mangnong retired cadre Jingpo stated:
In the past, the officer of mountain appointed the male youth officer --- team leader, "Mao Hu"(pronunciation), female youth officer --- vice team leader, "Chao Hu" (pronunciation) and they were tasked with being in charge of weddings or funerals, build houses and erect pillars, add thatch to roofs, etc in the village. When the men and women gathered, if they both went out privately, they would be fined. The discipline is very strict.
It lasted till nowadays, there are youth organizations, young team leaders in every village, in charge of the youth activity – dance "Mu-Nao-Zong-Ge", and manages the wedding or funerals in the village. They take some money, 30-50 Yuan each time. The money will be taken to fund the activities. By now, each village has about 300-500 Yuan.

Discussions and Recommendations

- **Eliminate the misunderstandings regarding "HIV-AIDS" by publicity and advocacy**

The anti-drug and HIV-AIDS prevention work has been carried out for many years in RuiLi city and it hasreceived good results in alternative planning and crackdown on drug transporting. [9]However, from the survey results, the local youth had some misunderstandings regarding HIV-AIDS. For example, the local respondents normally associate drugs with HIV-AIDS. During the interviews, when the study team mentioned HIV-AIDS, many youth would mention the problem of

[9]Zhang, X. and Wang, J. (2006). Epidemical Studies on HIV Infection in 12 Frontier Ports of Yunnan, Chinese Journal of Frontier Health and Quarantine, Vol.1.

drugs, and some young people thought that they would not getinfected by HIV-AIDS if they did not use drugs. They did not really understand how doing drugs would lead to HIV-AIDS transmission. They ignored the important influence of sexual activity. Furthermore, the survey data shows that many respondents were not very clear about how to prevent HIV-AIDS infection. Many believed HIV-AIDS could be transmitted via mosquito bites and that cleaning genitals after sexual life can prevent HIV-AIDS.

The study also found that most youth believed they would not become infected with HIV-AIDS. They thought this because they never went out to have sex and never touched drugs either and most female respondents believed their boyfriends or husbands were loyal to them. Most youth are not aware of the potential risks and preventative measures of HIV-AIDS. For example, in a longer term relationship (boyfriend and girlfriend, or couples), if condoms are used, it means that the couple "don't believe each other. Women also tend to give way to men in negotiating condom use.

Furthermore, the survey data shows that although there is no scientific data to support the misconception that respondents had regarding the wives from Burma being responsible for transmitting HIV-AIDS. This is not only misleading but also stigmatizes the wives from Burma.

This reinforces the need for sexual health education for local youth. It is urgent to provide complete, correct and comprehensive HIV-AIDS relevant knowledge and information andraise awareness for self-protection. For the WHRAP-SEA project, the publicity of HIV-AIDS knowledge should pay more attention to social and cultural factors. Reinforce knowledge about sexually transmitted diseases

The results of the survey revealed that the youth in the study areas lacked knowledge about STIs. Many youth said they never heard of STIs and knew nothing about the symptoms of STIs. In the interviews, many youths thought all STIs were the same as HIV-AIDS. They did not quite understand that there are other sexually transmitted diseases nor did they know their symptoms.

Consequently information on awareness about STI prevention is a significant gap that needs to be addressed. Additionally some youth expressed that if they found their partners to have a STI, they would not have sex with them. Some youth were not sure if they must use a condom in such cases. Hence local youth are at high risk of infection due to lack of information. The results from this study alloworganisationsto plan for the future intervention activities from a community needs based perspective.

• **Promoting condom use**

During the survey, the study team found that the local sex workers had a ratio of HIV-AIDS infection. There are differences between Chinese and Burmese sex workers in terms of the HIV-AIDS infection status. The local labourers and youth outside school contact sex workers and because of their cultural background, superstition, and lack of knowledge on safe sexual behaviour, many sex workers did not use condoms.

In the survey, many youth said they never used condoms because they did not like them, they were not comfortable, or they took other means of contraception. The youth had a lot of misconceptions regarding how to use condoms correctly. There were many youth who did not understand the dual effect of condom. There were differences among youth with different education levels, professions, and marital status on knowledge about the dual effect of condom.

Issues in relation to why local youths had some misunderstandings about condom use are due to not having awareness of HIV-AIDS prevention and safe sexual behaviour concepts. This study points out that in order to increase awareness in youths, a series of actions need to be taken keeping the local contexts in mind. Actions that promote correct knowledge on condom functions and use, correct concepts of safe sexual behaviour and promotion of youth self-protection need to be undertaken widely in the communities.

• **Strengthening awareness of relevant knowledge to prevent unintended pregnancies**

From the questionnaire survey, the study team found the average age for first sexual intercourse was very young. Among the 100 community youth interviewed, the minimum age for first sexual intercourse was 12 years old and the maximum age was 26 years old. And from the survey, some youth engaged in sexual behaviour before marriage and they would not marry the sexual partner.

On the issues of sexual health knowledge, especially emergency contraception pills and its effective time, only 56 youth had heard of this, and only 11 respondents knew the correct effective time for the pills. Some youth lacked the correct knowledge and understanding of contraception and some respondents said they had never taken any contraception measure. Some respondents mentioned that if they or their girlfriends became unintentionally pregnant, they would opt for an abortion. Throughmany youth indicated that they should go to the normal public hospital or family planning service station to have the abortion, but after the interviews, the study team found that youth preferred to go to private clinics for the procedure.

As the age for first sexual experience can be considered early, many youths had their first sexual activity at an immature age where they lacked knowledge, information and awareness of self-protection. They knew very little about contraception, and they were not aware of the risk to the female psychogenesis and reproductive health as well as mental health.

As young people are in their early stages of their sexual development, it is imperative for projects to consider youth characteristics and sexual demand when establishing a good supportive environment to carry out sexual health education for them. Such education should have relevant information on sexual maturity, sexual puberty and living selection so that youth will have healthy attitudes and will choose actions to support them in their sexual life and health.

[10]The policy on age of marriage in Yunnan ethnic groups was enacted in 1982

• **Sensitivity to traditions and culture when implementing community interventions**

According to the findings of this study, it can be detected that the age of marriage in ethnic minority communities previously was quite early(before 18 years old). However, China's marriage law and family planning policy has shifted this trend and now the age of marriage has been delayed to 18 for females and 20 for males. [10]The study has also found out that despite this, youths from ethnic minority communities had their first sexual intercourse at an early age. Influenced by modern culture, the local youth did not value the traditions which promoted sexual behaviours based on marriage. So in this situation, it is very important to develop interventions for sexual health education that keep traditions and culture in mind.

Youth with low education levels lack relevant knowledge on sexual health and self-protection. From the survey the study team found that due to economic, cultural and other reasons, the villagers did not pay much attention to literacy. Many villagers' education level was very limited, and as such they found it difficult to grasp the relevant knowledge provided through IEC materials. This needs to be kept in mind when designing such interventions for local communities.

In future prevention and awareness raising activities, more attention needs to be paid to youth with low educational attainment who need to be taught through interesting activities. IEC materials need to be developed which are easy to comprehend and should be based on the needs of the specific communities involved and also being cognizant of the communities and local ethnic groups' cultures and traditions. Initiatives for young people in these contexts should be designed with diverse activities which should aim to engage more youth so that the influence and effect of the initiatives are widespread.

• Migrant Youth's sexual and reproductive health education

The study also found that many local youth from the study sites migrate from their communities for work. There are also some who migrate to the study sites from other places in China or Burma also for work. They find employment in construction, farming and massage industries. The migrant youth are in a period of change as well as under pressure to survive. The living environment and social relationships have changed for them. Previously they were restrained by their families. Now they have to manage by themselves. They are currently also experiencing the impact of different sources of information. They are in a sexually active period and it is very important to strengthen their sexual health education, promote safe sexual behaviour concepts and self-protection concepts.

The youth are mobile and as such awareness raising activities carried out need to go beyond their home towns. The migrant Burmese youth employed by villagers in RuiLi have communication and cultural barriers. In these cases, the projects designed should be comprehensive and taking into account all the barriers. Short trainings about HIV, STIs, safe abortion and contraception usage could be designed and implemented as part of a larger life skills-based training framework. A team of core leaders from the Burmese migrants should be created so that they can become intermediaries for their counterparts in the villages and they will be able to conduct small workshops by themselves. The youth should be encouraged to take companions to these workshops to improve their ability to deal with the sexual health risks.

For those youth that migrate away from their communities, project implementers can take the opportunity when they come home for vacations and carry out a series of awareness raising activities. Longer term relationships should be established with these youth by project implementers. Ongoing communication should be carried out perhaps by using new technology e.g. mobile phones messaging or internet social sites where information on sexual health could be provided.

Conclusion

The findings of this study indicate that initiatives designed in communities where there are ethnic groups with their distinct cultures and traditions should take into consideration the different contexts, cultures and traditions so that interventions are positively received by the communities. This study provides key evidence to support this in the situation of RuiLi City in Yunnan Province, China where interventions for the Jingpo ethnic youth will be designed keeping this in mind. The study also points out the need for community based youth friendly interventions to improve the knowledge and protection skills of youth for their SRH as well as policy advocacy in this regard and the evidence generated by this study will hopefully be relevant to the specific needs of these groups.

IV

Young People's Sexuality in Indonesia- A Study in the Cities of Indramayu, Jakarta and Padang

Yasasan Jurnal Perempuan (Women Journal's Foundation-YJP)

Abstract

As part of WHRAP-SEA's project in Indonesia, Yayasan Jurnal Perempuan (YJP) commissioned a participatory intervention study focused on young people's sexuality. This study was necessary as there is an urgent need to generate evidence to respond to the Indonesian Ministry of Education and other stakeholders, such as religious leaders, arguments against young people's access to information and education on sexuality. The study, conducted from March to December 2011, included a biopyschosocial framework to explore young people's sexuality. Themes included reproductive organs and their function, puberty, pornography, menstruation, dating, pregnancy, abortion, masturbation, sexual intercourse, STIs, and HIV-AIDS. Quantitative and qualitative methods were utilised to gather data among 415 respondents. Regarding quantitative data, 374 participants from the project areas responded to a 140 item questionnaire. In terms of the results of this study, there is evidence which showcases how young people, especially young women and girls, have limited access to information regarding their sexuality. The information that they do have access to tends to be less than comprehensive. There tends to be an overemphasis on sexual myths that are harmful to young people, especially young women and girls. These myths relate to superstitious beliefs including interpretations of what constitutes a sin and judgement in the afterlife. There are also parental restrictions on what their children are accessing. As a follow up to this study, YJP has created a curriculum on CSE that covers seven essential elements of SRHR including gender, SRH and HIV, sexual citizenship rights, pleasure, and freedom from violence, diversity and relationships. This can be used to provide information to both in schools and out of school young people. YJP suggests that governments, parents, NGOs and relevant stakeholders should utilise this context specific curriculum to support young peoples' access to information.

Context

To set the context in Indonesia, here is a poignant statement by the Government of Indonesia's Minister of Education, Muhammad Nuh in regards to the young people's sexuality:

> *"I'm probably an old person. But I see that comprehensive sexual education in schools is not necessary. . ..The issue of sex, every society will surely have a natural knowledge without having anyone to teach. So I do not agree with the wishes of a comprehensive sexual education in schools."* [1]

This statement is devastating as SRHR is an integral part of human rights. This is recognised by the Universal Declaration of Human Rights and which has been ratified by the Indonesian government as part of its constitutional law No.39 in 1999.

Currently the Ministry of Education has not implemented or designed a CSE curriculum. The Ministry of Youth and Sport has developed a national policy on youth and stated the importance of physical and mental empowerment. [2]In addition, the Ministry of Health, Family Planning,

[1]Antara News. (2011). Mendiknastidaksetujupendidikanseks. ANTARA News. Retrieved on June 9th, 2012: http://www.antaranews.com/berita/1276084937/mendiknas-tidak-setuju-pendidikan-seks-di-

[2]Government of Indonesia. (2009). Undang-Undang No. 40 tentangKepemudaan. Retrieved on November 21, 2012 on Government of Indonesia Ministry of home affairs website:

the Population Bureau and the National AIDS Commission have developed a health education curriculum on RH for young people, as well as fostering school based extracurricular clubs to implement it. [3]Nevertheless the effort was implemented only as a pilot initiative with a small scale outreach. Some concerns have arisen with the implementation of the curricula as the content has not addressed the rights of young people in making decisions regarding their sexuality.[4] The restriction of information has resulted in young people who are not aware of their SRH and unable to access youth friendly health services.[5] This is also perceived as a result of the manifestation of oppression from religious fundamentalisms on these issues.[6].

The 2000 Indonesia Health Profile data indicates that young people account for 31% of the national population in Indonesia[7]. Several studies on young people's issues have conducted by Gajah Mada University and the results have shown arguments contrary to the Ministry of Education and Culture's statement above[8]. In particular, these studies show that information on sexuality given by the family alone is insufficient and ineffective if it is not complimented by peer coach/ sharing sessions[9]. More often, restriction of information regarding young people's sexuality within the family causes young people to access incomplete information from sources that are not always accurate.[10]

Objectives of the Study

This study is part of an intervention project for young people across the three cities by YJP. The project organises peer education sessions, training of trainers workshops especially for youth writers on SRHR issues, and advocacy dialogues with local and national stakeholders on issues of gender, SRH and HIV, sexual citizenship rights, pleasure, freedom from violence, diversity and relationships. This study attempts to show evidence that access to services and information on young people's SRHR is one of the key issues faced by young people and their significant others in the study sites.

Methodology

YJP designed the basis theorem on young people especially adolescent's SRHR by utilising a biopsychosocial approach. This approach infuses the influences from genetic, physiological, cognitive, affective, motivational, attitudinal, emotional and environmental factors as a key composite in the development of young people to addressing their SRHR needs. To get information on young people's knowledge, attitude and behaviour in regards to sexuality, the study had discussions on the reproductive organs and their functions, puberty, pornography, menstruation, dating, pregnancy, abortion, masturbation, sexual intercourse, STIs, HIV and AIDS, and the overarching question on the myths that are relevant to the issues.

Study Participants

Participants included 232 female respondents and 117 male respondents aged 15 to 19 years old (mean age 16 years). For qualitative data 41 participants (22 participants were women and 19 men) joined a three session focus group discussion in the project site areas. A triangulation process of quantitative and qualitative data was done with the involvement of youth activists that have expertise on young people's sexuality issues.

Conceptual construct

Figure 1 illustrates the three dimensions of young people's access to information and services on SRHR namely cognitive, affective and psychomotoral (behavioural) aspects. The research used a multi strategy design with mixed quantitative and qualitative data.

[3]Family Planning and Population Bureau Government of Indonesia.(2009). Panduan Pengelolaan PusatInformasi dan KonselingRemaja. Jakarta: BKKBN.

[4]UNFPA et al. (2012). Report card: HIV Prevention for Girls and Young Women. Jakarta: UNFPA. http://www.unfpa.org/hiv/docs/report-cards/indonesia_en.pdf

[5]Ibid

[6]Utomo, I. and Macdonald, P. (2009). Sexual and Reproductive Transitions of Young Indonesians in a Context of Contesting Values and Policy Inactivity. Australia National University, Australia.

[7]WHO and Indonesia Statistical Bureau. (2001). Indonesia Health Profile in the year of 2000. Jakarta: Indonesia Statistical Bureau. Indonesia.

[8]The Centre for Population and Policy Studies, Gadjah Mada University (Pusat Studi Kependudukan dan Kebijakan UGM). (2005). Seks dan Kehamilan Pranikah: Remaja Bali di Dua Dunia. Yogyakarta: UGM

[9]Ibid

[10]Ibid

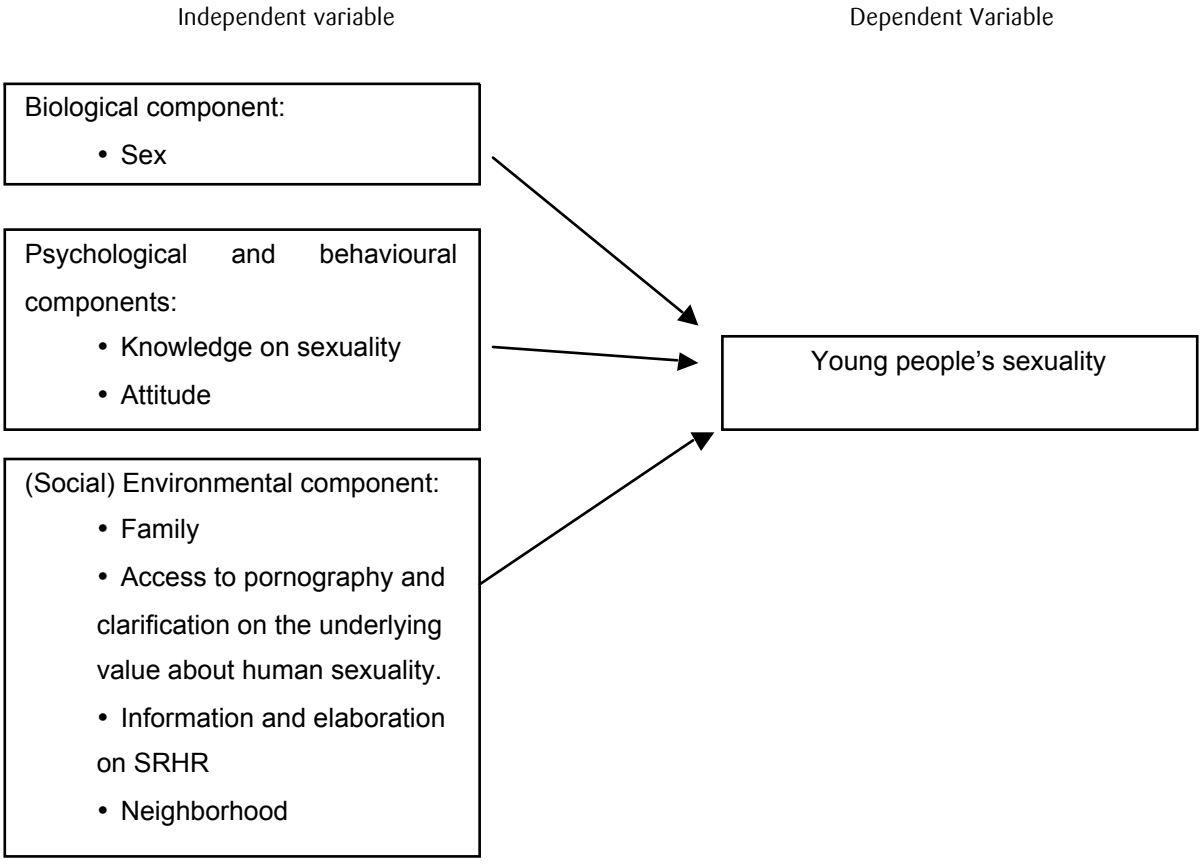


Figure 1: three dimensions of young people's access to information and services on SRHR

The qualitative data was then taken from focus group discussions and quantitative data was obtained from a questionnaire. A mixed random sampling method was used to select the participants. They were aged 16 to 24 years old and studied in public and private secondary schools (junior high, high, vocational and madrasah-Islamic schools). Three focus group discussions were organised which had 41 participants (22 women and 19 men). The discussions were guided by open ended questions on knowledge, attitude and behaviour on the issues of reproductive organs and their functions, puberty, pornography, menstruation, dating, pregnancy, abortion, masturbation, sexual intercourse, STIs, HIV and AIDS, and the overarching question, myths on sexuality as well as the source of these myths.

For quantitative data, the table below details the construct and methodologies used.

Variables	Operational Definition	Measurement Methods
Knowledge	Information known to someone about CSE such as the introduction of reproduction, puberty, sexual intercourse, contraception, masturbation, pornography, sexually transmitted infections and HIV-AIDS, pregnancy, abortion, dating, virginity, female circumcision and sexual violence.	FGD and In-depth Interview

Subjective norm	Anything that affects a person in the social environment to information on comprehensive sexuality education. This can be seen from a person's belief that there are elements in CSE.	FGD and In-depth Interview
Attitude	Actions based on the belief that as a result of a comprehensive knowledge of sexuality.	FGD and In-depth Interview

Table 1: Construct and methodologies used by the study for quantitative data.

For the questionnaire survey, the issues stated above were shaped into 140 items as seen in Table 2. From the project areas 374 participants filled the questionnaire out of which 232 were female 117 were male aged 15 to 19 years (mean age of 16 years). There was an even distribution of respondents from the three project sites. The data collected also included socio-economic factors such as parent's education level and amount of daily pocket money (to reflect the family income).

Variables	Operational Definition	Measurement Methods	Measurement Instruments	Indicators
Dependent Variables				
Adolescent sexual behaviours	Adolescent sexual behaviour arising as a result of the sexual drive from within him.	Fill in the answer choices in the questionnaire	Risky Not risky	• Kissing Starting from a brief kiss, kiss on the cheek to lip kissing with tongue play. • Petting Starting from touching the sensitive parts of the body leads to arousing sex drive. • Having sex • Once dated • I've been holding hands with boyfriend/ girlfriend • I once hugged by boyfriend/ girlfriend • ever kissed on the cheek with a boyfriend/ girlfriend • ever kissed on the cheek with my friends of the opposite sex • I've kissed the lips with boyfriend/ girlfriend • I've been kissed by my friends of the opposite sex • I had once to masturbate • I have never had sexual intercourse outside of marriage • I once read a pornographic book • I've been watching porn movies • I've been collecting pornographic images
Independent Variables				
Gender	The division of men according to type and can be viewed biologically, whether men and women.	Fill in the answer choices in the questionnaire	Men women	• Gender

Knowledge of sex and sexual	Perceptions of adolescents about sex and sexual problems that are obtained from the environment and then regarded as a thing which he believes are true.	All correct answers given a score1, while the wrong and did not know given a score 0.	The higher the score the higher knowledge.	• Comprehensive sex education • Pornography • Sex • virginity • Sexual behaviour (dating) • Masturbation • Pregnancy • Abortion • the myths on sexuality.
Attitude	Tendency to act based on beliefs about pre-marital sex.	All scores are summed between strongly agree, agree, disagree and strongly disagree.	The higher the score the more permissive the attitudes.	• Sexual behaviour (dating).
Behaviour between	Behaviour referred to as early behaviour in the stages of pre-marital sex.	All the answers Once (sometimes and often) given ascore1 and the answer Never given a score of 0.	The higher the score the more risky for having pre-marital sex.	• Sexual behaviour (dating).
Relevant factors				
Explanation of pornography	To what extent adolescents exposure to pornography from a variety of media.	All the answers Once (sometimes and often) given ascore1 and the answer Never given a score of 0.	The more higher the score the higher the exposure to pornography.	• Following • Discussing • listening
Explanation of reproductive health information	How many adolescents get information of adolescent reproductive health in schools?	All the answers Once (sometimes and often) given ascore1 and the answer Never given a score of 0.	The higher the score the higher the exposure to reproductive health information in schools.	• Environment.
Neighbourhood	Environmental influences on respondents	Every answer “yes” given a score1, while the other answerso. Answer choices: yes, no, and do not know.	The higher the score the more influential the environment against the respondents	• Sexual intercourse
Peers	Peer influence on respondents.	Every answer “yes” given a score1, while the other answerso. Answer choices: yes, no, and do not know.	The higher the score the more influential the environment against the respondents.	• Sexual intercourse

Family	Family influence on the respondents.	All the answers Once (sometimes and often) given ascore1 and the answer Never given a score of 0.	The higher the score the more support from the family.	

Table 2: Details of the survey questionnaire.

A triangulation of the data with expert review validation was done as part of the methodology. The experts were representatives from the local statistics bureau in the project site areas, school principals or executives, as well as a youth researcher from a national SRHR youth led organisation. To analyse the quantitative data, the experts used corrected item correlation in examining the validity of the questionnaire instrument set. To analyse the reliability, the experts used the Cronbach's alpha value. The hypothesis set of the study is the correlation between gender and family with the access of information on young people's sexuality as well as the correlation between access to information and affirmative behaviour on sexuality among young people.

Profile of Study Areas

For this study, three cities in Indonesia, Indramayu, Jakarta and Padang, were purposefully selected. These cities have high population densities. There is also a lack of information from the first two cities on young people's SRHR related issues. Padang has just adopted the sharia law and it has affected some of the key policies that affect young people's SRHR.[11] This includes polices such as compulsory virginity testing when going to public schools and government departments as well as obligations to wear hijab in public school and government departments.[12] Indramayu was selected based on its socio-economic profile as the second least developed area in the West Java province.[13] Lastly, Jakarta was selected as a control group due to the availability of information in the city on young people's SRHR.

[11] Radio Nederland Weredomroelp (RNW). (2010). HukumSyariah di Sumatera Barat. Jakarta: RNW.

[12] Ibid

[13] Indonesia Statistical Bureau. (2010). Social Economy Survey year of 2009. Jakarta: Indonesia Statistical Bureau, Indonesia.

Findings

In a nutshell, the study showed the validity in the premise that there are multiple factors related to the realisation of young people's sexuality. Particularly in regards to gender, type of school that young people attend; type of, how and the content of information given. Information on young people's sexuality should be delivered in a comprehensive manner to address issues such as the reproductive organs and their function, puberty, pornography, menstruation, dating, pregnancy, abortion, masturbation, sexual intercourse, STIs, and HIV-AIDS.

Access to Information and Myths on Sexuality

Each project site, given its context, has different realities regarding the access to information by young people. Social determinants such as poverty, different types of schools, as well as the access to overall information affect the accuracy of information on sexuality. Moreover, in the three project areas faulty information overshadowed the facts. Superstition, beliefs about evil spirits and consequences in the as preached in Islam; moulds beliefs on sexuality among young people especially young women and girls. Young women and girls in the study sites believed that female genital mutilation is common to 'control' their sexual desire in order to be 'good Muslims'. They also believed that evil spirits (kuntilanak) will come after them for their menstrual blood. Overall the misleading myths on sexuality support the statistical analysis that gender correlates with values and attitudes on SRHR in general, and access to information in particular ($p=0.0000$).

Accuracy and Comprehensiveness of the Information on Young People's Sexuality

The quantitative and qualitative data showcase that although young people are somewhat knowledgeable regarding their sexuality, the information is incomplete, incoherent, and not comprehensive. The knowledge of sexual intercourse, contraceptive methods, HIV and IMS, pregnancy and (access to safe) abortion is very limited. From the qualitative data, barriers in accessing information on these issues included parental restrictions as young people are considered too young to be accessing such information. According to the quantitative analysis, young women and girls had more access to accurate information whilst for young men and boys, their moral values caused some bias in believing and understanding this information (p= 0.097).

Qualitative Findings from the FGDs:

- **Knowledge**

In general, most of the respondents understood the functions of reproductive organs and mentioned that the penis and the vagina are reproductive organs. However there were several respondents that identified other parts of body as reproductive organs such as the ovum, sperm, etc...On the issue of puberty, most of the respondents obtained information through experience or believed myths. Menstruation was associated by the respondents with negative symptoms such as pain and discomfort. In addition to this the respondents believed in many myths associated with menstruation.

- Kuntilanak (women evil) will follow the women who are menstruating because kuntilanak likes blood.
- At the time of menstruation we should not scratch the skin with nails because there will be lines of the skin. In addition it should not be cutting hair and nails, because when get menstruation we should not remove the dirty from our bodies.
- If you are menstruating, you need to clean/wash the pads cleanly, because otherwise the menstrual blood will be licked by the devil.
- You may not take a nap if you are menstruating because it will cause blurred vision because the blood will rise to the head."
- At the time of menstruation you should not go to the beach and pool, you may not swim.

Male respondents said that they obtained information on 'wet dreams' from their religious leaders, at school, from the internet and friends.

- The information about wet dreams at first I got from my religious teacher (ustadz) and there are also prayers to be done at the time I had a wet dream. I was also told that if you already have wet dreams it means that I am able to impregnate a woman.
- Actually, I've got a bit explanation at school about wet dreams, but the language was difficult to understand.

In the discussion about masturbation, most of the respondents claimed that the information they received was confusing as it is mostly stated that masturbation would disturb their physical and mental health. Nevertheless most of the male respondents shared that they were masturbating, while female respondents refused to talk about this and claimed that they did not know what it was.

In general, most of the respondents knew about sexual intercourse and were able to elaborate what they knew of it in terms such as 'inserting the penis into the vagina'. The knowledge was very heteronormative. One female respondent from Indramayu said that sexual intercourse among young people is common and all respondents said information in relation to this was obtained from the internet.

In terms of contraception, condoms are best known to respondents, but most of the respondents had never seen a condom and did not know how to use them. Some did not know the function and form of condoms and other contraceptives. In addition to condoms, some respondents also mentioned birth control pills as well as implants and IUDs because they had seen their parents use them. Again information about contraceptive methods was obtained through the television and internet.

In general, respondents from the three cities knew about STIs and HIV-AIDS.

- HIV is a virus that attacks the immune system, while AIDS is a complication of all diseases.

Most of the respondents acknowledge that prevention of STIs and HIV-AIDS is done through not having sex and using sterile syringes. Regarding STIs, most of the respondents have only ever heard their names and do not know the symptoms or the causes. One male informant in Jakarta said that he learnt from watching television that t geckos can cure HIV.

Most respondents did not have sufficient information regarding pregnancies and also stated that unplanned pregnancies were common among young people. In addition, male respondents had more accurate knowledge of pregnancy (process, termination options and care) compared to female respondents. Some of them shared their experience in regards to unplanned pregnancies and were concerned that some of their friends who became pregnant were expelled from school. They did not think this was an appropriate response.

- Usually students who become pregnant have abortions rather not get caught by the school and being expelled from school.

Both male and female respondents elaborated a number of ways to abort a foetus, most of which were unsafe.

- Abortion can be done by falling on your stomach or hitting the stomach.
- Usually if women want an abortion they go to traditional birth attendants. You can also eat the young pineapple.
- Abortion with the curette.
- Abortion using drugs, massage, and can be done by drinking soda.
- Going to the doctor. The doctor usually gives some medications for abortion.

On the issue of female circumcision, most respondents mentioned that this was part of tradition, not harmful to women and needed to be done. Perceptions of female circumcision are heavily influenced by Islamic teachings.

- Female circumcision is to cover the clitoris so that women do not have passion.
- Cutting off the clitoris because if it is not cut it will grow long.
- In Indramayu, female circumcision has become a tradition-Rasulan tradition. Little girls are circumcised on the clitoris and then a thanksgiving feast is held. This is from the religion of Islam that women's lust should not be high.
- Female circumcision is to cut the umbilical cord, instead of cutting the clitoris.

Lastly, in the discussion of sexual violence respondents in Indramayu were reluctant to talk about the issue. Whilst most respondents in Jakarta and Padang shared that they knew some of their friends had experience sexual violence including rape.

- **Attitude**

Most of the female respondents reported negative attitudes towards their sexuality. For example, regarding menstruation, most of the respondents only learned about menstruation when they experienced it. Many were shocked and thought that it needed be hidden.

- Arriving at home after tutoring, I felt like urinating in my underpants. I took a bath and there was blood. I felt scared and then I told it to mother. Then mother taught me how to wear pads. Mother told me that I might not tell it to father.
- I felt ashamed because none of my friends had menstruation.
- I was afraid to tell parents, so I bought my own pads but I was wrong because what I bought was diapers. Then I also wore the pad in the wrong position.

In general, male respondents said that wet dreams were a sign of puberty in men and all male respondents in the group had reached puberty.

- The first time I had wet dreams, I did not dare tell my parents, preferring to talk to friends.
- No need to tell anyone about the first experience of having a wet dream because it is just that person who needs to know.

From the statements above, the female respondents told their mothers about their concerns in relation to menstruation and they also discussed the myths associated with menstruation. None of the male respondents knew of myths associated with wet dreams and generally found information regarding wet dreams over the internet as the term was difficult to explain.

When asked to put forward opinions about sexual intercourse, the responses varied. Most of the respondents claimed that they had never had sexual intercourse.

- In my opinion, from the Islamic view sexual intercourse before marriage is adultery.
- You should avoid having sex before marriage, because it is forbidden by the teachings of any religion and its effects can lead to transmission of HIV, pregnancy and can lead to depression.
- Having sexual intercourse at a young age can lead to many diseases, especially if the reproductive organs are not ready.
- When having sexual intercourse I rarely use condoms, because if I use condoms it feels awful, although aware of the dangers if not wearing a condom.

Both male and female respondents stated that abortion is a crime and sin as it killed a living being.

The respondent's attitude towards virginity was that virginity is important and must be maintained. Although respondents indicated they would not look down on a woman who was not a virgin, they still viewed virginity as something special. Virginity is essential and must be maintained, because it is something which gives worth to a woman.

- Virginity is very valuable, because if caught as not a virgin she will be deemed a bad girl.
- Virginity should not only be given to the husband, you could have given virginity for someone special even though he is not your husband.
- Virginity is not very important, because today's doctors can make a woman who had her hymen torn to be healed again.
- Virginity is a very important thing for a woman because men will be disappointed to find out that his bride was not a virgin anymore.

There was disagreement on a virginity tests for women and it was seen as an act of discrimination. However several respondents agreed that virginity tests were needed.

- I do not agree on virginity tests as the hymen tears not only due to sexual intercourse, bike riding can also cause tearing of the hymen.
- The virginity test actually discriminates against people who turned out not to be virgins.
- Virginity test is important because it is a way to know the students who are virgins or not. If she was not a virgin she can be expelled from school because the virus is spreading and giving the school a bad name.
- Virginity test is important to do before entering school or applying for a job, that they will not do free sex.

In terms of male virginity the respondents thought that it could not be determined.

Behaviour

Most of the respondents had been through puberty. They also occasionally masturbated (mostly male respondents). Most of the respondents accessed pornographic material as a source of information. The average age of the respondents who had sexual intercourse was around high school age, i.e. 16 and 17 years. Some respondents claimed to have had sexual intercourse with sex workers. Respondents also described activities undertaken in dating. Female respondents said their dating activity was usually just chatting and/or holding hands with their partners, whereas some male respondents indicated that they had had sexual intercourse with their girlfriend while dating.

Findings from Quantitative Data

Demographic Characteristics of respondents

This study was conducted with the participation of 374 young people in three cities, namely Indramayu (150 respondents), Jakarta (88 respondents) and Padang (136 respondents). Age of the respondents in this study ranged from 15 to 19 years. The respondents are the students of public and private high schools, and public and private vocational schools. Demographic characteristics are shown in Table 3.

Variables	Number (n=374)	Percentage (%)
Gender		
Female	232	62
Male	117	31.3
(Missing=25)		
Age		
15	9	2.4
16	49	13.1
17	31	8.3
18	12	3.2
19	2	0.5
(Missing=271)		
Types of school		
High School	111	29.7
Vocational School	117	31.3
Religion-based School/ Madrasah	96	25.7
(Missing=50)		
Allowance per day		
<Rp. 10,000,-	156	41.7
Rp. 10,000 – Rp. 25,000,-	162	46.2
Rp. 26,000 – Rp. 50,000,-	27	7.7
>Rp. 50,000,-	6	1.7
(Missing=23)		

Table 3: Demographic Characteristics

A majority of respondents in this study were young women and girls (62%). The age of the respondents ranged from age interval 15-19 years with median age of 16 years (13.1%). Respondents were largely from the vocational schools (31.3%). A total of 162 respondents (46.2%) receive an allowance per day between Rp. 10,000, - to Rp. 25,000, - (around 1 USD to 2.5 USD per day).

Test Validity

Test validity is conducted by looking at the correlation of corrected items. The Criterion of the validity test in the brief is 0.3. If the correlation is greater than 0.3, then the questions are categorized as valid. When the results of the validity of test scores of the indicators on knowledge (0.357); attitude (0.396); behavior between (0.482); family (0.395); access to pornography (0.445) and peers (0.487) have a correlation greater than 0.3, it can be concluded that the indicators are valid. As for the indicators of personal data (0.178); access to reproductive health information (0.009) and neighbourhood (0.278) have a correlation of less than 0.3, so that it can be concluded that the indicators are not valid.

Test Reliability

Test reliability is evaluated by looking at the value of Cronbach's alpha in each instrument. An indicator is said to be reliable if the Cronbach's alpha value is greater than 0.7. The results of the test reliability states that indicators of knowledge (0.723), attitude (0.778); behavior between (0.855); and access to pornography (0.839) have Cronbach's alpha value above the minimum limit of 0.70 so that it can be concluded that these indicators have good reliability. As for the indicators of personal data (0.178); family (0.559); access to reproductive health information (0.611); neighborhood (0.112) and peers (0.677) have Cronbach's alpha value below the minimum limit of 0.70, so it can be concluded that the indicators are less reliable.

Analysis of Data

- **Respondents Knowledge**

Regarding knowledge of SRH, of the 90 male respondents, only 39 respondents (43.3%) had good knowledge of SRH. Of the 188 female respondents, there are 103 respondents (54.8%) who have good knowledge of SRH. Through analysis it was found that the gender of respondents is not correlated with knowledge about reproductive health. Similarly, out of 97 respondents from vocational schools, only 42 respondents (43.3%) have good knowledge of SRH. Of the 193 respondents from high schools, there were 99 respondents (54.1%) who had good knowledge of SRH. Again through analysis, the conclusion is that the type of school is not correlated with knowledge of respondents about reproductive health.

- **Respondents Attitudes**

Domain	Attitude				p-value
	Not Permissive		Permissive		
	N	%	N	%	
Gender					
- Female	68	41.7	95	58.3	0
- Male	14	16.7	70	83.3	
Types of school					
- High School	52	30.8	117	69.2	0.433
- Vocational School	29	36.7	50	63.3	

Table 4: Data on respondents' attitudes

Table 4 shows that of 84 male respondents, 70 respondents (83.3%) have a permissive attitude towards sexuality. Of the 163 female respondents, only 95 respondents (58.3%) have

a permissive attitude towards sexuality. Analysis indicates that gender is correlated with the attitudes of the respondent towards reproductive health. It also shows that the type of school does not correlate with the attitude of respondents towards reproductive health.

- **Respondents Behaviour**

Domain	Behavior between (dating)				p-value
	Less risky		Risky		
	N	%	N	%	
Gender					
- Female	106	48.8	111	51.2	0.221
- Male	46	41.1	66	58.9	
Types of school					
- High School	106	50.7	103	49.3	0.036
- Vocational School	27	38.2	76	61.8	

Table 5: Data for respondents dating behaviour

Table 5 shows that of 112 male respondents, only 66 respondents (58.9%) are likely to have pre-marital sex. Of the 217 female respondents, there are 111 respondents (51.2%) at risk of having pre-marital sex. The table also shows that of 123 respondents from vocational school, there are 76 respondents (61.8%) who are likely to have pre-marital sex. Of the 209 respondents from high school, only 103 respondents (49.3%) are likely to of have pre-marital sex.

In terms of support from families, the data shows that out of 107 male respondents, only 60 respondents (56.1%) got support and attention from their parents regarding SRHR. Of the 214 female respondents, there were121 respondents (56.6%) who got the support and attention from their parents regarding SRHR.

Out of 110 male respondents, 85 respondents (77.3%) had access to pornography. Of the 212 female respondents, only 86 respondents (40.6%) have had access to pornography. However this significance did not translate to the type of schools that the respondents were from.

Domain	Access to Reproductive Health Information				p-value
	Never		Ever		
	N	%	N	%	
Gender					
- Female	84	38.5	134	61.5	0.098
- Male	55	48.7	58	51.3	
Types of school					
- High School	89	41.8	124	58.2	1
- Vocational School	50	41.7	70	58.3	

Table 6: Data on access to RH information by the respondents.

Table 6 shows that of 113 male respondents, only 58 respondents (51.3%) have access to RH information. Of the 218 female respondents, there were 134 respondents (61.5%) who have access to RH information. The table also shows that from the 120 respondents from vocational school, only 70 respondents (58.3%) and of the 213 respondents from high school, only124 respondents (58.2%) had access to RH information. Analysis indicated that both gender as well as type of school is not correlated with access to reproductive health information.

Domain	Access to Reproductive Health Information				p-value
	Never		Ever		
	N	%	N	%	
Knowledge					
- Low	68	50.4	67	49.6	0.002
- High	44	31.4	96	68.6	

Table 7: Data on knowledge of how to access RH information by respondents.

Table 7 outlines that of the 140 respondents with good knowledge, 96 respondents (68.6%) have access to RH information. Of 135 respondents who have poor knowledge, only 67 respondents (49.6%) had access to RH information. This indicates that knowledge around sexuality correlates with access to reproductive health information.

Limitations of this Study

The translation between the construct (definition of sexuality) into the items in the questionnaire was uneven and disproportionate. In addition, the questionnaire consisted of 140 items which proved to be a burden on the respondents. The discussion on questionnaire items might affect the validity and reliability of the quantitative data and needs to be addressed when analysing the results. In addition, the sampling of respondents was uneven in capturing the gender balance for the study. The respondents were mainly young women and girls which outnumbered young men and boys by 30%. Therefore the interpretation of the quantitative data might be affected. Specific discussions regarding the environment of the respondents while filling the questionnaire should be considered also as at some instances parents helped respondents to fill the questionnaire and some parents joined the respondents in discussions as they thought that issues under discussion were taboo and parental supervision was needed. To broaden the sample of the study, it is advisable that data collection from different areas of Indonesia especially the central and eastern part need to be done to conclude the general review of the country.

Recommendations

This is one of the first studies that examine the level of, and access to information on SRHR for young people in the Indonesian cities of Indramayu, Padang and Jakarta. While there is ample information on this for the city of Jakarta, there is not enough information for the other two cities. Despite the limitations, the study revealed that most of young people have limited information on their sexuality. Moreover the information is patchy, inaccurate and misleading.

The findings of this study can provide guidance to local government officials in the study sites for developing CSE as well as providing youth friendly services. Specifically, this study puts forward the following recommendations:

For governments:

- Young people's sexuality should be framed in an affirmative way to address the myths around it.
- The information on young people's sexuality should address all the issues in a non-judgemental way as well as ensure that the information is standardised, accurate and comprehensive. Abstinence only information is not helpful in addressing the issues of young people's sexuality.
- The channels for providing information on young people's sexuality needs to be broadened and together with schools and the formal education system, peer educators should be included. The role of peer educators needs to be recognised.
- Ultimately, the government should be accountable in providing access to information in regards to young people's sexuality in a comprehensive manner. Partnership with CSOs is important in creating the curriculum as well as ensuring youth friendly health services are available to follow up the information dissemination. Referral systems that do not place emphasis on the age of users or have a requirement for parental consent are important.

For young people:

- Young people should claim their leadership and participation rights by starting initiatives and joining current programmes on young people's SRHR led by the government and NGOs such as Pelayanan Kesehatan Peduli Remaja (youth friendly health services scheme in the public health centre led by the Ministry of Health), Pusat Informasi Konseling Kesehatan Reproduksi Remaja (peer counselling group led by the Family Planning and Population Bureau).

For parents:

- Parents need give space to young people exploring their sexuality. Restricting information on sexuality will cause more harm than good. Trust building between parents and children is necessary and the relationship between parents and children should be based on the realisation of young people's SRHR.

V

Lao PDR – Understanding the Sexual and Reproductive Health Realities and Needs of Young Akha Girls

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Abstract

Recent studies in Lao People's Democratic Republic (PDR)suggest that low knowledge of SRH, low condom usage among sexually active young people; as well as limited accessibility to adolescent SRH services have a negative impact on the sexual health of young people particularly in terms of risks in contracting STDs/STIs and HIV-AIDS[1]. An extensive literature review that has been done reveals that limited research has been conducted in the context of Lao PDR on the level of understanding of young people in tribal groups like the Akha regarding their sexual health and their healthcare service utilisation. Drawing on this need a mixed method Knowledge, Attitude and Practices (KAP) study was conducted with the Akha community from2010-2011.The findings of this study demonstrate that there is a significant gap in understanding in SRH knowledge and attitudes towards sexuality among Akha ethnic girls in Lao PDR. Additionally, context specific challenges prevent ethnic adolescent girls from seeking SRH services. Information about SRH is essential to inform preventive strategies for adolescent health in order to reduce the myths in perception of sexual behaviours in this context and the study concluded that that it is very important that efforts are made to reach out-of-school and in-school Akha youth to increase their sexual knowledge. Based on the findings and experience of this study the following programme strategies need to be implemented. These include: A national policy introducing complex sexuality education to out-of-school tribal girls. Sex education must include material that will increase knowledge about: conception, sexual development and contraception. There needs to be multiple strategies implemented to keep adolescents in schools and promote enrolment of adolescents in secondary schools and higher education.

Context

Lao PDR is a small country in the heart of the greater Mekong subregion and is classified as a least-developed country. However human development indicators for the country have been improving steadily. Lao PDR's rating has also improved in the UNDP's Gender-Related Development Index[2]. The Lao PDR is inhabited by 5.6 million people, with a high population growth rate (the most recent estimate is 2.8% per annum[3]) resulting from a high fertility rate (4.9, one of the highest in Asia[4]). The population is likely to double by the year 2025 if the current annual growth rate remains unchanged[5]. Though 80% of the population resides in rural areas, the country is rapidly urbanising: its cities and towns are growing by 4.6% per year, the second highest rate in Southeast Asia[6]. Lao PDR has a young population with 62% aged less than 24 years, and 23.7% of the population aged 10-24 years[7]. Although the population ratio favours females, gender inequality exists[8].

In Lao PDR today young people face a multiplicity of challenges regarding their SRH such as sexual violence and the breakdown of relationships[9]. HIV-AIDS is also one of the problems within young people's SRHR issues[10]. Issues related to gender and ethnicity have been highlighted, as government policies on land allocation and titling, shifting cultivation, and opium production

[1]United Nations (2009). "The Millennium Development Goals Report 2009. Statistical Annex".

[2]UNDP (2004).Human Development Report 2004. New York: Oxford University Press. United States of America.

[3]Ibid

[4]Ibid

[5]National Statistic Centre. (2006). Lao Reproductive Health Survey 2005.Vientiene: UNFPA, Laos.

[6]Ibid

[7]Ibid

[8]Ibid

[9]United Nations. (2009). "The Millennium Development Goals Report 2009.Statistical Annex". United States of America.

[10]Ibid

increasingly affect the livelihoods and practices of ethnic minority groups. In addition, ethnic minority societies in Lao PDR are dynamic and constantly changing. Rapid social change is especially evident in upland villages that are relocating closer to roads and markets or that are being amalgamated with other villages including other ethnic groups. A recent study of relocated ethnic minority villages in the provinces of Luang Namtha and Sekong found numerous changes in cultural patterns, including the adoption of lowland-style housing, dress, marriage practices, and technologies. Traditional norms and practices are also changing as young people migrate to urban centres and to Thailand to work part of the year[11].

Progress towards achieving reduction in maternal mortality appears to be slow. While national statistics report the maternal mortality ratio (MMR) to be 410 per 100,000 live births in 2005, the rate estimated by the WHO and UNICEF was 660[12]. The MDG target is to reach a MMR of 175 per 100,000 live births by 2015. The rural MMR is more than three times higher than urban ratio which points to significant disparities[13]. Only 19% of all births during 2000-06 were attended by skilled health personnel[14]. Access to emergency obstetric care was almost non-existent in rural areas, and the Lao Reproductive Health Survey reported that 9 out of 10 maternal deaths took place at home[15].

Early marriage

Marriage before the age of 18 is a reality for many young women. Early marriage and pregnancy in adolescence is the norm in Lao PDR. Marriage usually happens quickly – i.e. weeks to months after a first conversation between a boy and a girl. As a result, in both highland villages and lowland communities, many adolescent girls are married by the age of 16 or17 and start childbearing shortly thereafter[16]. According to the Lao Reproductive Health Survey (LRHS), 2005, 8.6% and 8.9% of women aged 15-24 years and 25-49 years were married by the age of 15 and by the age of 18 years about half of women aged 25-49 years were married[17]. Significant percentages of women reported first sexual intercourse by the ages 17, 19 and 21 years[18].

Contraceptive use

The contraceptive prevalence rate for currently married women is 35% for modern methods and 3.4% for traditional methods. The LRHS (2005) indicates that the percentage of usage increases with the increasing age of women up to the age group of 40-44 years old. Among unmarried youth the Lao Youth Union Adolescent Reproductive Health (LYU ARH) Survey in 2000 revealed that only 5% used any contraceptive methods of which 3.1% were condom users[19]. The use of any contraceptive methods increases by age from3%, to 6% and 12% for young adolescents (15-17), older adolescents (18-19) and youth (20-25) respectively.

STIs/HIV Knowledge

The LYU ARH Survey found that 51% respondents did not know or had not heard of STIs. Of those who did know of STIs, levels of knowledge were higher among people ages 20 to 25 than among those ages 15 to 19 years (62% versus 42%). Males were slightly more knowledgeable than females (55% versus 41%). Urban respondents were considerably more knowledgeable than their rural counterparts (69% versus 40%). Respondents with some education were more than twice as knowledgeable about STIs (52%) than those with no education (21%)[20]. Previous studies have found that youth have inaccurate knowledge about modes of HIV transmission. This includes beliefs such as: that taking medicine before intercourse and washing the genitals after intercourse provides protection against HIV[21]. Some also believe that HIV can be transmitted through contact with the sweat or saliva of an infected person and via mosquitoes[22].

Knowledge on Reproduction and Contraceptives

Many girls in peri-urban areas and in areas where the national reproductive health programme has been introduced seem to have heard about different family planning methods, mostly from women in the village who are using contraception (oral contraceptives, injectables, and to a lesser extent sterilisation). Some also know about their side-effects from relatives or from rumours that circulate in the community. However, among both married and unmarried adolescents, knowledge

[11] Alton, C. and Houmphanh, R. (2004). Service Delivery and Resettlement: Options for Development Planning (UNDP/ECHO livelihoods study). Vientiane, Laos.

[12] National Statistic Centre.(2006). Lao Reproductive Health Survey 2005.Vientiene: UNFPA, Laos.

[13] Ibid

[14] Ibid

[15] Ibid

[16] Luang Namtha Provincial Health Department. (2010). Health Statistical data.

[17] National Statistic Centre. (2006). Lao Reproductive Health Survey 2005.Vientiene: UNFPA.

[18] Lao Youth Union, Japanese Organization for International Cooperation in Family Planning and UNFPA.(2001). Adolescent Reproductive Health Survey, 2000.Vientiene: Lao Youth Union, Japanese Organization for International Cooperation in Family Planning and UNFPA.

[19] Ibid

[20] Ibid

[21] Ibid

[22] Ibid

about contraception was found to be limited or inaccurate. Some adolescents in rural areas reported that they were afraid of using birth spacing methods[23]. According to the Adolescent Reproductive Health Survey (2000)[24], 42% of young people know that condoms can prevent pregnancy and 76% knew that self-induced abortion as dangerous. About 29% of young people knew about fertility periods. Regarding the knowledge of contraceptive methods, 55.1% of youth knew of any contraceptive method and 50.4% knew about condoms[25]. The Reproductive Health Initiative for Youth in Asia (RHIYA) project[26] carried out in Laos suggested that the percentage of young people who had ever used modern contraceptives increased greatly from 57% to 73% at the endline. Similarly, the percentage use of modern contraceptives during the last instance of sexual intercourse increased from 39% to 58% at the endline. A Men's sexual behaviour study showed that only 42.1% of young men in Vientiane used condoms consistently. About 73.3% of respondents said they used a condom during their last sexual encounter with a non-regular partner. Again, married men (78.2%) reported higher use than unmarried men (72%)[27]. Contraceptive use among unmarried young people is very low. The RHIYA project showed that about 4% of young people aged 15-24 had ever used condoms and that about 51% respondents did not know or had not heard of STIs. Of those who did know of STIs, levels of knowledge were higher among people aged 20 to 25 than among those aged 15 to 19 years. The LYU ARH Survey showed that educated youth's knowledge of HIV-AIDS is comparatively high as75% of respondents had heard of AIDS[28].

Traditional Values and Attitudes / Marriage:

The major risk factors for adverse RH status among adolescents result from: cultural practices that promote early marriage and pregnancy; high risk sexual behaviour that appear more commonly than is acknowledged by the community and service providers; women's low social status in comparison to men, particularly among ethnic minorities. In some ethnic groups like the Akha, there were some rites of passage for puberty and cultural acceptance of multiple sex partners that make adolescents more at risk of STIs[29]. Cultural norms prevent parents from talking to their children about SRH. Pressing SRH concerns among ethnic minorities include early marriage, STIs/HIV-AIDS and access to SRH services for unmarried youth.

Accessibility to RH Services

Access to health services remains a key challenge, particularly in remote rural areas. Given that the highland areas are mainly inhabited by the non Lao-Tai ethno-linguistic groups and health access of these groups is limited. The difficulty in reaching a health care site was cited as a reason why many women of these groups did not seek treatment, with the highest percent of women being from the Chine-Tibet group (38%)[30]. Almost half the population in rural areas with road access and more than 70% of those living in rural areas without road access have to travel more than 10 kilometres to reach a hospital. Only a small fraction of hospitals are equipped to perform surgeries, which means that emergency obstetric care is unavailable to the vast majority of rural women in Lao PDR[31]. The provision of RH services to young people is not adequate. Young people currently have no access to RH services unless they are married and they feel embarrassed to openly discuss their sexual activities, therefore young girls are increasingly resorting to unsafe abortions, engaging in risky sexual behaviours and suffering from STIs[32].

Objectives of the Study

The objectives of this KAP study were to provide the University of Health Sciences some means to assess young people in ethnic communities knowledge of and attitudes towards SRH and to assess their RH problems. The study also aimed to analyse accessibility and utilisation of SRHR of ethnic Akha adolescents and to identify the barriers and challenges in accessing adolescents SRHR. The study also examined the sexual behaviour patterns of Akha girls and factors associated with sexual risk behaviours. The outcomes of this study will be used to develop the appropriate intervention for the Akha girls in light of the needs expressed.

[23] Ibid

[24] Ibid

[25] Ibid

[26] RHIYA is funded by the European Union (EU) and is a regional programme being implemented in seven Asian countries (Bangladesh, Cambodia, Laos, Nepal, Pakistan, Sri Lanka, and Vietnam). It is divided into two phases. Phase I was implemented from 1999 and 2002 as a baseline and Phased II took place from 2003 to 2006.

[27] Toole, M., et al. (2006). "Understanding male sexual behaviour in planning HIV prevention programmes: Lessons from Laos, a low prevalence country." Sexually Transmitted Infections, Vol. 82, pp. 135-138.

[28] Lao Youth Union/Japanese Organization for International Cooperation in Family Planning/ UNFPA (2001) Adolescent Reproductive Health Survey, 2000. Lao.

[29] Lyttleton, C., P. Cohen, H. Rattanavong, B. Thongkhamhane, and S. Sisaengrat. (2004). Watermelons, bars and trucks: dangerous intersections in Northwest Lao PDR : An ethnographic study of social change and health vulnerability along the road through Muang Sing and Muang Long. Institute for Cultural Research of Laos and Macquarie University.

[30] GRID. (2005). Lao Gender Profile.With support of the World Bank, November 2005.

[31] Ibid

[32] United Nations Population Fund (UNFPA). (2003). Available on line http://www.unfpa.org/swp/2003.

Methodology

This is exploratory study is nested in an intervention study using a combination of quantitative and qualitative research methods in order to understand the realities of young people's SRH knowledge, attitudes towards sexuality and sexual risk behaviours, their needs to CSE and accessibility to SRH services. This was across-sectional mixed methods study. It included Akha adolescent girls aged 14 to 19 years from the Sing and Long districts as study participants and was conducted from November 2010 to January 2011. The sampling frame of Aka villages and households with Akha girls was prepared and then Akha adolescent girls were identified using systematic random sampling. Face-to-face interviews were carried out by using structured questionnaires on SRH knowledge, attitudes towards premarital sex and sexuality education, sexual behaviours, reproductive health problems, and accessibility to adolescents SRH services. In-depth interviews and focus group discussions were conducted with young Akha girls and health care providers about SRH among female adolescents and the barriers of accessing SRH services among Akha girls. Descriptive and inferential statistical analysis was performed for the quantitative data and thematic analysis was used for qualitative data.

The survey instrument was adapted from a core questionnaire developed by the WHO[33], it was modified to be self-administered, to conform to cultural sentiments and to incorporate insights gained from the study's exploratory phase. The adolescent survey questionnaire comprised the following sections:

- **Background characteristics of respondents:** Sex, age, education, currently going to school,
- **Family and social group information:** Parent's marital status, education, occupation, family size, and family structure,
- **Reproductive experiences:** age of menarche, source of sexual reproductive health information, such as the experience of 'break through vagina' and 'welcome guest'. 'Break through vagina'is the first pre-pubertal sex act thought to enable sexual maturing in girls and boys. The practice of 'welcome guest' involves adolescent girls entertaining visitors to their villages by, among other things, providing sex.
- **Knowledge about reproductive health:** The adolescents were asked to assess the accuracy of three statements on reproductive physiology, namely, that a woman can become pregnant at first sexual intercourse, that a woman could fall pregnant during the first sexual intercourse, kissing/hugging does not result in pregnancy, unprotected vaginal sexual intercourse can lead to pregnancy and getting HIV-AIDS and the role of hormones in shaping the body. A summary index was devised that assigned a score of 1 for each correct response and 0 for each incorrect response, yielding a total score ranging from 0 to 1.
- **Contraceptive methods:** knowledge of information on and use of services (including questions about correct use of), and perceptions of different sources of contraceptive methods. Answers were evaluated using a 2-point scale: "yes" and "no". Correct answers were credited with a score of one and incorrect answer with a score of zero.
- **Awareness of STIs:** The young girls were asked whether they had heard of STIs and HIV-AIDS and the major sources of information related to STIs and HIV-AIDS. For STIs, they were asked about the symptoms of STIs, transmission routes, partner notification and the consequences of untreated STIs. In addition, the adolescents were asked whether seven listed symptoms indicate the presence of STIs.
- **Awareness of HIV-AIDS:** The young girls were asked whether they had heard of HIV-AIDS and what their major source of information related to HIV-AIDS was. The respondents were asked about transmission routes; whether infectious signs develop quickly; and prevention such as using female condoms, taking antibiotics, having a single partner. Responses were scored 1 if correct and 0 if not. In total, scores on the HIV-AIDS awareness range from 2 to 9.
- Respondents were asked about their opinion regarding **premarital sex** among boys and girls and the teaching of sexuality education both for in school and out of school adolescents.
- **History of sexual relationships:** Given the sensitivity of the topic, the respondents were asked about whether they had ever had sexual contact with a young woman and, if so, the number of partners they had and the type of contraceptive used. Probing or follow-up questions were asked regarding the nature of sexual experience during the last six months. This included

[33]Cleland. J., Ingham, R. and Stone, N. Asking Young People About Sexual and Reproductive Behaviours: Introduction to Illustrative Core Instruments, UNDP/ UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction: Geneva, <http://www.who.int/ reproductive-health/adolescent/ questionnaire.html>, accessed August. 25, 2011.

characteristics of sexual relationships and contraceptive methods used with the first sex partner, receiving money or material goods in exchange for sex, reasons for abstaining from sex for those who had never had sex or did not have sex in the 6 months prior to the survey.
- **Reproductive Health Problems among adolescents:** Adolescents were asked to elicit the reproductive health problems among people their own age in the form of open-ended questions.
- **Accessibility to reproductive health services:** The physical availability was measured demand, supply, infrastructure, personnel and use. The geographical accessibility includes distance and means of transport. The measurement of financial affordability entails direct and indirect costs. The acceptability was measured by asking about the characteristic of providers.

Profile of the Study Area

The study was carried out in the urban and rural areas of Luang Namtha province in the northern part of Lao PDR through the selection of a community-based sample. There are increasing transportation and communication links between these areas with other parts of Laos including the North East and East West corridor, which opens this province to neighbouring countries of Thailand and China (Yunnan) which are hot-spots for HIV-AIDS. Luang Namtha Province occupies an area of 9,325 square kilometers and has a total population of 145,231 people with 73,873 females[34]. It comprises 5 districts, 380 villages and 26,077 households and 32 ethnic minority groups. The population growth is 2.4% and the population density is 16 persons per km2. The province is mountainous, home to a large number of minorities. It is populated by a variety of different ethnic groups such as Khamu, Akha, Hmong, and Yao (Mien). Besides this, the province also consists of low land Lao, Tai Lue, Tai Neua and Tai Dam[35].

Luang Namtha province relies on agricultural and upland cultivation. This province has undergone a lot of change in terms of socio-economic development and there is increasing mobility which has aggravated the HIV-AIDS pandemic. The Luang Namtha province includes many ethnic groups and some groups have traditional sexually liberal customs which increases their vulnerability to HIV-AIDS[36].

The Akha are a Tibeto-Burman ethnic group that first appeared in Lao PDR around the mid-19th century. Akha life is characterised by a ritual and ethical code which provides them with strict guidelines on how to live their lives-this is sometimes which called the "Akha way" (Akhazang). The "Akha Way" not only includes all their traditions, ceremonies and customary law, but it also determines how they cultivate their fields, hunt animals, view and treat sickness, and the manner in which they both relate to one another and outsiders[37]. The population of Akha in Luang Namtha province is 36,531. Long and Sing districts are the target study sites as these districts are composed of different ethnic groups. This is a mountainous district west of Muang Sing that shares a 50 km-long border with Myanmar. There are over nine ethnic groups in the district and a high prevalence of poverty.

Findings

Overall, 409 female Akha adolescents participated in the study. The mean age of participants was 15.6+0.52. About 49.6% of the unmarried adolescents interviewed had had primary schooling, 14.4% had reached middle school and 2.2% had reached high school. Various project volunteers seemed to be the preferred persons for discussions about SRH information.. The study revealed a moderate level of knowledge on reproductive health, a low level on STIs/HIV-AIDS and moderate to high knowledge on contraception. 57.7% of 409 female students reported ever having sexual intercourse. Of adolescent girls who had engaged in sexual intercourse during the last six months, 70% reported having a single sexual partner and 17.5% had two partners, the most partners a respondent had was13. About 56.2% did not use condoms during the last six months prior to the interview and 46.3% did not use a condom during their most recent sexual encounter. They also practiced some sexual rites of passage such as – 'break through vagina' and 'welcome guest'. Thus, these behaviours made them more vulnerable to STIs/HIV-AIDS. Factors associated with sexually risky behaviours s included currently going to school, experience of 'welcome guest', drinking alcohol, knowledge on RH, knowledge of HIV-AIDS and attitudes

[34]Luangnamtha Provincial Health Department (2010).Health Statistical data.

[35]Ibid

[36]Ibid

[37]Viet Vision Travel. (2006). Lao travel; Laos tours-Laos adventure travel-Laos family. Available at the website: http://www.vietvisiontravel.com/Laos_travel/Laos_tours/Laos_vacations/Laos_attractions/Luang_Namtha_province/

towards sexuality. A small percentage of respondents (5.4%) reported RH problems during the last year which included pain during their menstrual cycle, unwanted pregnancies and STIs/ HIV-AIDS. Only 1.2% of the respondents reported having STIs during the past year. They lacked access to SRH services and information. The closest RH facilities were health centres. Qualitative data corroborated the quantitative findings. The main barriers of not seeking health care were affordability, financial barriers, distance, shyness and embarrassment.

A. Quantitative Data

- **Sexual Maturation and Sexual Culture**
  The mean age for menarche was 14.1+1.01 with the age of menarche of adolescents from Long district being lower than adolescents from Sing district. Almost two thirds (61.4%) of the females indicated that they experienced 'Break through vagina' and 19.3% experienced 'Welcome guest'. The age of initiating 'Break through vagina' ranged from 11 to 17 years with a mean of 13.5+1.08; while the mean age of experiencing 'Welcome guest' was 14.8+1.34 and ranged from 11 to 18 years.
- **Source of SRH Information**
  71.9% of female respondents received SRH information mostly through various project volunteers (57.5%), friends (14.6%), and schools (12.6%). A negligible proportion reported discussing the matter with parents and health personnel.
- **Parents' Characteristic**
  Most of the adolescent's parents were married (77.5%), while only 21.3% were divorced and widowed. 83.1% of their fathers and 93.6% of their mothers were alive. The majority of their fathers had no literacy (86.2%) with only 12.6% of them having primary education; while almost all mothers had no education (96.9%). The main occupation of fathers and mothers was farmers (97.9% and 97.6% respectively). Akha adolescents live in extended families with the mean family size of 7.8+7.5
- **Reproductive Health knowledge**
  Participants' knowledge of reproductive health issues varied widely, most of the girls had the knowledge that unprotected vaginal sexual intercourse can lead to pregnancies and the effect of hormones have related to sexual development. Few adolescent girls knew about when pregnancies occur in the menstrual cycle (9.3%). Some of them still had misperceptions about conception for example, 49.9% thought that girls cannot get pregnant during the first sexual intercourse.
- **Contraception**
  One quarter of the respondents were aware of contraception and this information was sourced through health volunteers or project's volunteers (44.5%), followed by friends (19.5%) and parents (15.6%). The most common contraceptive known about was condoms (88.3%) and oral pills (86.8%). Only 57.1% of the respondents discussed contraceptives with friends. There was a high rate of unprotected sexual activity among the respondents, with 90.4% of them indicating they had sex without any contraception. They got contraceptives from various project officers and health volunteers (46.9%); district hospitals (25.0%) and health centres (21.9%) depending on the convenience (68.8%). Methods of contraception that were easily accessible at the local health care facilities were condoms (90%) and oral pills (36.7%).The majority (75.0%) mentioned that there were no barriers in accessing contraceptive methods for adolescents. The main barriers to accessing contraceptives were being shy and embarrassed (18.8%), fearful (9.4%) and not knowing where to go (9.4%).
- **Sexually Transmitted Infections**
  About 81.7% of respondents had heard about STIs. The main source of information regarding STIs was through various project's volunteers (68%), friends (20.4%), medical staff (18.3%) and schools (11.7%). Very few respondents received information from parents and media. The mean score of knowledge on STIs was 7.8+1.46 with a range from 4 to 12, suggesting poor to moderate knowledge.
- **Awareness of HIV-AIDS**
  Overall, 88.8% of respondents had heard of HIV-AIDS. About half of them had obtained information about AIDS from various project's volunteers (65.7%) and friends (20.5%), while a

small proportion had heard about HIV-AIDS from medical staff (15%) and schools (10%), media and newspapers (8.9%) and parents (5.3%). The level of HIV-AIDS awareness did not differ by district. Adolescent girls aged 14-19 years old in this study had a low level of knowledge of HIV-AIDS and had a lot of misperceptions about HIV-AIDS such as: a person will not get HIV if she or he is taking antibiotics; (27.4%) or of they wash their genitals after sex; (36.8%)and a person will get HIV-AIDS by sharing a glass of water with someone that has HIV (33.5%).

- **Attitudes Towards Premarital Sex and Sexuality Education**
  About one third (65.3%) and 62.8% of respondents agreed and strongly agreed respectively that unmarried young women should not have sex; 63.6% felt that unmarried members of the opposite sex should not even form friendships. Forty-eight percent believed that young people who have premarital sex should be punished. Regarding attitudes towards sexuality education, 95.4% and 93.6% of respondents believed that it is important for sex education to be taught in schools and among out-of-school youth respectively.
- **Health Risk Behaviours**
  The study revealed that 32.5% of respondents had ever drunk alcohol during the past 30 days. Nearly half of respondents had drunk alcohol at least one day during the past 30 days. Only 1% of respondents used any illicit drugs during their lifetime. Only 3 out 4 respondents used any illicit drugs during the past 30 days.
- **Sexual Behaviour**
  Of the 409 female students, 57.7% reported ever having sexual intercourse. All respondents had vaginal sexual intercourse, while few of them had oral sex (3.4%) and anal sex (3.8%). The mean age at first sexual intercourse was 13.7+1.09. From the findings, by age 14, about 78.4% of the females had had sex. Analysis by disaggregating the data by age shows that sexual behaviour varies widely between age groups.
- **Sexual Experiences During the Last Six Months**
  Among unmarried sexually active girls, 80.4% reported having ever had sex during the last six months and almost 70% said they currently had a steady sexual partner. Of adolescent girls who had engaged in sexual intercourse during the last six months, 70% reported having a single sexual partner and 17.5% had two partners, with a broad range to 13 partners. About 56.2% did not use condoms during the last six months prior to the interview and 46.3% did not use a condom during their most recent sexual encounter. One third of respondents (35.0%) always used a condom when having sexual intercourse with their current partner at the beginning of the relationship.
- **Type of Sexual partners in the last six months**
  Among those respondents who were sexually active, the type of sexual partners included friends (78.7%), casual sex partners (40.0%), and clients (1.3%). About one third of respondents who had friends as sex partners did not use condoms. About 4.8% and 7.9% of respondents used drugs and drank respectively when they had sex with friends. The mean of casual sex partners was 1.3+.54 with a range of 1 to 3, while only 3.1% of them had more than 3 casual sex partners. Half of the respondents who had casual sex partners did not use condoms. About 6.3% of respondents used drugs and drank respectively when they had sex with casual partners.
- **Reason for Not Having Sexual Intercourse During the Last Six Months**
  The main reasons for not having sex included, being afraid to get pregnant (55.3%), being too young (34.4%), and going to school (16.1%).
- **Exposure to Sexually Transmitted Infections (STIs)**
  Only 1.2% of respondents reported having STIs during the past year which included 0.5% with ulcers or sores on the genital area, 0.5% had itching and 0.5% had vaginal discharge
- **RH Problems**
  A small percentage of respondents (5.4%) reported RH problems during the last year. Among respondents who reported having RH problems, 100% had headaches and pain during menses, and 4.6% had vaginal discharge problems.
- **Care Seeking Behaviour for RH Problems**
  About two fifths of the respondents had sought care for their genital symptoms in the last year and reported to a range of different health facilities. 66%had visited the district hospital and 11.1% had sought care from traditional healers due to convenience and confidentiality (44.4% for each). The main barriers mentioned by those who had not sought care (n=13) were normal

symptoms (53.9%), mild symptoms (30.8%), being shy (23.1%) and mistrust of health facilities and/or lack of money (7.7% for each).

- **Accessibility to RH Services**
  The majority of respondents (77.8%) reported that their houses are far away from the health facilities which provided SRH services. It ranged from 6 to 60 km with a median of 8 km. All respondents went to the closest health facilities by motorcycles.
- **Availability of RH Services**
  66%would wait for 1-10 minutes for services and 88.9% mentioned that the opening hours were appropriate for young people to attend, whereas 44.4% suggested that reproductive services should be available to all young people.
- **Financial Affordability**
  78% of respondents who used services could afford to pay for them. The payments included direct and indirect costs. The direct costs ranged from 10,000 to 300,000 Lao Kip (LAK) (1US$=8,050 LAK).
- **Acceptability of SRH Services**
  Seventy seven percent (77.8%) of respondents reported that SRH services are very useful because they got better after receiving SRH services. All respondents preferred to receive the SRH services from health care providers of the same sex.
- **Adolescents Who Did Not Have Any SRH Problems**
  Among those who did not have SRH problems, 39.9% knew about the places providing SRH services. The health facilities were cited as district hospital (57.9%) and health centre (15.1%). 70% of respondents reported that the services provided to adolescents should be friendly and three quarters of respondents cited confidentiality. About 48.1% and 48.4% of respondents mentioned that youth in the village accessed SRH information and services respectively. 76% of respondents suggested that SRH services for women should be with a minimal fee, whereas 33.1% mentioned free services for women.

B. Qualitative data

- **SRH Issues Among Adolescent Girls**
  The most common RH problem among Akha adolescent girls in Luang Namtha province was pain during their menstrual cycle. STIs were also mentioned by some adolescents as they did not know how to prevent them. The common symptoms were vaginal discharge, itching of the genitals and urinary complaints.

  Girl, 17 years old stated:
  I heard about STIs among young people in our village as they had vaginal discharge and pain during urination.

  Girl, 15 years old stated:
  My friend complained with itching and having some exanthema in the sex organs.

  The other RH problems mentioned were unwanted pregnancy among unmarried girls.

  Girl, 14 year old stated:
  One girl got pregnant; however, parents did not know until she got abdominal pain and brought her to the hospital. Then they knew that her daughter pregnant and delivered a baby. They gave the baby to the hospital as they felt shy and embarrassed in front of villagers.

  In the Akha culture, pregnancies are as a gift from God. Therefore, unwanted pregnancies lead to marriages.

  Girl, 15 year old stated:
  If the girls got pregnant without marriage, they have to keep pregnancy. If they had abortions, they will commit a sin or violate spirit of the village. Then, they have to tell the boys. If the

boys are single, they have to marry soon. If the boys or men are already married, they have to find or hire someone to marry with the girls. So, there is no abortion in the village.

Some girls did not find any solutions so their parents took them to be the minor wife of a married man and had the pregnant girls stay with the man until they delivered and left their children with him if the girls wanted to leave.

Girl, 18 years old stated:
There were three girls with unwanted pregnancies. One was the minor wife of the man in the village; two went to marry with Chinese men in China.

- **Contributing Factors to Sexually Risky Behaviours**

Attitudes towards sexuality among adolescents are a concern in the northern part of Lao PDR. Premarital sex appears to be more acceptable to both males and females in the Akha sexual culture. Most young people in the Akha culture start having sex at an earlier age and they can choose to have sex with anyone after arite of passage. Multiple sex partners are perceived as acceptable which results in more adolescents being exposed to STIs.

Girl, 15 years old stated:
I heard that one youth leader who did 'break through vagina' for the young girls had multiple sex partners. He had sex with many girls in the village and other villages as well.

It should also be noted that, Akha adolescents practice a rite of passage whereby all girls and boys enable their bodies to mature into adulthood through a first pre-pubertal sex act called the 'Break through vagina' for girls which is the first sex and they usually do not prepare for it by obtaining contraceptives.

Girl, 15 years old stated:
Girls who have 'break through vagina' do not take contraceptives as they are perceived as not having sex.

Many girls also participated in the 'Welcome guest' practice whereby visiting men to any Akha village will be entertained and served sexually by young women of the host village. This also makes them more vulnerable to STIs/HIV-AIDS.

Girl, 17 year old stated:
Welcome guest might also make girls pregnant because the Lao youth leader forced girls to sleep with guests

Female health care provider, 39 years old stated:
The sexual culture, including 'Break through vagina' and 'Welcome guest' are contributing factors to sexual risk behaviours among Akha adolescents.

The other factor is the lower use of contraception among adolescents. Poor correspondence between knowledge and use of modern contraceptives has drawn attention to adolescent's perceptions about the positive and negative aspects of modern contraceptive use. As illustrated, most adolescents in the villages do not use condoms even though they know about them. They think that using condoms is not natural.

Girl, 15 years old stated:
Adolescents did not like to use condoms as they felt not natural. The other reason was that they did not know the consequences of no condom use and they did not know that who had STIs or not

Some did not use condoms if they were lovers. They used condoms when they slept with guests (welcome guests). Some girls did not sleep with boyfriends if the boys did not use

condoms because they were afraid of getting STIs and/ or getting pregnant. Some of them felt shy and embarrassed to get condoms from village health volunteers or health centres. Some adolescents have to buy condoms from drug stores at for about 2,000LAK.

Girl, 18 years old stated:
Most adolescents felt uncomfortable to ask for condoms from village health volunteers because they asked why they need condoms, so they did not dare to get it. They felt shy to ask more than 2- 3times, so after that they had unprotected sex.

The other issue is that the lack of knowledge related to STIs. Most adolescents did not know how to prevent STIs and they did not know to use condoms.

Girl, 18 years old stated:
Adolescents did not know how to prevent themselves from contracting STIs as they lack of knowledge and they were not afraid and they did not protect themselves.

- **Health Care seeking behaviours**

However, the health seeking behaviour for these complaints remains poor and all these problems were better elicited and diagnosed during medical checkups. Most adolescent girls did not consider their problems important enough to seek care. Few said that problems subsided on their own. They felt that menstrual problems such as pain and discomfort during menses were very common for girls and they must learn to bear the pain. Thus girls only sought care when the pain was unbearable or during exams or when they had to miss school. Some of them mentioned that they were too shy to approach the public health facilities such as health centres and district hospitals.

Girl, 15 years old stated:
Most adolescents went to use health services at the health center because it is close to their house. The health center is easy and comfortable. They waited about 5 minutes and then they have been checked by the medical auxiliary nurse and this was not expensive. However, there were very few health workers at the health center. Sometimes, they did not meet any health workers.

Similarly white discharge and the itching of genitals are not taken seriously. Usually girls go to private drug stores. Some of them go to buy medicines from village health volunteers. Few of them get treated by god spirit healers. After trying these treatments, if they still did not feel better, they sought health care at the district hospitals and traditional healers or spirit healers.

Girl, 17 years old stated:
If STIs were not cured, they went to traditional healers and spirit healers by killing chickens or pig to sacrifice to the spirit god. If there is not better, they just left it.

Some adolescents have problems with unwanted pregnancies. Participants reported that they tried to buy a Chinese medicine known as cytotec to perform medical abortions. If this was not successful, they went to see Chinese doctors in China.

Girl, 18 years old stated:
Some adolescents used the Chinese abortificient drugs to get aborted.

- **Barriers Young People Face in Accessing Public Health Services for SRH Problems**

i. Lack of money

Adolescents from ethnic groups stated that they could not afford to pay for health care services if they have SRH problems.

Girl, 17 years old stated:
Adolescents do not go to hospitals if their parents do not have money. Some have relatives,

so they could borrow from relatives as there were direct and indirect expenses for using the health services.

ii. Distance to Facilities

Poor road conditions were mentioned by adolescents as one of the barriers. The other reasons cited by key informants include the location of the health facilities being far from their villages and a lack of available transport.

Girl, 17 years old stated:

We stayed far from the health centre and we have to walk from our village to the health centre for about 2 hours. There is no public transportation from our village to the city; there is only one truck in our village.

iii. Shyness and Embarrassment

Shyness was often mentioned by adolescents as Akha adolescent girls would not dare discuss their SR concerns with healthcare providers.

Girl, 17 years old stated:

Akha girls do not go to the hospital. Even if they have illness, they do not go to see health care providers. If they have a severe illness, they just buy drugs at the drugstores.

Male health care provider, 52 years old stated:

They are afraid to be seen by others, so they did not use health services at the public health facilities.

Akha adolescent girls also shared that they have difficulties in communication with health care providers, as most of them do not speak the Lao Loum language.

Girl, 18 years old stated:

Akha girls cannot speak the Lao Loum language, so they did not dare to speak with the health care providers. In addition, the health care providers could not speak their Akha dialect language, so, this makes it difficult to communicate.

iv. Perspectives of Health Workers

Lack of quality and quantity of health workers was mentioned by health care providers. Staff at the health centres did not have enough knowledge to provide RH services to adolescents as some of them are primary health care workers or paramedics and they could provide only health education on hygiene and sanitation. There were no health care providers trained to provide youth friendly services.

Male health center staff, aged 45 years old stated:

At our health center, there are only three health personnel. One is a medical assistant, two paramedics as the primary health care workers. We mainly provide basic primary care and first aid.

Female health center staff, aged 35 years old stated:

None of us have been trained in adolescent reproductive health services. We just provided family planning services to women such as pills and condom.

The basic SRH services provided to adolescents were family planning and health education on STIs/HIV-AIDS.

v. Outreach activities to adolescents

There are not enough outreach programmes for adolescents at the village level as they have problems with the poor road conditions, especially during the rainy season and a lack of transportation to do outreach services. When the outreach team went to the villages, health

education was provided separately for married and unmarried adolescents as the topics of were different.

There is no specific division responsible for adolescent RH issues and they do not have specific rooms for adolescents. Consultation rooms at the outpatient ward were used. There were very few adolescents coming to use services at the district hospital.

Female health care provider, 49 years stated:

There were about 10 adolescents coming to use services per year at our district hospital. Some adolescents having suspected symptoms of STIs asked about health care providers and we did provided treatment to them and provided counselling and asked to follow up.

Discussions

This study assessed the knowledge, attitudes and practices of SRH among Akha female adolescents and their accessibility to SRH services in their rural communities. Female adolescents in this sample reported high rates of premarital sex and risky sexual behaviours.

i. Knowledge of RH and Contraception

The results presented in this study showed a moderate level of knowledge of reproduction and moderate to high level of knowledge of contraception with some misperceptions. It is possible that many participants received some sexuality education from the various projects implemented in Luang Namtha province. However, there were some misperceptions due to a low level of education and low socio-economic status. It is difficult to compare this finding to previous studies due to the scarcity of literature on SRH among ethnic girls. Misunderstandings are also evident among young people on issues related to puberty, and fertile period. This study showed that females had more knowledge about contraceptive methods. In addition, the most heard of method is condoms (50.4%) followed by pills (36.4%), IUD (29%) and injections (28.9%)[38].

ii. Knowledge of STIs/HIV-AIDS

Data analysis demonstrate that misperceptions of STIs/HIV-AIDS and familiarity with the signs and symptoms of STIs was poor and relatively small proportions of respondents knew that likely symptoms of STIs among women. This phenomenon may be explained by inadequacy in access to sources of information accessible by Akha girls as only a small number of them had attended formal sex education in schools. This finding was in accordance with previous studies in Iran and India[39]. However, data on knowledge of STIs/HV/AIDS related to different ethnic groups is not available, highlighting the need to have valid and comparable data and also be able to develop appropriate strategies for prevention directed to relevant groups. Similar to a previous study in Nigeria, many young people harbour misconceptions such as the belief that mosquitoes can transmit HIV infection, and false claims that use of contraceptives can cause infertility[40]. The National HIV-AIDS and Reproductive Health Survey (NARHS) showed that only 7% and 44% of 15–19 year olds knew of STI symptoms in men and women respectively[41].

iii. Sexual Attitudes Towards Sexuality and Sex Education

Attitudes towards premarital sex reflect socio-cultural norms about sexuality. Akha girls had ambivalent attitudes towards premarital sex for both boys and girls; on the other hand, according to their sexual culture, Akha girls have to pass a rite of passage such as 'break through vagina' to be mature and adult as well as practice ' welcome guest'[42]. These customary practices entail an early sexual debut for girls and relatively free sexual relations among adolescent Akha of both sexes[43]. Two third of respondents experienced 'breakthrough vagina' and one fifth experienced 'welcome guest'.

Overall our respondent's attitudes towards sex education were positive. This could be explained by the fact that that they agreed more on providing sex education to young people. However, few of them agreed that discussions about sex education encourage young people to have sex. This is similar to other studies in different countries which have also found that most adolescents hold positive attitude towards sexuality education[44]. Most students and parents

[38] National Statistic Centre.(2006). Lao Reproductive Health Survey, 2005. Supported by UNFPA

[39] Mohammadi, M.R., Kazem, M.,Farideh, K.A.,Farahani, S.,Alikhani, M., Zare, F.R.,Tehrani, A. R., and Farshid, A. (2006). Reproductive Knowledge, Attitudes and Behavior Among Adolescent Males in Tehran, Iran. International Family Planning Perspectives.32(1):35-44; and Mittal, K. and Goel, M.K. (2010) Knowledge Regarding Reproductive Health among Urban Adolescent Girls of Haryana Indian J Community Med. 35(4): 529-530.

[40] Ajuwon A.J (2000). Effects of educational intervention on reproductive health knowledge, attitude and sexual behavior among secondary school students in rural Oyo state. PhD thesis of the University of Ibadan; and Amazigo. U, Silva. N, Kaufman.J. and Obikeze, D.S.(1998).Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria. Inter Fam Plan Pers. 23(1):28-33.

[41] The National HIV-AIDS and Reproductive Health Survey (NARHS)

[42] Ingebrigtsen, K. and C. Lyttleton. (2006). Investigation of alleged sexual exploitation and abuse of Akha girls and women by Norwegian Church Aid (NCA) in Laos. NORAD; and Skeldon, R. (2000). Population Mobility and HIV Vulnerability in Southeast Asia: An Assessment and Analysis. UNDP, Southeast Asia HIV and Development Project. http://siteresources.worldbank.org/INTTSR/Resources/462613-1135099994537/Mobilitypaper.pdf (accessed October 16, 2011).

[43] Lyttleton, C., P. Cohen, H. Rattanavong, B. Thongkhamhane, and S. Sisaengrat. (2004). Watermelons, bars and trucks: dangerous intersections in Northwest Lao PDR : An ethnographic study of social change and health vulnerability along the road through Muang Sing and Muang Long. Institute for Cultural Research of Laos and Macquarie University; and Sychareun, V., Faxelid, E., Thomsen, S., Somphet, V., and Popenoe, R. (2011) Customary adolescent sexual practices among the Akha of northern Lao PDR: considerations for public health. Culture, Health and Sexuality, in press.

[44] Ogunjimi, L.O. (2010). Attitude of students and parents towards the teaching of sex education in secondary schools in Cross Rivers State. Educational Research and Review Vol. 1 (9), pp. 347-349.

believed that the teaching of sex education would complement efforts being made towards the control of HIV-AIDS.

iv. Sexual Risk Behaviours

It is generally assumed in Lao society that sexual contact does not occur among unmarried adolescents. However, sexual practice varies across the country and ethnically. There has been some undocumented evidence that sexual relationships do occur freely among some ethnic groups such as the Akha ethnicity[45]. The study findings also suggest that sexual activity among Akha adolescents takes place in a context in which premarital sex is accepted for girls and boys. A substantial majority-slightly higher than half of adolescent females aged 14–19 in this study have had premarital sex as premarital sexual contact is culturally acceptable among Akha ethnic group[46].

The sexual initiation of female Akha adolescents still occurs earlier than that of other ethnic groups. More than three quarters of Akha girls had their first sexual intercourse between 11-14 years of age. This finding is in accordance with a previous study in Lao PDR where the youngest age of first sex was 13 years and the proportion of sexually active young women increased with age[47]. Women who sexually debut at earlier ages are more likely to participate in high-risk behaviours and experience unintended pregnancy, HIV and STIs[48]. Indeed, although most respondents (72%) knew about condoms, many had misconceptions that could well discourage regular condom use. Consistent with these findings, a major source of information for adolescents on puberty and sexual matters was one that is likely to be unreliable—peers. Previous studies in Lao PDR also mention that participants lack knowledge of where to buy condoms and for women, stigma is factor inhibiting the use of protection[49]. In this study the vast majority (84.72%) of adolescents reported having used condoms in their first sexual intercourse. This study's finding was even higher than the previous study in Lao PDR which had reported that only about 3.1% of young people aged 15-24 had ever used condoms. In many parts of the country, access to condoms remains limited[50]. The study revealed high prevalence of multiple sex partners among Akha girls. Both boys and girls have multiple sex partners, while boys often reported having multiple concurrent partners, girls tended to have sequential partners[51].

v. Adolescent SRH Issues

The study findings revealed a small proportion of adolescents reported sexual and reproductive health problems which are consistent with the previous study (Barkat and Majid, 2003). The main reproductive health problem was menstrual problems, the commonest being dysmenorrhoea, early pregnancy, unwanted pregnancy and STIs/HIV-AIDS.

vi. Accessibility to SRH Information and Services

Ethnic adolescents and youth in Lao PDR are particularly vulnerable to health risks, especially in the area of reproductive health. This is due to their lack of access to information and services and societal pressure to perform as adults notwithstanding the physical, mental, and emotional changes they are undergoing. The current information and services that are available are not specific to adolescents, and the quality of such information and services is often poor or inappropriate for the age group. Information regarding puberty and sexual health, mostly gained from friends, mass media, and religious teachers, is likely to be incomplete, uninformative or obscured by religious and moral messages. As most parents still hold conservative norms, they feel uncomfortable discussing sexual issues with their teenage children. In this study, the project's volunteers followed by friends were the important sources of SRH information. This could be explained by different cultural contexts and different ethnic groups as the sample for this study is Akha ethnic girls. Availability can be measured in terms of the opportunity to access the health care as and when needed. This study also found similar common problems of limited hours, long waiting times, absentee health workers as in many parts of the developing world[52]. Young people are uncertain that services are open to all young people.

Financial access, or affordability, is now considered one of the most important determinants of access and is most directly associated with dimensions of poverty. Apart from the direct cost of treatment and informal payments, there are also indirect costs that discourage the poor

[45] Lyttleton, C., P. Cohen, H. Rattanavong, B. Thongkhamhane, and S. Sisaengrat. (2004). Watermelons, bars and trucks: dangerous intersections in Northwest Lao PDR : An ethnographic study of social change and health vulnerability along the road through Muang Sing and Muang Long. Institute for Cultural Research of Laos and Macquarie University; and Sychareun, V., Faxelid, E., Thomsen, S., Somphet, V., and Popenoe, R. (2011) Customary adolescent sexual practices among the Akha of northern Lao PDR: considerations for public health. Culture, Health and Sexuality, in press.

[46] Lyttleton, C., P. Cohen, H. Rattanavong, B. Thongkhamhane, and S. Sisaengrat. (2004). Watermelons, bars and trucks: dangerous intersections in Northwest Lao PDR : An ethnographic study of social change and health vulnerability along the road through Muang Sing and Muang Long. Institute for Cultural Research of Laos and Macquarie University.

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[48] Pettifor. A.E., Straten, A., Dunbar, M.S., Shiboski,S.C.,andPadian, N.S.(2004). Early age of first sex: a risk factorfor HIV infection among women in Zimbabwe. Aids, 18:1435-1442; Mardh, P.A., Creatsas, G., Guaschino, S., Hellberg, D., and Henry-Suchet, J. (2000). Correlation between an early sexual debut, and reproductive health and behavioral factors: a multinational European study. Eur J ContraceptReprod Health Care, 5:177-182; and Mnyika, K.S., Klepp, K.I., Kvale, G., and Ole-Kingori, N.(1997).Determinants of high-risk sexual behaviour andcondom use among adults in the Arusha region, Tanzania. Int J STD AIDS, 8:176-183.

[49] Butler, R. and Bannavong, S.(2001). Women and Barriers to Condom use in the Lao PDR:Developing a research led Behavior Change Communication" ICAAP Abstract 0612.

[50] Sisouphanthong, B., et al. (2000). Report of the adolescent reproductive health survey. Vientiane.

[51] Sychareun, V., Faxelid, E., Thomsen, S., Somphet, V., and Popenoe, R. (2011) Customary adolescent sexual practices among the Akha of northern Lao PDR: considerations for public health.Culture, Health and Sexuality, in press.

[52] Chaudhury, N. &Hammer, J.S. (2004). Ghost doctors: absenteeism in rural Bangladeshi health facilities. World Bank Econ. Rev. 3: 423-441; Hanson, K. et al. (2003). Expanding access to health interventions: a framework for understanding the constraints to scaling up. J. Int. Dev. 1: 1-14; and Mendis, S. et al. (2007). The availability and affordability of selected essential medicines for chronic diseases in six lowand middle-income countries. Bull. WHO.85: 279-288.

from seeking treatment. These indirect costs include the opportunity cost of time of both for the patient and those accompanying him or her, transportation costs, and expenses on food. There is increasing focus not only on these financial barriers to accessing care but also on the economic consequences of paying for health services[53].

Acceptability is another dimension of quality of care. There has been relatively little research on the concept of acceptability in health services in less developed countries or on how the acceptability of health services are related to poor or vulnerable groups. Most patients will consult with different types of providers, especially for young people, they would like to consult with the same sex providers.

vii. Factors Associated with Sexual Risk Behaviours

a. Age

The study revealed that older age adolescents are more likely to have had premarital sex which was in accordance with previous studies[54]. The association between age cohort and premarital sex is substantial. This study found a positive association between age cohort and premarital sex, but it cannot be concluded that the likelihood of premarital sex is declining among the younger cohort; the association is undoubtedly an artefact of the truncated exposure among the younger cohort.

b. Educational level

Educational level was found to be a significant protective factor for risky sexual behaviours. Adolescents who had a higher level of education were less likely to engage in high risk sexual behaviours. In the school environment, adolescents may delay their sexual initiation and risky sexual behaviours by having access to information and skills. Similarly previous studies also found that school connectedness and higher level of education are protective factor for risky sexual behaviours[55]. Time spent in academic activities is also negatively related to early intercourse, particularly for girls[56]. Female adolescents' own level of academic achievement was positively related to age at sexual debut[57]. Adolescents who stay in school longer are less likely to engage in sexually risky behaviours. It is unclear, however, whether adolescents who stay in school are less likely to engage in risky sex or whether sexually active adolescents who engage in risky sex are more likely than others to drop out of school, and are missed in school-based studies[58].

c. District Difference

The study revealed that adolescent girls from Long district have more reported premarital sexual intercourse compared to adolescent from Sing district. This might be due Long district having a 63.5%Akha population as compared to 44% in Sing district.

d. Drinking Alcohol and Sexual Risk Behaviours

Available literature suggests that the global burden of disease with regard to both alcohol and unsafe sex is considerable. A significant relationship between alcohol use and sexual experience has been documented[59]. The findings of this study indicate that sexual intercourse was positively associated with alcohol, even after adjusting for age and education. Previous studies have shown that prior substance use increases the probability of an adolescent initiating sexual activity. Individuals who drink consistently report more partners than those who abstain. Two plausible explanations have been suggested for this association. First, substance use and premarital sex may both indicate a general inclination to take risks. Second, substance use tends to diminish both inhibitions and the ability to make rational decisions, thereby increasing the likelihood of sexual contact. Studies also have shown that binge drinkers are clearly more likely to have sex with multiple partners within a relatively short time period[60].

e. Knowledge on STIs and Sexual Risk Behaviours

HIV-AIDS knowledge may also be seen as a proxy for general reproductive health knowledge. The observation that youths who start their sexual careers earlier have, on average, poorer reproductive health knowledge than those who delay the onset may indicate that the former

[53] Mcintyre, D. et al. (2006). What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? Soc.Sci. Med. 4: 858-865; and Russell, S. (2004). The economic burden of illness for households in developing countries: a review of studies focusing on malaria, tuberculosis, and human immunodeficiencyvirus/acquired immunodeficiency syndrome. Am. J. Trop. Med. Hyg. 71(2 Suppl): 147–155.

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[58] Paul-Ebhohimhen, V.A., Poobalan, A. and Van Teijlingen, E.R. (2008). A systematic review of school-based sexual health interventions to prevent STI/HIV in Sub-Saharan Africa, BMC Public Health, Vol. 8, Art. 4.

group is at increased risk, not only for HIV-AIDS, but also for other STIs and for unwanted pregnancy. It was interesting that a higher score of STIs knowledge distinguished students who did and did not report having sex. Because this study was cross-sectional, it cannot be discerned if greater knowledge of sex increased the likelihood of having sex, or if having sex made one more knowledgeable about it.

f. Knowledge on RH and Sexual Risk Behaviours

This study suggested that Akha girls who had good knowledge on RH were associated with less sexual activity. The cross sectional design makes it difficult to interfere how knowledge of reproductive health was temporally related to sexual experience; however, another study revealed that poorer knowledge of reproductive biology is predictive of earlier sexual initiation[61].

g. Sexual Attitudes Towards Premarital Sex and Sexual Risk Behaviours

Sexual risk behaviours are also related to attitudes and behavioural skills. The findings of this study support findings of Wang et al (2006) that 'Attitude towards Premarital Sex' was the only factor that independently had an impact on sexual risk behaviours[62].

Limitations of this Study

The limitations of this study must be acknowledged and suggested that its findings be interpreted cautiously. This study was limited by its cross-sectional design. Determining causality must be based on future longitudinal research. Secondly, sexual behaviour is a sensitive subject and socially unacceptable in Lao cultural settings, thus it is possible that girls underreported their behaviours. However, by ensuring privacy during the completion of the questionnaire and using the anonymous self-administered survey, every attempt was made to minimize this bias. This study did not focus on obtaining data from the Akha male adolescents. Therefore, data obtained from the Akha female adolescents with low socioeconomic status and in the rural areas of Lao PDR cannot be considered representative of the whole eligible population of Lao adolescents. One of the frequently questioned methodological limitations in survey research may be how to establish the validity of the adaptation of instruments developed in other countries. The other problem was the small sample size for adolescents who reported SRH problems, thus, the reported SRH problems were just presented descriptively. There is a need to have a bigger sample size of adolescents with reported of SRH problems during the last year.

Conclusion and Recommendations

This is one of the first studies that examines knowledge of SRH , attitudes and accessibility to adolescent SRH information and services among female Akha adolescents in the Luang Namtha province, Lao PDR. It also updates estimates of sexual activity in this population. The study revealed poor knowledge of contraception, STIs/HIV-AIDS, with comparatively moderate knowledge on reproductive health. In addition, the findings also found a significant proportion of Akha girls engaged in premarital sex, early first sexual experience, multiple sex partners, and low condom use. Given these factors female adolescents are at significant risk in contracting STIs/ HIV-AIDS and have limited ability in making informed SRHR related choices.

The findings of this study provide guidance to health educators for developing effective and feasible intervention strategies targeting Akha girls, in particular out-of-school girls who are at increased risk for HIV/STDs infection.

- Preventative interventions for Akha girls should be designed to delay their sexual initiation and to reduce the risks to their health.

- A policy introducing CSE to out-of-school Akha and other ethnic girls should be considered. Sex education must include material that will increase sex-related knowledge, conception, sexual development and contraception. Information about SRH is essential to inform preventive strategies for adolescent health in order to reduce the myths in perception of sexual behaviours.

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- Training peer educators on SRH with emphasis to provide knowledge on physiology on sexual development should be addressed. Keeping adolescents in the schools or reduce the number of out-of school youth, and promote enrolment adolescents in secondary schools and higher education in long term perspective. In the school environment, adolescents may delay their sexual initiation and risky sexual behaviours by having access to information and skills.

- Increase adolescent‘s accessibility to accessSRH information and services by providing youth friendly services at the district level.

- As these issues carry high cultural sensitivity, area-specific communication strategies may help. Risk reduction messages should be relevant to the socio-cultural context and ethnicity. School based sex education & peer to peer education should be provided in the local language in order to improve awareness of risk and knowledge of risk reduction strategies, increase self-effectiveness and intention to practice safer sex and delay age of first sex.

- Additional research is required to disentangle differences due to different ethnicities from those due to location (urban vs. suburban), and to uncover the processes that produce these differences.

VI

The Philippines- A Participative Intervention Study in an Urban Poor Community in Metro Manila to Reduce the Risks of Unintended Pregnancies Among Adolescent Women

Likhaan Center for Women's Health

Abstract

This paper presents results of an intervention study on peer sexuality education with teenage girls in Metro Manila, in the Philippines. A peer education plan to reduce the risk of unintended pregnancies, and a questionnaire to measure its effectiveness was developed based on data from five focus group discussions among teenage girls. Self-administered pre-test questionnaires were filled out by 291 girls aged 15-19 from 2 poor communities. The peer education sessions were completed over a 12 month period (2010-2011) followed by a post-test administered to 107 girls. Analysis of data reveals that a half-day peer education session intervention among teenage girls by trained community youth leaders can improve information and motivation relevant to pregnancy risk-reduction. The intervention appears to have stronger co-relations to improved information as compared to improved motivation specifically related to factors that involve personal and interpersonal relationships. This includes attitudes on pressures to have sex by one's boyfriend; the need to marry one's first sexual partner; and talking about sex issues with friends. The sessions were not as successful in improving minimal personal plans about the timing of sex, marriage and having children which served as the only measures of behavioural skills. The present model will be most effective with younger teens, generally those without boyfriends, who need relatively uncomplicated behaviours to maintain pregnancy risk-reduction. Additional strategies will be required to work with older teens or those with boyfriends to address risk reduction and protection behaviour related to personal and interpersonal relationships, and behavioural skills.

Background

Sex, sexuality and contraception are contentious topics in the Philippines. Despite widespread support, the legislature has stalled for more than a decade on a proposed national law on reproductive health (RH). The RH bill mandates government programmes and funding for contraception, sexuality and RH curriculum in schools and enhanced maternal mortality reduction.

In the meantime, the adolescent fertility rate (AFR)—already high to begin with the Philippines, which has the highest AFR among the 10 member countries of the Association of Southeast Asian Nations[i], has further increased. Among girls aged 15 to 19, the National Demographic and Health Survey (NDHS)[ii] recorded a rate of 54 live births per 1,000 in 2008, up from 50 in 1993 and 46 in 1998.

[i] World Bank. (2012). Open Data - Adolescent fertility rate. On-line database at http://data.worldbank.org/indicator/SP.ADO.TFRT . According to the World Bank, the AFRs for 2010 are as follows: Philippines 50, Indonesia 43, Thailand 40, Cambodia 36, Lao PDR 34, Brunei Darussalam 24, Viet Nam 24, Myanmar 14, Malaysia 12, and Singapore 6.

[ii] All Demographic and Health Survey (DHS) data were gathered from ICF International's on-line database at http://www.statcompiler.com/.

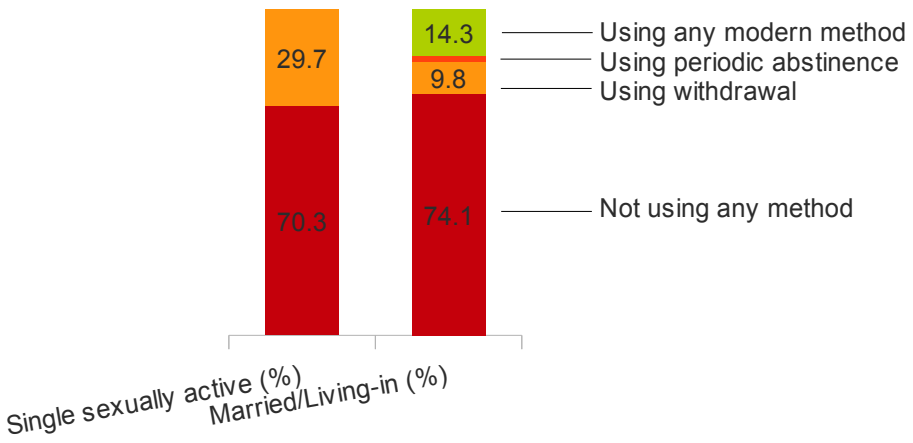

Figure1: Current use of contraception among females 15-19, Philippines, 2008.

Two proximate factors tracked by the NDHS contribute to the problem: 1) the growth in proportion of teens (unless specified, teens will be used to refer to girls 15 to 19) that are sexually active; and 2) the very low rates of modern contraceptive use among those teens, both married or unmarried (Figure 1).

In the 2008 survey, 8.1% of teens reported having sex in the past month, up from 5.8% in 1993; and 7.4% were in a live-in relationship, up from 2.7% in 1993. In the same survey, 74%of teens married or living-in were not using any form of contraception, yet only 17% wanted a child within the next two years.

Repeated DHS surveys show the age at which teen pregnancy and motherhood generally starts and peaks. From less than 1% at age 15, the proportion continually rises until age 19. From 1993 to 2008, at least 3 out of 4 teens who had started motherhood were between 18 to 19 years old (Figure 2).

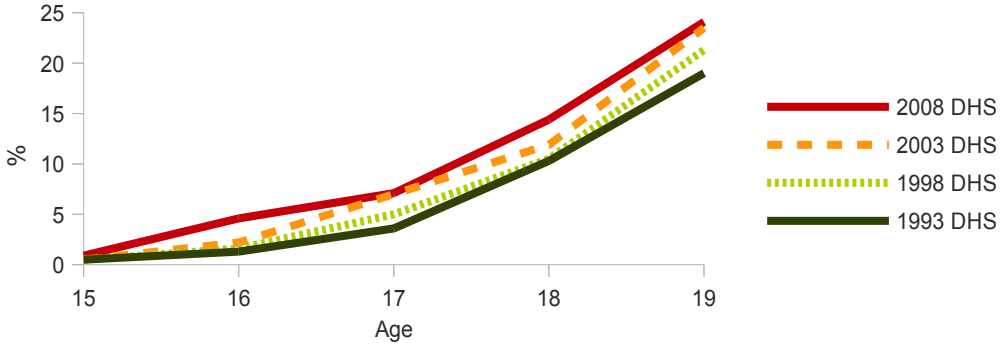

Figure 2: %age pregnant or with children among females 15-19, Philippines, 1993-2008

In addition, data aggregation masks the impact of social inequities. In 2008 for example, 18.5 % of teens in the poorest quintile—almost 1 in 5—were already mothers or pregnant, 5 times more than the 3.8 % rate among the wealthiest (Figure 3). Those with no education or primary level education had rates of 30.8 and 17.1 % respectively, compared to 8.6 % for those with secondary or higher
Figure 3: %age of girls 15-19 who are mothers or currently pregnant, Philippines

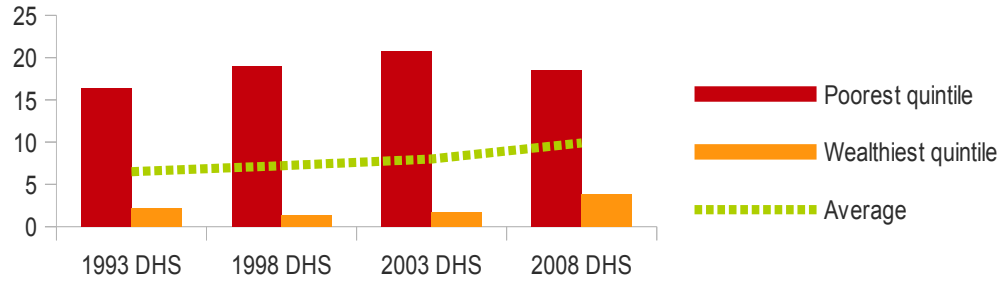

Figure 3: %age of girls 15-19 who are mothers or currently pregnant, Philippines

Likhaan Center for Women's Health, runs several community-based health programs in poor localities. Among adolescents, Likhaan has over the years conducted short education sessions on SRH issues, helped them self-organise and participate in national advocacy actions and campaigns, and provided contraception and counselling to sexually active ones. Community organisers and youth leaders teach and facilitate in peer education sessions, a programme that grew without too much planning, driven primarily by problems such as teen pregnancies and the absence of SRH education in schools.

Objective

Likhaan conducted this study to improve its peer education programme, in order to contribute to the reduction of unintended pregnancies among adolescents. Specifically, the study wanted to systematically identify and deliver key issues and messages, and measure the immediate effects on knowledge, attitudes, values and intended behaviour that reduce the risk of teen pregnancies.

Methodology

The study was conducted in Malabon City, specifically in barangays Catmon and Tonsuya where two of the largest slum areas in the city are located. The lowest geo-political subdivision in the Philippines is called the barangay. The 2010 Census of the National Statistics Office pegged the population of the two barangays at 36,450 and 39,354 respectively[iii]. Likhaan runs a community-based health programme which provides family planning and other RH services to women in those areas.

[iii] National Statistics Office. (2012). Census of Population and Housing 2010: Population Counts - National Capital Region. http://www.census.gov.ph/sites/default/files/attachments/hsd/pressrelease/National%20Capital%20Region.pdf

The study began with focus group discussions (FGDs) to elicit ideas and experiences relevant to unintended pregnancies. Five FGDs with six to ten adolescent girls each were completed and grouped as follows: sexually active in live-in relationships (2); not sexually active (2); had an unintended pregnancy (1). The FGD outputs were synthesised and categorised into major themes as risky or protective. Other relevant but non-specific ideas were flagged. The peer education content and pre-test post-test questions were then based on the FGD results.

Initially, the main part of the study had a pre-test post-test control group design as described in Fisher and Foreit's operations research handbook[iv], with 300 teen participants evenly divided and randomly assigned to an experimental and a control group. A total of 291 teens were enrolled through a random walk sampling within the visibly poor areas—communities with small dwellings made of light or dilapidated materials. Each completed a self-administered pre-test questionnaire, composed of prompts made up of test statements to rate as somewhat or definitely right or wrong, and a few direct questions.

When the peer education sessions started, serious barriers surfaced. Only 56 of the original enrolled participants managed to attend. Many were absent despite repeated follow-ups due to one or more of the following reasons: had moved out of the community or identified dwelling place; had heavy work or school activities or both; had lost interest. The design was changed to complete the study. New participants interested in peer education sessions were recruited in the same community through snowball sampling. This proved more effective since friends encouraged each other in pushing through with the education sessions. However, the sampling method reduced the age homogeneity of the participants. A total of 180 attended, with ages ranging from 11 to 20.

For the purpose of evaluating the peer education sessions, the following groupings were used:

- Pre-test group: 291 adolescents aged 15-19, responded to questionnaire prior to any education session
- Post- test group: 107 adolescents aged 15-19, responded to questionnaire immediately after the education session (56 from the pre-test group and 51 new participants)

The post-test group was compared to the pre-test group to detect any difference in knowledge, attitudes, values and intended behaviour immediately after the peer education session. A total of 114 participants aged 11-14 and 15 participants aged 20 and above were excluded from this analysis.

A team of teen leaders of the local community youth association led the peer education sessions. This was done to simulate typical sessions being done by Likhaan's community programme. Each session lasted four hours. The main topics were: planning and decision-making within intimate relationships; talking about sexual and reproductive health; physiology of pregnancy; and methods of contraception. The post-test was given immediately after each session. The gap between pre-test and post-test was 12 months.

• Designing the Intervention: Identifying protective behaviours and risky replies

The study team identified three plausible protective behaviours by study participants that can reduce teen pregnancies. One, sexual intercourse can be delayed until after the teen years (primary abstinence). Khan and Mishra (2008) in their comparative DHS report on youth SRH gave this standard definition: "A respondent is practicing primary abstinence if she or he has never had sex. This is defined only for never-married youth[v]." Two, sexually active teens can reduce the frequency of sex, or revert back to abstinence (secondary abstinence, defined in 2004 by the WHO[vi] and other international agencies as "a prolonged period of voluntary sexual inactivity following sexual initiation," currently set in DHS reports at 12 months). Three, correct and consistent use of modern contraceptives can be learned by all, and promptly started once teens become sexually active.

Sexually active teens can also stop using traditional methods of contraception like withdrawal, but this must be closely bound with the use of modern contraceptives or secondary abstinence to reduce teen pregnancy. Otherwise, continuing sex minus any protection from traditional methods can increase pregnancy risks.

The study team linked the prompts and the issues they probe to one or more of the above behaviours. We then classified replies that hinder protective behaviours as risky (Table 1). We used Fisher's IMB Model of behaviour change (1992) to look for hindering factors in the areas of Information, Motivation and Behavioural Skills[vii].

Replies that signal the absence of correct information were deemed risky. For example, the statement "A woman who stands up and urinates after having sex will not get pregnant" generated opinions of somewhat right, definitely right and don't know. These were classified as risky.

Replies that weaken the motivation to practice a protective behaviour were also deemed risky. For example, the statement "It is ok to break-up with a boyfriend who says he will leave you if you don't have sex" got the label somewhat wrong, definitely wrong and don't know from participants. All these were classified as risky.

Finally, to probe behavioural skills even in a limited way, teens were asked about their plans such as: when to have boyfriends, have sex, and marry or live-in, and have children. We thought that adolescents in this age group should at least be able to establish a time-frame for their intimate relationships. Replies were processed case to case. For example, we classified as risky the replies that meant anytime to the question "By your standards, how long must your

[iv] Fisher, J. D. and William A. F. (1992). Changing AIDS - Risk Behavior. CHIP Documents. Paper 2. Center for Health, Intervention, and Prevention (CHIP) http://digitalcommons.uconn.edu/chip_docs/2

[v] Khan, S. and Mishra, V. (2008). Youth Reproductive and Sexual Health. DHS Comparative Reports No. 19. Calverton, Maryland, USA: Macro International Inc.

[vi] World Health Organization. (2004). National AIDS programmes : a guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people.

[vii] Fisher, A., Foreit, J., Laing, J., Stoeckel, J. and Townsend, J. (2002). Designing HIV/AIDS intervention studies: an operations research handbook. The Population Council Inc.

relationship be with a boyfriend before agreeing to have sex with him?" In all cases, we counted don't know replies as risky.

Null hypothesis was set to no difference in proportions and means between the pre-test and post-test groups, i.e., the peer education will not result in any measurable change in either direction (risky or protective). The data was analysed using, as appropriate, the t-test, z-test and Fisher's exact test. P-values greater than 0.05 (5%) were considered not statistically significant; i.e., chance cannot be ruled out to explain any difference. We used the statistical software Minitab 15.1.30 (Minitab Inc.).

Prompts	Replies classified as risky	Behaviours that can be hindered by risky replies
Contraceptives lead to future infertility	somewhat right, definitely right, don't know	contraceptive learning and use
Contraceptives lead to promiscuity	somewhat right, definitely right, don't know	
Give all youth 15+ contraceptive info	somewhat wrong, definitely wrong, don't know	
Having sex, must use contraceptives	somewhat wrong, definitely wrong, don't know	
Knowing condom use ok for sex active youth	somewhat wrong, definitely wrong, don't know	
Ok to get health centre contraceptives	somewhat wrong, definitely wrong, don't know	
Youth have rights to health centre contraceptives	somewhat wrong, definitely wrong, don't know	
Side effects make contraceptives unsafe	somewhat right, definitely right, don't know	
Stand after sex to avoid pregnancy	somewhat right, definitely right, don't know	
Must marry first sex partner[viii]	somewhat right, definitely right, don't know	secondary abstinence, contraceptive learning and use
Those with BF should plan to avoid pregnancy	somewhat wrong, definitely wrong, don't know	
How long before marrying BF	anytime, don't know	primary abstinence
How long before sex with BF	anytime, don't know	
Right age to have BF	don't know	
No pregnancy on first sex	somewhat right, definitely right, don't know	primary abstinence, contraceptive learning and use
Ok to leave BF pressing for sex	somewhat wrong, definitely wrong, don't know	primary and secondary abstinence
Planned age to marry	age 15-19, don't know	
Sharing lessons/problems on sex is bad[ix]	somewhat right, definitely right, don't know	

[viii] The belief or norm that a woman must marry her first sex partner (e.g., to uphold one's honor, dignity) can weaken the motivation to use contraception or reduce the frequency of sex or revert to secondary abstinence once sexual intercourse has started, if she rationalizes that marriage is bound to or must happen anyway.

[ix] Attitudes among female teens that restrict sex-related discussions can leave those who are or about to be sexually active alone in dealing with problems or complex decisions. In some instances, FGD participants narrated how pregnancy marked the first time they learned about their friends' sexual activity.

[x] ICF International. (2012). MEASURE DHS Statcompiler. On-line database at http://www.statcompiler.com/

Planned age to have child	age 15-19, don't know	primary and secondary abstinence, contraceptive learning and use
School sex ed for all youth 15+	somewhat wrong, definitely wrong, don't know	
Sex ed leads to promiscuity	somewhat right, definitely right, don't know	

Table I: Risk classification and behaviours hindered by risky replies

Results

i. Description and comparability of the pre-test and post-test groups

The pre-test and post-test groups had mean or average ages of 16.6 and 16.7 years respectively. The difference is not statistically significant ($p>0.05$). Compared with the post-test group, the pre-test had more 15-year olds (30% vs. 13%) and less 16-year olds (20% vs. 42%). Though statistically significant, the differences are in adjacent ages, and where no impact on the results is expected.

The two groups had the same proportions of teens that are married, living-in, with boyfriends and single, further supporting comparability. Teens in relationships in the pre-test group had a mean duration of 8.3 months, compared to 13.3 in the post-test group. The difference is statistically significant, but the gap is too short (around 3 to 7 months at a 95% confidence interval or CI) to have any substantial impact on the study.

ii. Opinion on peer educators

The participants were asked if they thought young people trained in sex education and contraception would be effective in teaching the same to their peers. At pre-test, a slight majority (58%) thought that peer educators would be effective. The proportion was 82% at post-test. These results indicate that peer SRH education was largely not a barrier to receptivity in this study. One should note however that 12% of the post-test group remained unconvinced about the effectiveness of peer educators.

iii. Comparison of pre-test and post-test groups

- Plans

  When asked about the right age to have a boyfriend, both pre-test and post-test had mean replies of 18 to 19. However, respondents in relationships (40%) had a mean age of 17 and duration of 1 year, which means they had boyfriends at around 16. On this point, it is apparent that plans or norms differ from actual behaviour.

  When asked how long before they will agree to have sex with a boyfriend, 46 and 42 % respectively in the pre-test and post-test groups said they plan not to do it with a boyfriend. Some 11 and 17 % gave numeric replies, both with a mean of four years. None of these differences are statistically significant. The peer education sessions had no measurable impact encouraging or discouraging abstinence.

  The participants were asked about their planned age to marry. Those with numeric replies had means of 24 and 25 for pre-test and post-test respectively. The planned age to have a child was 26 in both; and the length of time before marrying or living-in with their boyfriends was 6 years in both. None of these differences are statistically significant. The only significant difference came from those who said they did not know how long before marrying or living-in. The proportion declined from 60% at pre-test to 45% at post-test.

- Risky replies
  The replies were ranked and grouped into four broad categories for analysis. Those in the 76 to 100 % range were classified as High; 51 to 75 % Mid-high; 26 to 50 % Mid-low; and 0 to 25 % Low. For example, the prompt "Contraceptives lead to future infertility" had 83.2 % of the pre-test teens replying somewhat right, definitely right or don't know. This was categorised as High. The prompt "Ok to get health centre contraceptives" got 18.6 % pre-test replies of somewhat wrong, definitely wrong or do not know. This was categorised as Low.

  Figure 4 shows the frequency per category for both the pre-test and post-test groups. In the pre-test group, 5 prompts were High and another 5 Mid-high, which means that in nearly half of the 21 prompts, majority of the respondents had risky replies. In the post-test group, only 1 prompt remained High, and the Low category doubled from 4 to 8. The two middle categories did not change. An uneven decline in risky replies occurred.

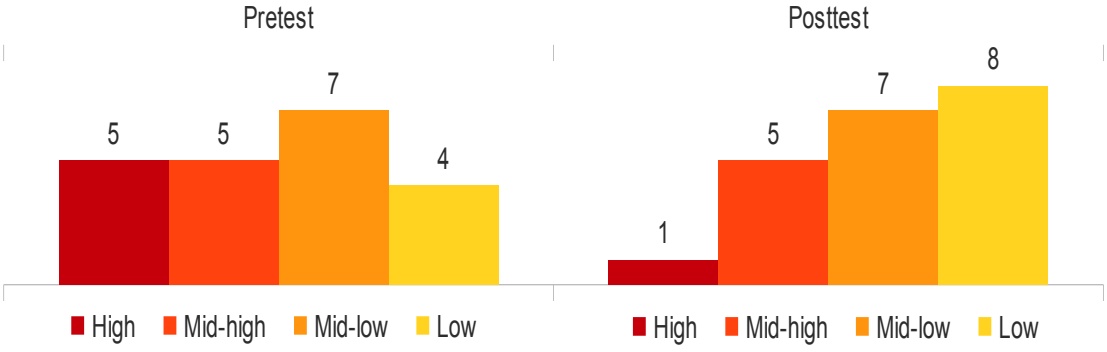

Figure 4: Number of prompts per risk category

Of the 21 prompts, 3 had no statistically significant change: right age to have BF; sharing lessons/problems on sex is bad; OK to leave BF pressing for sex. All the rest had positive changes, ranging from 12 to 39 % decline in proportions with risky replies. The detailed comparison between pre-test and post-test groups is presented graphically in Figure 5.

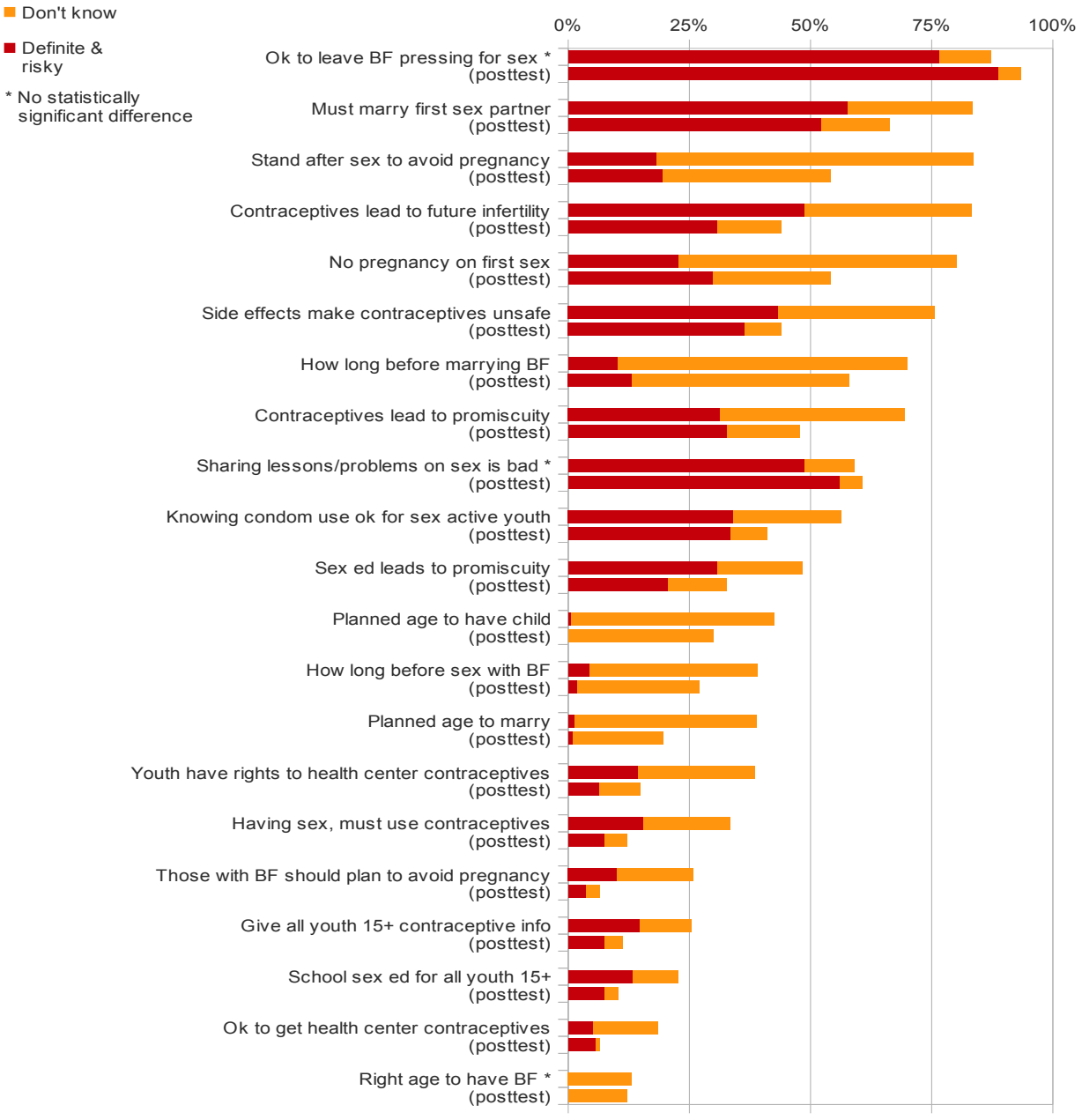

Figure 5: Comparison of pre-test to post-test group in proportion with risky replies

Finally, the results were summarised in Figure 6 by placing the prompts in order of increasing proportion of risky replies in pre-test (rightmost is riskiest), and increasing improvements after post-test (topmost has best improvement). The prompts were also classified as were also as relevant to preventing teen pregnancies via factors of information (I), motivation (M) or behavioural skills (B).

Quadrant A has the worst results where the majority of the pre-test replies were risky and improvements by post-test were small or nil. The area has five prompts, four of them factors relevant to motivation, and one to behavioural skills.

Quadrant B has the best results where, like Quadrant A, the majority of the pre-test replies were risky, but medium to large improvements were measured at post-test. The area also has five prompts but with a different mix: only one motivation factor, and four on information.

Quadrant C contains moderately good results. Less than half of the pre-test replies were risky and the post-test group had a moderate degree of improvement. Only two prompts affecting motivation used.

Finally, Quadrant D is a mixed area. Its left half contains cases unproblematic from the start, and its right half has cases with moderately poor results (i.e., 25 to 50% risky replies at pre-test and almost no improvement at post-test). The left half has five prompts: one behavioural skills and four motivation factors. The right half has four: one motivation and three behavioural skills factors.

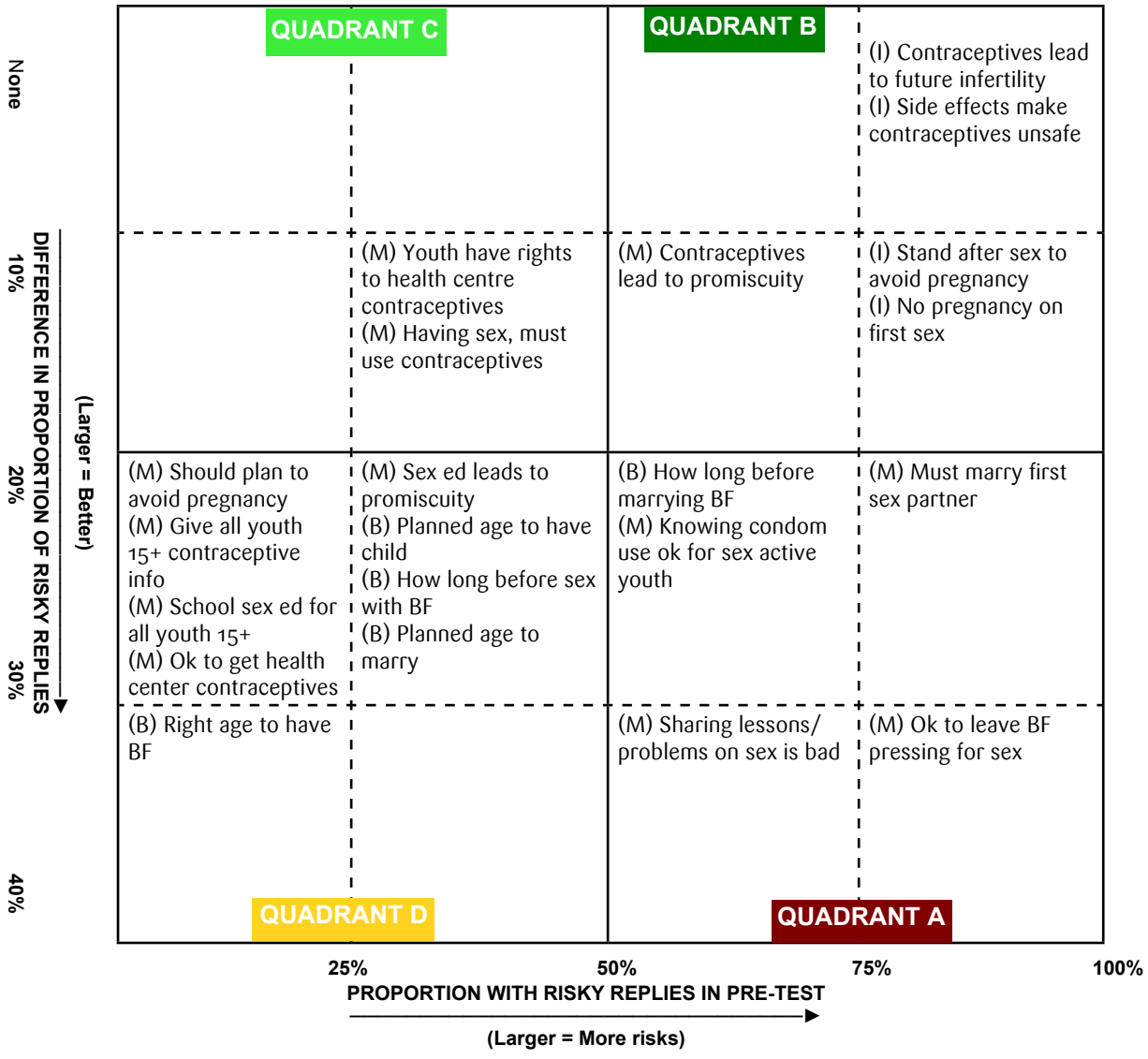

Figure 6: Summary of risks and changes in risks

Discussion

Fisher (1992) created a model to explain behaviour change in HIV-AIDS prevention which can potentially be used in other risk-reduction efforts such as preventing teen pregnancies. Called the Information-Motivation-Behaviour skills model (IMB model), it proposes three distinct factors that are needed to start and sustain risk-reduction behaviour. The IMB model acknowledges the necessity of information relevant to the problem and the protective behaviour, but stresses that these are not enough. People must also have sufficient motivation to act on the information that they possess (e.g., accepting that the benefits of prevention outweigh the costs), or overcome attitudes, norms and other ideas that demotivate them. The model then posits that information and motivation work together to activate the development of risk-reduction behavioural skills (e.g., communication and assertiveness skills) to initiate and maintain behavioural change. Finally, the model states that risk-reduction information and motivation may also directly affect risk-reduction behaviours when the latter are uncomplicated.

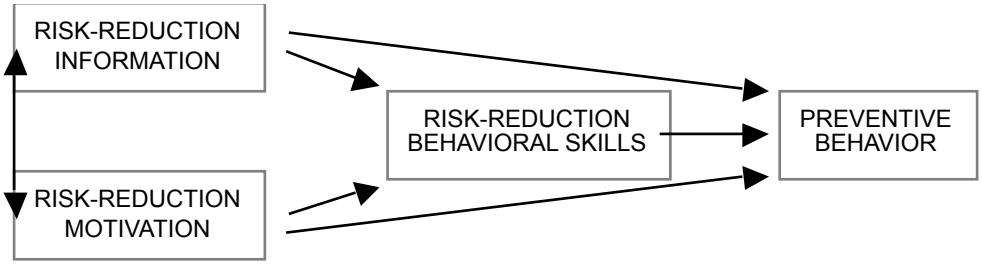

Figure 7. The Information-Motivation-Behaviour skills (IMB) model

Assuming that the IMB model is applicable to risk-reduction efforts in teen pregnancy, it is apparent that the short peer education sessions in this study was most effective in improving information, got mixed results in improving motivation, and was not effective in the limited areas of behavioural skills that we attempted to influence (see Figure 6). The study results are discussed under the relevant IMB headings.

• **Information**

Most pre-test participants did not know: that contraceptives are safe; that they do not cause future fertility problems; that standing or urinating after sex will not prevent pregnancy; and that pregnancy-free first sex is a myth. Any of these myths can weaken risk-reduction behaviours. There can be reduced motivation to learn about and use contraceptives. There can be increased motivation to end abstinence based on a false sense of security with folk methods or pregnancy-free first sex. Worse, these myths reinforce each other. For example, contraceptives can be viewed as a difficult and dangerous choice compared to folk methods, or contraceptives can be seen as unnecessary during first sex. Fortunately, this study shows that even short, one-off peer education sessions can make a dent, substantially reducing all of the above misinformation.

Will advances in risk-reduction information lead to preventive behaviour? Fisher thought it was possible for uncomplicated behaviours. Writing about HIV-AIDS, he said: "Information may be both necessary and sufficient for prevention when risk-reduction behaviour requires a relatively uncomplicated behavioural performance (e.g., avoiding sexual contact as opposed to acquiring, discussing, and consistently using condoms)."

In this study, 74 and 86% of those aged 15 in the pre-test and post-test groups had no boyfriends or partners. These are consistent with NDHS 2008 findings that 98% of women 20 to 49 have not had sexual intercourse by age 15. Therefore, during the early teen years, avoiding sex may be a relatively uncomplicated behaviour to promote, and information by itself may confer enough protection. For example, those in the early teens who understand that they have pregnancy risks from the first intercourse onwards and that folk methods do not work may decide

to delay sex until they are older or have access to modern contraceptives.

By age 18 however, the NDHS says that 18.3% have already had sex. This is low when compared to other countries such as that seen in Asian countries with DHS surveys in the last 5 years which have the following rates of sex by age 18: Cambodia in 2010-19.2%; Indonesia in 2007-30.3%; Maldives in 2009-26.8%; Nepal in 2011-50.6%; and Timor-Leste in 2009-10-21.7% . However, this is enough to triple the adolescent fertility rate (54 per 1,000) if a high proportion gets pregnant. In our study, around half of participants aged 17 to 19 already have boyfriends or partners. Older teens have to handle more complicated behaviours to avoid pregnancy.

At least two sources of complications are apparent. First, there is another person involved. Teens have to deal not only with their own beliefs, attitudes and behaviours but that of their boyfriends or partners as well. For teens with boyfriends or partners, sex is a real possibility instead of just a topic for conversation. Second, there is more than one way of avoiding pregnancy. Earlier, the study argued that three protective behaviours are plausible: primary abstinence, secondary abstinence and contraceptive learning and use. Each of these choices will in turn require different motivations and behavioural skills to implement, such as assertiveness for abstinence, or correct and consistent use of the various contraceptives (with each type of contraception requiring specific skills). In sum, the study team thinks that information is needed but will not be sufficient for risk-reduction in older teens.

• Motivation

Attitudes about the respondents' own behaviours and interpersonal relationships (e.g., with boyfriends, first sexual partners and female friends) proved very difficult to change to less risky levels. This was in sharp contrast to attitudes concerning others further away, such as young people in general. Three difficult cases stand out. In the pre-test and post-test groups, majority said that: 1) it is not ok to break-up with a boyfriend who will leave if one does not have sex; 2) one must marry the first man she has sex with; and 3) it is not ok to share sex problems or lessons with friends who are not yet sexually active. The attitude about condom use by sexually active teens was negative and difficult to change, and stood out in contrast to the largely positive views about contraceptive use. How these weaken the motivation to practice pregnancy risk-reduction will be discussed individually.

i. Handling pressures to have sex

The first response above implies that boyfriends can successfully pressure the teen participants to have sex. Other studies state that most young women in the Philippines do not approve of sex among unmarried couples. These studies cite various underlying reasons, such as the youths' desire to finish school or get a job first; concerns about pregnancy, and possible physical, social and emotional consequences; lack of maturity; fear of ageing prematurely (getting "losyang"); and the importance of virginity[xi]. This study indicates that a young woman's motivation to refrain from sex before marriage, whatever the underlying reason, may be weakened or overpowered by a stronger motivation to preserve her relationship. This counteracts pregnancy risk-reduction based on primary abstinence and secondary abstinence. It may also counteract the use of contraception that relies on male cooperation, such as condoms. Young women pressured to have sex to preserve a relationship can similarly be pressured to allow sex without condoms.

This study does not imply that all or most male partners will resort to the above pressure tactics, or that all or most sexual activities can be rooted to such tactics. Those issues were not investigated.

The YAFS 2002 study suggests that a substantial proportion of the first sexual intercourse among unmarried youth may have involved pressure. Among female respondents, 35% said it was wanted, 39% did not plan for it but it happened anyway, 27% said it was not wanted but they went along with it, and 5% said it was against their will.

ii. Marrying first sexual partner

The need to marry the first sexual partner can be viewed as an attitude or norm that decreases

[xi] University of the Philippines Population Institute (UPPI) and Demographic Research and Development Foundation, Inc. (DRDF). The Filipino Youth: 2002 YAFS Datasheet; and World Health Organisation Western Pacific Region. (2005). Sexual and Reproductive Health of Adolescents and Youths in the Philippines – A Review of Literature and Projects, 1995-2003. WHO.

the risk of teen pregnancy, but other evidence indicate that the opposite effect is more likely. A decreasing risk scenario may go like this: because sex leads to marriage, a teenager is motivated to take time, know her boyfriend first and delay sex or reserve it until after marriage. However, this response will probably be effective only if her capacity to resist pressured sex is high, which is not true for most of the study participants. It is also not prudent to assume that males have the same degree of motivation to marry their first sexual partners, and therefore the same desire to delay sex until both partners know and are sure of each other. A WHO Western Pacific Region (2005)[xii] study on the SRH of adolescents and youths cites the existence of double standards on sexual norms, as described in these excerpts:

> *There is a double standard. The average Filipino male expects to marry a virgin but also wants to "devirginise" a girl when given the chance.*
>
> *While women were encouraged to be virgins until marriage and to be faithful to their husbands within marriage, men were encouraged to be macho and freely exercise their sexuality.*
>
> *It is acceptable and expected that Filipino men will be sexually experienced prior to marriage. On the other hand, a double standard exists for women concerning appropriate sexual conduct before and after marriage. A woman is supposed to be sexually available to her husband whenever he wants. But prior to marriage, females can put on the brakes and delay having sex. There is tremendous cultural value placed on virginity before marriage and fertility after marriage.*

As argued earlier, the strong acceptance of the need to marry the first sexual partner can increase the risk of teen pregnancy once sexual intercourse has started, if she rationalises that marriage is bound to or must happen anyway. Such rationalisation weakens the motivation to use contraception, or to reduce the frequency of sex or to revert to secondary abstinence. This is consistent with studies and data in the WHO Western Pacific Region (2005)[xiii] study:

> *It was also observed that marital status is significantly associated with PMS. "The %age of those reporting premarital sex experience is 12.4% among single youth compared to a higher 23.9% among ever-married youth, indicating that somehow, PMS experience initiates or accelerates the process of marriage".*
>
> *National data also show that more than one third or 36% of young women conceive before marriage.*

In addition, the high value placed on virginity can limit the socially acceptable options of sexually active young women. For example, using contraceptives because one is not yet sure about marrying the current boyfriend—a rational option especially in the Philippines where divorce is prohibited—contradicts the norms linking virginity with marriage. As a result, even a highly motivated but unmarried contraceptive user will have difficulties justifying her practice to her significant others.

iii. Talking about sex

Not sharing problems or lessons about sex with sexually inexperienced friends can leave teens on the verge of sexually activity alone in dealing with problems or pressures. This increases the risk of teen pregnancies. For example, pressure to have sex from boyfriends may be easier to resist with the help of friends. Lessons about proper contraceptive use may be easier to spread—by organised peer education programs or even by successful individuals—if sex was not such a taboo subject even among friends.

Peers or friends are probably not the best source of factual information on SRH, as shown by the mostly risky replies on information prompts in this study. However, this should be differentiated from the capacity of peers to help strengthen the motivation to avoid teen pregnancy. This study shows that even at pre-test, a very large majority had protective replies

[xii] World Health Organization Western Pacific Region. (2005). Sexual and Reproductive Health of Adolescents and Youths in the Philippines – A Review of Literature and Projects, 1995-2003. WHO.

[xiii] Ibid

to the following: that teens with boyfriends should plan to avoid pregnancy; that all youths 15 and above, regardless of sexual experience, should receive contraceptive information and school sex education; and that young people should not be embarrassed to go to the health centre to get contraceptives. The protective replies grew even further at post-test, and expanded to include support of views that sexually active youths who don't want children yet should use contraceptives.

It is possible that current norms among the study participants are generally protective, but taboos restricting sex discussions and negative attitudes that alienate and gag those perceived as sexually experienced prevent the spread of protective ideas. For example, many study participants used insulting labels like "makati" (itchy) and "higad" (hairy caterpillars that cause skin irritations) to call sexually active, unmarried teens, asserting that "sexual itch" drives their behaviour. Within this environment, teens may mistakenly believe that the majority of their significant others have views oppositional to the protective study results cited above; e.g., that contraceptive information and school sex education should not be available; that sexually active youths should not use contraceptives; and so on. Fisher, explaining Fishbein and Ajzen's theory of reasoned action, describes this factor that affects motivation as "subjective norm ... or perception of what significant others think should be done with respect to the behaviour in question."

iv. Knowing proper condom use for sexually active youths

At both pre-test and post-test, opinions about condoms were markedly more negative than opinions about contraceptives where condom use had 23 and 29% more risky replies than contraceptive use for sexually active youth at pre-test and post-test respectively, both premised on interventions for sexually active youths. It is unclear from the study why this is so. It may be that the female participants generally perceive that they have weak control over condom use, as discussed earlier in the section about handling pressures to have sex. Owing to its use in STI prevention, condoms may also be associated more strongly by participants to promiscuity or "liking sex too much," traits that are in direct opposition to the strong virginity norm.

Whatever the cause, it should be noted that among these teens, pregnancy prevention based largely on condom promotion face two major difficulties: vulnerability to pressure from boyfriends and the negative attitude to condoms. Including female-controlled and other types of contraceptives (e.g., pills, injectables, implants, intrauterine devices, etc.) and promoting double protection can overcome both difficulties. Doing prevention programmes among males may be another viable add-on solution, but this study was not designed to provide ideas or lessons for such efforts.

Attitudes with positive results and changes

The respondents' attitudes about the behaviour of young people in general or about macro-level SRH policies proved easier to move towards less risky levels. In three cases, moderate degrees of risk reduction occurred from pre-test to post-test. These include views on contraceptive use leading to promiscuity; on the rights of young people to access contraceptives in government health centers; and on whether sexually active youths should use contraceptives. In four other cases, risky attitudes at pre-test were already small to begin with, yet small improvements still occurred. These include views on teens with boyfriends planning to avoid pregnancy; youths 15 and above, regardless of sexual experience, receiving contraceptive information and school sex education; and young people being embarrassed to go to the health centre to get contraceptives.

Summary of motivation factors

A pattern can be seen from these results. Attitudes by study participants about personal and interpersonal behaviours were more risky and harder to change. Attitudes about other young people were less risky and easier to change.

To illustrate, most teens believed that it is not ok for them to break-up with boyfriends threatening to leave if they will not agree to sex. After this view was discussed in peer education

sessions, no measurable change occurred. On the other hand, a majority already believed that young people having sex must use contraceptives. After the peer education sessions, this opinion became a dominant majority. It appears that participants had one standard for themselves and their intimates, and a different one for others.

• **Behavioural Skills**

Measurement of behavioural skills settled on having or not having personal plans about five concerns: when to have a boyfriend, marry and have children; and how long before having sex and marrying her boyfriend. Plans were seen as the meeting point before the necessary behavioural skills diverge, depending on the circumstances of each participant—e.g., whether she has a current relationship or not, sexually active or not, etc.—and her chosen path of avoiding pregnancy (Figure 8). Only the absence of plans or carefree attitudes about the timing of sex or marriage was classified as risky.

Personal plans, compared to other skills, are admittedly further off from the actual behaviour that will prevent an unintended pregnancy (e.g., planning to have children at age 24, versus the skills to take contraceptive pills on time everyday and correctly handling missed pills. However, personal plans about when to do things are applicable to everyone and easy to measure, and may be treated as the bottommost skill that teens should have. In addition, thinking about the timing for sex, marriage and children is a prerequisite for choosing a pregnancy-prevention path (primary abstinence, secondary abstinence or contraception) and developing the behavioural skills for that path.

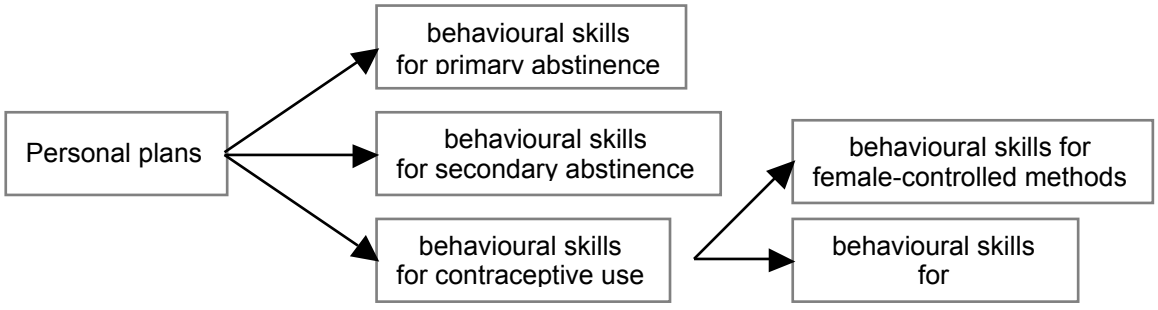

Figure 8: Personal plans and its relationship to other behavioural skills for teen pregnancy prevention

On the question of when is it right to have a boyfriend, teens without plans comprised a very low proportion. The rates were 13% at pre-test and 12% at post-test. If we assume that this is a relatively safe level, then the other plans can be compared to this one. At pre-test, those without plans on the timing of sex with a boyfriend, marriage and children were three times greater and five times greater on how long before marrying a boyfriend. All these changed little at post-test, especially when compared to improvements in the information issues. The question on planned age to marry generated the largest improvement.

However, majority of study participants were not in any relationship (59% in the pre-test and 55% in the post-test group), and for teens without boyfriends, preventing pregnancy require uncomplicated behaviour. This may explain why many do not even have a response when they intend to marry, have sex and have children. In sum, improving the planning skills of study participants were somewhat difficult, but the reasons are hard to pin down.

Conclusions and Recommendations

Data from this intervention study reveals that half-day peer education sessions among teenage girls by trained community youth leaders over a year can improve information and motivation factors relevant to pregnancy risk-reduction, i.e., abstinence and contraceptive use. Information

factors include correcting misinformation about the safety of contraceptives, the effectiveness of folk methods, and pregnancy-free first sex. Motivation factors include attitudes and norms about the youth in general and macro-level SRH policies, such as views on contraceptive use and promiscuity; on the rights of young people to access government-supplied contraceptives; and on contraceptive use by sexually active youths.

However, these peer education sessions were weak in improving motivation factors that involve personal and interpersonal relationships, such as attitudes on pressures to have sex by one's boyfriend; the need to marry one's first sexual partner; and talking about sex issues with friends. The sessions were also weak in improving minimal personal plans about the timing of sex, marriage and having children which served as the only measures of behavioural skills.

The peer education sessions as currently done will be more effective with younger teens, generally those without boyfriends, who need relatively uncomplicated behaviours to do or maintain pregnancy risk-reduction. Older teens or those with boyfriends need better results in two areas: motivation factors involving personal and interpersonal relationships, and behavioural skills.

The following general measures are recommended to improve peer education and other efforts at teen pregnancy risk-reduction:

- Add more attention and time to motivation and behavioural skills that proved difficult to improve. Stronger lessons about gender inequities and empowerment and more effective teaching and learning methods are probably needed.

- Use issues with positive opinions to start an opening into negative and difficult-to-improve areas. For example, the majority prescribe protective ideas for young people in general—e.g., sexually active youths should use contraceptives, there must be sex education in schools, etc.—but expose themselves to risky ideas—e.g., must marry first sexual partner, must not talk about sex with friends, etc. Participants should be encouraged to reconcile their protective prescription for others to their risky ideas for themselves and their intimates.

- Develop better content and indicators for behavioural skills. Questions and discussions about the timing of sex, marriage and childbirth may be too general and easy. The study has opened up more relevant areas for developing behavioural skills, such as how to handle boyfriends pressing for sex, or how to start and carry on sex discussions with friends.

- More attention should be given to female-controlled contraceptive methods, including emergency contraception. Information, motivation and behavioural skills in support of these methods should be promoted, especially if their low motivation or ability to resist sexual pressures from boyfriends continue to be difficult to change.

- Participants in peer education sessions should be segmented by age (e.g., 15-16 and below separated from 17 and above) or the presence or absence of boyfriends. This will enable more focused content, such as mainly information and motivation for the younger teens, and more time for motivation and behavioural skills for older teens.

VII

Vietnam- Working With Young Factory Workers in Hanoi

Center for Creative Initiative in Health and Population (CCIHP)

Abstract

Young factory workers, the major labour force in Vietnam with a median age 25 years old[1], are vulnerable as they do not have access to information and services regarding their sexual and reproductive health and rights. There is always risk of unwanted pregnancies, sexual assault and STI's keeping into consideration their working and living environment.[2] Findings of this intervention study showed that young factory workers have many concerns and queries about SRH related issues like menstruation, abortion, RTIs, STIs, love relationships, etc... It also reflected the reality within the group that the negotiation skills of female factory workers need to be strengthened so that they have better bargaining positions with their male partners. In consultation with factory leaders it was agreed that the 'club' model trialled at the study sites could be shared and implemented in other factories. They shared that the clubs could improve the situation of the target group in relation to the concerns raised. CCIHP and its local partner with support from ARROW implemented a project "Strengthening Gender Equality, Sexual and Reproductive Health and Rights for young workers of Central Enterprise in Hanoi" targeting young factory workers. The project focused on enhancing knowledge, attitude and practice relating to SRH of young people in the factories. Working with a local partner the project has successfully been able to bring change in knowledge, attitude and behaviour of young factory workers as well as the concerned stakeholders like the youth union, factory managers, etc... The positive change seen is expected to help them gain access to existing health and youth centres for their SRH needs and thus improving their quality of life.

Context

Vietnam's national economy is becoming more dependent on commerce and industries. [3]These industries employ a large number of young workers who are mostly from the rural areas. Issues related to SRH such as unwanted pregnancies, prevalence of HIV-AIDS, violence within love and marriage relationship, sexual abuse, etc... are increasing among young people in Vietnam.[4] Therefore, young people working in factories falling under the broad category of young people are also facing similar problems. In addition to this, the living conditions and facilities being provided to young factory workers and their backgrounds with less exposure to the knowledge on SRH make them even more vulnerable.

Objectives

Realising the needs of young people in factories, CCIHP collaborated with the Central Enterprise Youth Union of Vietnam to implement a project called "Strengthening Gender Equality, Sexual and Reproductive Health and Rights for young workers of Central Enterprise in Hanoi" from February 2011 to January 2012. The main objective of the project was to improve awareness levels on issues related to SRHR of young factory workers in Hanoi, Vietnam. Participants in the study included young factory workers (single young workers under the age of 30 working in five factories in Hanoi), the factory managers, staff and Youth Union staff and local leaders.

[1]Bloomberg. (2007). Mukherjee, A. After China, Vietnam will be the world Factory. Retrieved on 27 November 2012 on Bloomberg website: http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aDjLoAs_b1h4.

[2]IPPF and UNFPA. (2003). Bondurant, Anthony et al. Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF Vietnam Country Evaluation Report. Hanoi: UNFPA

[3]Bloomberg. (2007). Mukherjee, A. After China, Vietnam will be the world Factory. Retrieved on 27 November 2012 on Bloomberg website: http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aDjLoAs_b1h4.

[4]IPPF and UNFPA. (2003). Bondurant, Anthony et al. Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF Vietnam Country Evaluation Report. Hanoi: UNFPA

Methodology

CCIHP realised the need to work with the young factory workers in Hanoi decided to design and implement an intervention study to assess the real needs of the target population in the area. These needs were assessed through a needs assessment survey using practical research action tools that were used through focus group discussions and peer education sessions. Two local organisations, the Vietnam Youth Federation and the Central Enterprise Youth Union collaborated in this assessment. The planning of the project was done in a participatory way. An orientation and planning meeting was organised among representatives from national partners, the target audience, youth club members, factory managers and leaders and health staff. During this meeting all the partners identified their roles in terms of the implementation of the project. The meeting provided the participants with knowledge of project tools, implementation of activities and monitoring and evaluation.

With the support of national partners, the project was able to reach out to five government owned and private factories that produce garments and processed food that h employed over 2,000 young people of which 60% were young women. Based on the needs assessment, different materials were developed including manuals for trainers and handbooks for members. Separate publications were created for the male and female workers which covered 14 different topics relating to young people's sexuality. A curriculum for providing CSE was also developed. The curriculum includes practical learning sessions on menstruation, violence, gender and sexual orientation, HIV, STIs and STDs, gender, etc... A five day training of trainers (ToT) workshop was organized for the women in these factories. The trainings were cascaded to 10 youth clubs reaching about 200 factory workers including the factory managers. The clubs are informal gathering spaces for the young workers where they are able to organise and join activities conducted by the youth unions. CCIHP also developed a map for existing youth-serving health centres in the target area with lists of facilities and services being provided by them.

The clubs where the trainings were implemented had a diverse group of young workers with specific needs. During the period of seven months from May-December 2011, a number of workshops and meetings, as part of an orientation programme, were held in these clubs covering a range of topics. The content of these training programmes was prepared in-advance keeping in consideration active participation of the members. The local partner, the Central Enterprise Youth Union supported in management of all the activities including providing input on the topics of the trainings.

In the aspect of project management, the Central Enterprise Youth Union played an important role. They frequently contacted the factories and their management about the project implementation and had regular meetings with them. Project coordinators were consulted CCIHP regularly. Project coordinators from the Youth Union requested the management board of the factories to follow up on the outcomes of meetings and workshops. They also urged the management board to encourage the club members to participate actively in the activities and to enable preparations for the creation of an environment for workshops, conducting club activities as well as celebrating festivals. Project officers' organised regular meetings with key trainers to run club sessions, actively took part in the training courses themselves and took responsibility for the financial liquidation of all activities conducted. Each partner for this project was assigned a different set of roles.

	Partner	Specific roles
i.	Project management board (project leaders from the factories and CCHIP as well as the youth union)	- study the project - create conditions for the youth union to participate in the project - reward the individuals who have excellent achievement in implementing the project

ii.	Project Coordinators- Youth Union staff	- analyse, discuss and persuade the leaders to implement the project in factories - encourage the young workers to participate in the project - follow up on activities conducted - evaluate the quality of the activities during the project implementation process.
iii.	Health staff from CCIHP	- Coordinate with the Youth Union to integrate the project contents with health care activities for young workers in factories
iv.	Key trainers from the youth union and CCIHP	- develop the training plans and practice skills and methods to convey the knowledge to the club members in the best possible way.
v.	Young factory workers	- be active and creative in the project implementation period - raise awareness to develop clubs in other factories.

Monitoring and evaluation was integral to the project. On-going monitoring of activities as well as evaluation of the project was done to ensure the effectiveness of the project. Through the monitoring and evaluation exercises, changes in the target audience in terms of their knowledge, attitude and behaviour on issues related to their SRH were recorded.

Findings:

The needs assessment survey conducted before the implementation of the project provided important information about the actual status and needs of young factory workers. It showed that young workers have many concerns and queries about SRH related issues like menstruation, abortion, RTIs, STDs, love relationship, etc. It also reflected the reality among the group that the negotiation skills of female workers need to be strengthened so that they have better bargaining position in front of their male partners.

A young female worker said that, "we are unmarried so we do not think about these (SRHR) issues".

Another female worker shared that, "in our living area, young women and male live side by side, so if they fall in love with each other, they can live together and surely they will have sex. No one say about this but as far as I think and know, many girls have unwanted pregnancy and have to abort it".

These statements signify that:

- Awareness on SRH among young workers is limited.
- Young workers admit that they are at risk of unwanted pregnancies and RTIs.
- Young workers face many difficulties in accessing SRH services.
- Young women in factories have lower decision making power in comparison to their male partners.

The factory project management board agreed that the club model could improve the situation of the target group and as such could be implemented in other factories as well. One of the factory leaders from the Song Duong tissue paper factory said that, "we are concerned and quite agree with the issues that workers are now facing in their lives, so we are ready to receive and make the best condition for workers".

The outcomes of the activities in the project were very tangible in terms of the positive change created among the young factory workers who were the target group and also with the related stakeholders. The training materials including manuals for trainers and handbook for club members that were produced after the needs assessment proved to be very beneficial to deal with the needs of the young factory workers. In that way the quality of the sessions that were implemented in different clubs were good which was indicated by the active participation of the club members in the session. Despite the strict time schedules in the factories, young workers were keen to participate in the sessions. The training of trainers workshop conducted to produce key trainers was a success too. Evaluation of the trainings has shown that all (100%) of the participants found the topics in the trainings useful. It also shows that the information delivered was precise and focused to the needs expressed.

There was noticeable change in the knowledge, attitude and behaviours of the young workers in the factories after the implementation of the project. Their knowledge on family planning contraceptives methods, masturbation and early ejaculation among males increased after the club sessions. This is illustrated in the figure below.

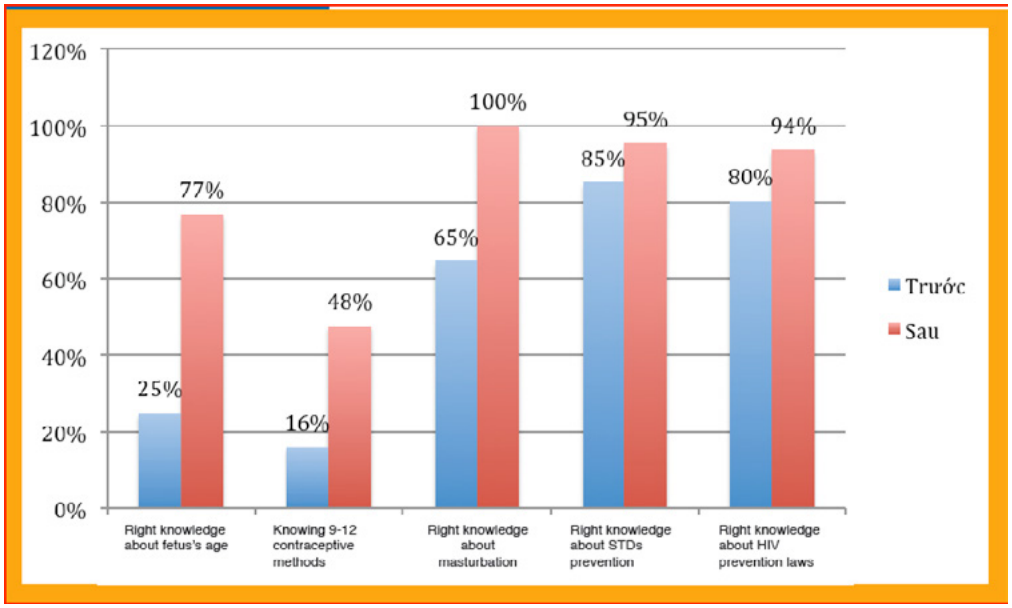

Figure 1: Percentage of respondents and level of knowledge on SRH issues before and after the project.

This change in the knowledge level of workers has led to a positive change in the young workers' attitude toward SRH issues. The number of young workers who were ready and willing to buy condoms increased from 64.20% in the beginning of project to 72.31% in the end. When the club sessions finished, 100% of young workers were comfortable when around people living with HIV-AIDS. No one said that they would report them to the managers or suggest the dismissal

of workers infected by HIV-AIDS. On the contrary, all the young workers said that they would maintain their relationships and would provide encouragement to those colleagues in difficult situations.

Young workers also had more open opinions on sexuality, love and virginity. Opinions like "girls who have sex before marriage are bad" or "girls who lost their virginity are valueless" changed gradually. Before participating in the clubs, 52.94% of the young male workers disagreed with opinion that girls who have sex before marriage were bad but after their participation in the club activities this number increased to nearly 91%. All (100%) young male workers did not agree that the value of a girl was decided by her virginity. With correct knowledge regarding early ejaculation, instead of feeling weak and wanting to leave their partners, all male workers chose communication, seeking encouragement, sharing with partners, and finding out the reasons and solutions for this issue. Figure 2 illustrates the changes in attitude. Being equipped with knowledge of sexual rights also affected the young workers' attitudes in acknowledging the sexual rights of others. They showed their respect for others' rights and did not impose their own opinions on others. The findings showed that the change in attitude almost doubled from 48.15% in the beginning to 83.08% in the end.

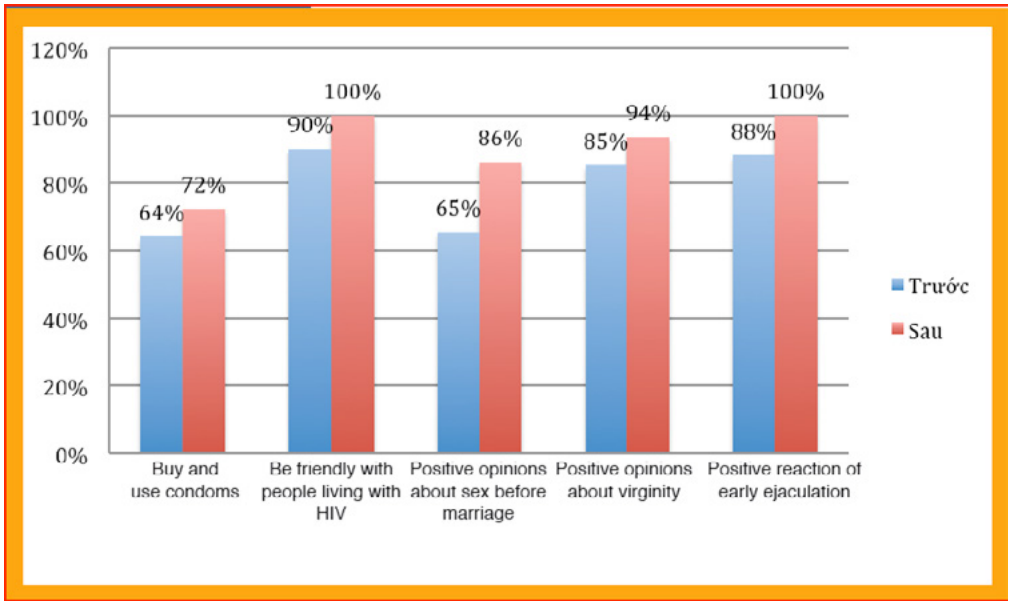

Figure 2: Percentage of respondents with change in attitude on different SRH related issues

Young factory workers as part of the project acquired knowledge and felt more confident in communicating with their friends including discussing SRH issues. This further implies that they would be willing to seek health services. According to the young factory workers, they felt pleased when participating in clubs with a satisfaction score of 4.71 in average out of 5. The details could be seen in figure 3 below.

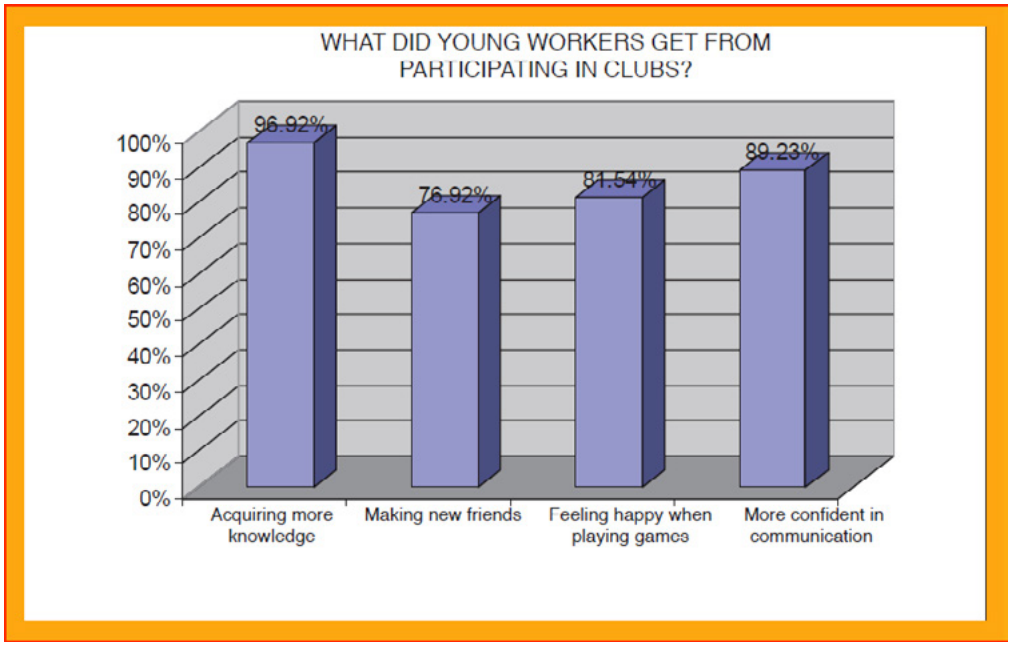

Figure 3: Feedback from young works on their participation in clubs

The local partner for the project, the Central Enterprise Youth Union was very active in a management role even though this was the first time they had collaborated with a non-governmental organisation. Key trainers always promoted their activeness and exemplary attitude in the project implementation processes as well as being active in advocating with factory leaders for implementing project activities. Regular meetings between the Central Enterprise Youth Union and key trainers helped to plan the sessions which was helpful in deciding the content of the club activities within the limited available time. Project officers from the Central Enterprise Youth Union also were able to build good relationships with the factory leaders which made the project implementation easier.

There are few good examples which showcase the positive changes in the project.

December 2011: The Central Enterprise Youth Union, CCIHP and the five factories collaborated to organise a club festival for young workers. The festival attracted participation of more than 200 young workers from the five factories. The main attraction of the festival was a talent competition among the clubs in factories in which participants presented different forms of art like plays, fashion show, question and answers, songs related to social issues like gender, sexuality, reproductive health and rights. The competition was among factories and prizes were distributed accordingly. During the event a network of eight youth service centres for youth was set up and the network provided 500 cards with 30% discounts for young workers in the factories for the services provided.

A female worker in Hai Nam Sewing factory shared:

Actually, it is not my first time to participate in a club like this because I used to be a member of a club in my living shelter. However, in the factory club, the members are of the same age so it is easier to talk about sensitive issues like sexuality and reproductive health and everybody seems more open. After participating in this club, I have knowledge that I have not known before and it is very useful for me to prepare for my marriage life in the coming time.

This shows the growth in confidence of young workers in the project area.

Besides the positive changes seen among the young factory workers, the project also helped to create an environment of learning and sharing through which the Youth Union could be better positioned to improve their roles in the factories.

Discussion

As this project was collaborative in nature between a Youth Union and an NGO, it was taken into consideration to create space to share concerns and challenges from either of the sides for smooth implementation of project activities and also to avoid any possible confusion.

Some of the factories could not implement club sessions regularly due to the work schedule and manufacturing conditions. This impacted on the time that the trainers had with the factory workers and it also affected the sessions conducted.

Most of the factory managers were concerned about issues such as the support to the project including financial support. Therefore, it is necessary to have detailed consultations with factory managers for them to realise that the project would benefit workers in their factories and ultimately benefit the factories themselves. Sometimes it was also realised that SRH is a sensitive topic for some factory managers so to make them understand the content of the workshops through regular communication is very important.

Key trainers were important players in implementing the project activities as they consulted the Youth Union and gathered young workers in the clubs. Therefore it was realised that it is important to set up a team of key staff. In addition, key trainers also need to enhance their negotiation skills in order to persuade managers and to encourage young workers to participate in the activities.

It would be much easier if key trainers have good relationships with the Youth Union members to create an environment in which they can share problems. This would help to implement the project smoothly. Having more communication and good relationships with factory managers would also make the project implementation much more comfortable.

Monitoring and evaluation at every step of the project is crucial to gauge the effectiveness of activities. To help with this, some guidelines for each of the key partners need to be set up in the early stages of the project.

Recommendations

Some recommendations for different stakeholders who combined their efforts for the success of the project include the following:

i. Central Enterprise Youth Union

Leaders in Central Enterprise Youth Union should be very involved in the project process as well as share difficulties of project officers in advocating and setting up clubs in factories. Leaders in Central Enterprise Youth Union should discuss frequently with project officers to have the adequate support. Staff on the project management board should be more active in building project activities.

ii. CCIHP

This project is meaningful to young people in general and the young workers in factories in particular. During the project process, CCIHP created an enabling environment for the young workers to have knowledge and information about SRHR and access new activities and improve their individual and team skills. However, CCIHP should share their difficulties more with the factory managements as due to the strict manufacturing conditions and time schedules, young workers are not able to fully engage in club activities. The factory management could also be more flexible with unexpected situations such as finance, time for activities, and assigning more experienced staff in the project.

iii. To factory managers

The factory managers need to create enabling conditions for the Youth Union to implement the project and to consider the project as a main activity of the Youth Union in factories which contribute to producing high-quality skilled workers.

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