“Young Men Like Us”:

Experiences and Changes in Sex, Relationships and Reproductive Health among Young, Urban Cambodian Men.

Peer Ethnographic Research on urban male sexual behaviour

January 2007

ACKNOWLEDGEMENTS

This report was authored by Rebecca Hayden in 2006, who also contributed to data collection and analysis. Luke Bearup made significant contributions to the research design, and sections of this final report draw on data collection, analysis and reporting conducted by Luke in 2004. Karen Rowe also assisted with strengthening data collection and in editing report drafts.

The research was made possible by the participation and enthusiasm of the Peer Ethnographic Researchers and the young people who agreed to share their experience and perspectives. Playing Safe project staff, including Tong Soprach, Sok Va Tola, and Ros Vantha and CARE's implementing partners assisted with analysis, reflection and review.

And finally, CARE would like to thank the EC/UNFPA Reproductive Health Initiative for Youth in Asia who made this report possible.

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Glossary of Terms and Acronyms

bauk:	Literally, 'plus', in slang idiom, *bauk* refers to multiple males having sex with one woman, with or without her consent
CS	Change Stories
daoe leng:	to go out for fun, for example on a walk, ride or drive.
HIV	Human Immunodeficiency Virus
Kep Thmei:	A small town 15 km along the National Rd No. 1 outside of Phnom Penh that is renowned for guesthouses available to young people and prostitutes.
khsae	[literal] rope or string. A traditional system of hierarchical social relationships.
khteuy	Slang derogatory term for a male who has sex with other males or who appears feminine
knong	[literal] back. The position of authority or power upon whom a *khsae* is dependent.
Krou Khmer	Traditional Khmer doctor in Khmer medicine
MSM	Men who have sex with men
neehyom prah	A description for something the most 'cool' or popular
NGO	nongovernmental organization
PER	Peer Ethnographic Research
PERs	Peer Ethnographic Researchers
PSI	Population Services International
RHIYA	Reproductive Health Initiative for Youth in Asia
srey thea ban dam plough	literally means a girl you can go fishing for to try and hook and is used to refer to a woman from the street or recreational area who agrees to sex after flirting.

SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund

Executive Summary

This report is the product of a research project undertaken over a sixteen month period by the Playing Safe Project of CARE International in Cambodia. Implemented between 2003 and 2006, Playing Safe was funded under the second EC/UNFPA's Reproductive Health Initiative for Youth in Asia (RHIYA). The key purpose of the research is to contribute to an increased understanding of critical sexual and reproductive health (SRH) issues in Cambodia through exploring the way that young, urban, middle class men in Phnom Penh experience sex, sexual relationships, drug use and access to sexual and reproductive health information and services. The secondary goal of the research is to provide insight into the impact of Playing Safe, particularly focusing on the utility of peer education and outreach strategies as employed by the project, with a view to informing future similarly targeted interventions.

The results presented in this paper were gained through the application of two distinct but complementary qualitative in-depth, semi structured interview approaches; the Peer Ethnographic Tool, developed by Kristin Hawkins and Neil Price (2000a, 2000b) and the Most Significant Change technique, developed by Rick Davies and Jess Dart (2005). Two rounds of data collection were conducted for the purposes of revealing changes and relative stability in young men's experiences of factors influencing their sexual health. The Peer Ethnographic tool was employed to provide a detailed, population wide context of experiences and change over the research period, while the Most Significant Change technique, drawing on a more restricted sample group was utilised to provide insight into the specific experiences and changes of young men who had participated on some level in Playing Safe project activities, providing an indication as to the impact of the project on this group.

The findings of this report indicate that there have been changes in the level of knowledge among young, middle class urban Khmer males surrounding key SRH issues including HIV/AIDS, condom use, drugs and access to services. The report findings further suggest that behaviour and choices around sex and SRH amongst this group do not reflect the simple application of demonstrated knowledge, but rather a complex interaction of social norms and contextual influences.

Further, the results of the study demonstrate that the design and implementation modality of CARE's Playing Safe Project is appropriate for working with the identified target group; with evidence of change amongst young men having interactions with the project emerging to document project impact in conjunction with evidence supporting the implementation logic of the intervention.

Key Findings and Conclusions by Topic

HIV/AIDS

- *HIV Knowledge is high amongst this group of young men.*

- Knowledge of the nature of HIV/AIDS amongst this group was seen to increase across the research period, with growing understanding leading to increased interest in and access to VCCT services.

Sexual Relationships and Activities

- *Sexual debut is overtly socially negotiated and strongly influenced by peers*
- *The stories from peer educators of the Playing Safe project suggest that these social constructions may be renegotiated on an individual level.*
- *Sweetheart relationships are common and frequently preferred amongst this group of young men, and condom use with sweethearts among this target group appears to have increased over the period of the research project.*
- *Condom use decisions in sweetheart relationships are dominated by men's own risk assessment.* There was no mention of fear of transmitting disease to partners, or of 'keeping partners safe' outside of a minority of Playing Safe peer educator stories.
- *The Change Stories from peer educators of Playing Safe indicate that peers are both making different choices and doing their decision making differently to the wider target group.*
- *Engaging in commercial sex is 'normal' and common amongst these young men. Condom use within a commercial sex context is more consistent than within sweetheart relationships, based on the young men's perception that sex workers will transmit HIV/AIDS, and the fact that many (most) sex workers insist that clients use condoms.*
- Young men appear to be reducing the frequency of their engagements with commercial sex as a result of the perceived HIV risk associated with this activity
- *Most respondents reported feeling peer pressure to be involved in commercial sex in a group - bauk.*
- *Descriptions of bauk were consistent across time, describing various levels of coercion, humiliation, intimidation and/or physical violence.*
- *Round two data indicates that bauk is an increasingly normalised concept amongst young men.*
- *Round two data also indicates some reduction in the practice of bauk. This reduction is largely the result of an increased understanding of the (HIV/AIDS) risks associated with bauk and demonstrates almost no understanding of bauk as a violation of Human Rights, identifying Human Rights awareness within the context of sexual relationships as an area for continued work.*

Drug Use

- *Knowledge and use of drugs is common among this group of young men, almost all Peer Ethnographic Research cases and a significant number of Change Stories cases demonstrated either knowledge of and/or experience with drug use.*
- *There is an apparent increase in the intravenous use of heroin by this group.*
- *Access to money appears to be the determining factor in levels of drug use.*

- *The Playing Safe model has been shown to effectively contribute to behaviour change in drug use habits; providing support for the design of the Playing Safe intervention.*
- *Drug use has emerged as specifically linked with sexual activity and sexual violence.* Some second round respondents identified taking drugs in order to have sex for longer. This identifies a shift in drug habits to where the 'drug/sex' linkage is acknowledged, planned and exploited.

Condoms

- *Condom use appears to be increasing over the research period.*
- *Access to condoms appears only to be constrained by residual embarrassment about purchasing condoms.* No respondents identified either locating condoms to buy, or the cost of condoms as a prohibitive factor.

Access to Sexual and Reproductive Health Services

- *Young men have increasingly accessed health services.* They most commonly reported accessing NGO clinics, health centres, private clinics and hospitals for reproductive health services.
- *Young men talk with each other about accessing health services, acting as informal referral networks for their friends.*
- *Referrals through the Playing Safe van outreach activity have been seen to increase youth access to reproductive health services.* Peer educators are able to both provide information about available services and strongly advocate to other young people about the benefits of accessing appropriate services.

Access to Sexual and Reproductive Health Information

- *Respondents are able to identify a variety of sources of SRH information, including clinical service points, media and NGO activity.* There remains conflict between the knowledge and practice of accessing information with many respondents simultaneously identifying service delivery points as places where "you need to be sick to go".
- *Young men themselves are frequently acting as sources of information, regularly reporting that they 'retell' what they have learned about sex and sexual health to their friends.*

Perceptions of Peer Educators

- *Responses about peer educators in particular were very positive, with respondents articulating some of the foundational reasons for the employment of peer education models.*

Perceptions of Outreach Models

- *The outreach was perceived as a model having the benefits of peer education, plus the addition of a number of special features making it especially suitable for youth.*
- *The use of a youth relevant approach, employing popular culture through karaoke and specifically youth targeted educational spots was seen as a key factor in the*

value of the outreach model used by Playing Safe. Youth friendly aspects of the outreach model were also valued, free access to information in a convenient location were reported as important and 'good' for young people.

Playing Safe Health Messages

- *Condom use, HIV/AIDS transmission and prevention, contraception, sexually transmitted infections (STIs), drug use and available services information were the most commonly reported messages recalled from Playing Safe.* Evidence from both the second round of Peer Ethnographic Research (PER) interviews and the Change Stories suggest that these messages are being recalled and heeded by young people.
- *Messages relating to social change; gender concepts and Human Rights appear to be being less well recalled and consequently less followed by young men.* The apparently limited impact of these Behaviour Change Communication messages through the Playing Safe model raises questions as to cost effectiveness of using peer education and high scale outreach for the dissemination of relatively common and 'basic' sexual and reproductive health messages.

Communication

- *Young men talk about sex with their friends.* Young men involved in the research indicated that they and their friends engage in two distinct types of 'sex talk'. This provides an insight into the way that groups of young men may encourage and support each other in adopting new or different sexual and reproductive health behaviours as this informal group self monitoring would allow for 'positive' peer pressure to be placed on group members not conforming to new group standards.
- *Evidence of 'learning' talking implies that young men are willing and comfortable to learn from their peers, and that they share health information, not only stories of sexual exploits.*

Perceptions of women

- *Responses clearly demonstrate that young men's perceptions of women are informed by their attitudes around female sexuality*. The vulnerability of women seen to deviate from strict traditional norms of 'appropriate' sexual behaviour, including sex workers, to sexual violence is clearly demonstrated by the conceptual normalisation of bauk against sex workers but not "good and accurate girls".
- *Disregard for the rights, welfare and health of 'sweethearts' and 'other' partners was similarly demonstrated through the absence of consideration of these factors in condom use decisions in the majority of cases*, as well as in the reporting of coercion, rape and sexual violence perpetrated against women other than sex workers.

Key Recommendations

- Develop the messages and materials of Playing Safe (other male-centred SRH interventions) to respond to the need for increased dissemination of social change messages and exploit the lessons learned from the pilot phase of the project.
- Initiate research into the construction of modern gendered identities in Cambodian youth culture, enabling young men to be provided with facilities to explore alternative definitions of masculinity.
- Work with appropriate ministries and state bodies in the production of public education campaigns specifically targeting (male) youth and focusing on Human Rights, Cambodian law and Gender.
- Strengthening and expansion of current quality improvement and awareness raising campaigns focusing on young peoples access to sexual and reproductive health services.
- Increase the availability of sexual and reproductive health information to young people outside of 'health service' sites.
- Develop/strengthen quality assuredness measures within peer education programs; ensuring peer educators meet the expectations of youth seeking their services.
- Continue marketing condom use a part of pleasurable and loving sex.
- Conduct research to explore the evolving links between drug use and sexual behaviour, with a view to integrating learning into future reproductive health programming.

Introduction

Research Purpose

The aim of this research, undertaken over a sixteen month time period by the Playing Safe project of CARE International in Cambodia, is to contribute to increased understanding of critical SRH issues in Cambodia through exploring the way that young, urban middle class men in Phnom Penh experience sex, sexual relationships, drug use, and access to sexual and reproductive health information and services.[1] At the commencement of this research project in October 2004, the goal of the study was expressed in the following exploratory hypothesis:

> *How do young Khmer urban middle class males experience (a) sex and condom use; (b) drug and alcohol use; and (c) access to sexual health information, and services?*

The research was designed to include two rounds of data collection conducted at a 16 month interval. Information was sought about young male behaviour in relation to sex, drugs and accessing information and services. Two rounds of data collection were conducted for the purpose of tracking change and relative stability in young men's experiences of their sexual and reproductive health. The research employed adapted versions of two distinct but complementary qualitative in-depth, semi-structured interviewing approaches; the Peer Ethnographic Tool, developed by Kristen Hawkins and Neil Price (2000a, 2000b), and the Most Significant Change Technique, developed by Rick Davies and Jess Dart (2005). Descriptions of these two methods, and the specific ways in which this research project used them are included in the methodology section of this report.

It was also intended that the research provide insight into the impact of the Playing Safe project itself, with particular focus on the utility of the peer education and outreach strategies employed in the implementation, with a vision of contributing to the design of future similarly targeted interventions. Overall, this study seeks to develop a comprehensive image of young men's experiences of their sexual and reproductive health. By investigating changes in youth's knowledge, learning, and behaviour, this research expects to contribute to a practical understanding of what young men know, how they feel and what they do as a result of their knowledge and feelings.

Issues and Context

HIV/AIDS

[1] Playing Safe was funded under the second EC/UNFPA's Reproductive Health Initiative for Youth in Asia (RHIYA)

Cambodia has an HIV epidemic with an adult prevalence rate believed to be the highest in South East Asia. The age profile of this epidemic, with the majority of new infections occurring in the 15-29 year old age group, means that success in combating HIV in Cambodia is contingent on effectively reaching Cambodian youth. In addition, the Cambodia HIV epidemic is becoming increasingly feminised, with declining incidence rates in males since the mid 1990's being unmatched by similar declines in incidence amongst women, with the result that the gender distribution of people living with HIV is becoming steadily more equal over time. This combined with the fact that the majority of newly infected women are infected by their spouse points to the importance of working with both men and women to combat HIV in Cambodia (NCHADS, 2002).

Youth

The youthful face of the Cambodian HIV epidemic is particularly concerning given Cambodia's demographic breakdown. Cambodia has a large and growing youth population as a result of a post- Khmer Rouge 'baby boom' commencing in 1980 that has only recently abated through the introduction of family planning services. In 2004, at the commencement of this research project, over one third (36.2%) of the Cambodian population were aged between 10 and 24 years of age. Thus, the sheer number of youth, relative to the size of the population, gives this group the ability to significantly determine the health status of the Cambodian population at large.

Sex and Sexual and Reproductive Health

Previous studies in to the sexual behaviour and the sexual and reproductive health knowledge of young people in Cambodia, particularly in Phnom Penh, indicate that young people are vulnerable to sexual and reproductive health problems. Of interest to this study are findings from the Reproductive Health Initiative for Youth in Asia baseline survey (RHIYA, 2004) indicating that gaps exist within young peoples knowledge relating to sexual and reproductive health. This was particularly evident around STIs with the CARE sample of young middleclass, urban, Khmer men (the target group of this study) being the most likely of all respondents to suggest that 'washing the body' was a way to prevent STI transmission. (RHIYA, 2004) This strikingly demonstrates the need for increased information amongst this group of middle class urban men, despite their perceived 'educated' and 'privileged' status.

Studies (Fletcher and Wilkinson, 2002, Bearup, 2003, Soprach, 2004) exploring the sexual behaviour of young men in Phnom Penh in particular have given evidence that this lack of knowledge is combined with high levels of sexual activity, putting young men, and their partners at risk. Each of these studies, amongst others, have identified that young men engage in various types of sexual relationships, with varying levels of risk attached.

In addition, these studies highlight a particularly troubling aspect of young men's sexual behaviour, involvement in group or gang rape, known colloquially in Khmer as 'bauk'. Bauk first received attention in 2002 as a result of the Wilkinson and Fletcher PSI-funded

study “Love, Sex and Condoms; Sweetheart Relationships in Phnom Penh” which identified the practice as ‘commonplace’ amongst male university students. Bauk involves exploitation of power and status, coercion, threats, and often physical violence. It is rape and, therefore, a crime within the Cambodian legal context. (LICHADO, 2005) It is often (though not exclusively) perpetrated against sex workers and often goes unreported and unpunished. Bauk is a demonstration of young men’s attitudes towards some women and as such, irrespective of possible repercussions on the sexual health status of the individuals involved, it is an issue of human rights and thus clearly integral to the promotion of “safe and responsible” sexual behaviour.

Bauk (and other sexual practices) is occurring within the context of an expanding ‘youth culture’ within Cambodia, particularly within the capital where youth are more exposed to the influence of global youth culture through access to television, videos and the internet. As this group solidifies and becomes self aware, there is an ongoing renegotiation of acceptable practice and social, sexual mores, giving an unprecedented opportunity to agencies to work with young people to create positive outcomes. However, this renegotiation is taking place in a context in traditional social attitudes towards male and female sexuality may be seen to place a higher social value on men than women, leading to unequal gendered relationships (LICHADO, 2005) and creating circumstances in which young men dominate the negotiation of sex and condom use, often leaving their female partners unable to exercise their reproductive health choices and human rights.

Peer Education

Peer education is a widely used approach to reproductive health promotion and HIV prevention. World wide, the number of peer education projects is continually growing, yet there are few specialised tools for systematically evaluating the relative efficiency and effectiveness of the approach. (Svenson and Burke, 2005) Generally, peer education (particularly amongst youth and young people) is seen to produce sound results, hence its popularity amongst implementing agencies, but there is limited available analysis as to *why* this is. Peer education is assumed be effective as a result of the presumptions that:

a.) Young people are happiest talking about private or sensitive issues with their peers.
b.) Training young people as ‘peer educators’ is sufficient both to equip them with necessary information and endow them with the necessary status to expect that their ability to provide an information ‘service’ will be recognised by their peers.
c.) young people will change their behaviour as a result of information and advocacy provided by other young people,
d.) There will be a multiplier effect, whereby young people will share information gained through peer educators with other young people.
e.) Its reliance on unpaid volunteers, leading to low operation costs makes peer education relatively cost-efficient.

Whether these presumptions hold clearly determines the ability of peer education to be an effective behaviour change tool. This research study does not attempt to be a comprehensive examination of the dynamics of peer relationships, however, it does seek

to gain insight into youth perceptions of peer education and channels and systems of information sharing between young men, allowing for some tentative conclusions as to the likely efficacy of peer education as an approach with this particular group.

Playing Safe

Playing Safe is an adolescent reproductive health project targeting urban middle class male youth in Phnom Penh; responding to the needs of this group for sexual and reproductive health information and access to services. The project officially began in September 2003 under the second EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA). Playing Safe was designed as a male focused project in response to lessons learned by CARE in the Sewing a Healthy Future project which identified the need for youth male specific initiatives in recognition of their determining role in condom and sex negotiation and a growing understanding of the importance of involving men in sexual and reproductive health in general and the global fight against HIV/AIDS in particular. Playing Safe seeks to empower young males to create positive social networks/opportunities, and to utilize these social structures for encouraging safe and responsible sexual practice with the overall objective of:

> *Contributing to enabling safer sexual and reproductive health behaviour, including increased utilization of quality youth friendly services among target adolescents and youth in program intervention areas.*

Beyond this, Playing Safe has adopted a holistic approach to reproductive health. It aims to integrate concepts of gender equity, human rights and consent into the key messages of the project in reaction to mounting evidence of criminal and antisocial behaviour towards women within Cambodia by this group of relatively privileged male youth. The project is implemented through a peer education model, whereby teams of youth (initially young men, but eventually including young women) are trained in a comprehensive life skills curriculum before commencing a three month period of 'formal' peer educator status. During their time as peer educators for the project, youth are expected to participate in a minimum number and variety of project activities including structured outreach, in-reach, peer to peer contact and formal health promotion activities. Of principle relevance to this report, Playing Safe involves peers in structured outreach through the use of a mobile health promotion van, seen as a unique form of outreach within Phnom Penh.

Playing Safe 'van outreach' activity is conducted three evenings a week from 4:30 until 8:30 pm and it rotates around on different nights to cover approximately 20 strategically selected sites throughout the capital. The van is outfitted with karaoke and audio-visual equipment for the screening of health promotion information 'spots'. In addition to participating in free karaoke (very popular amongst Khmer youth) the outreach activity engages onlookers in reproductive health quizzes and competitions that present five key messages: 1) HIV/AIDS transmission and prevention, 2) STI transmission and prevention, 3) condom use and contraception, 4) Human Rights and gender, and 5) information about available sexual and reproductive health services. The van is staffed by teams of peer educators supported by project staff and serves as a base for peer educators

to distribute IEC and BCC materials and messages to youth in the surrounding area. In addition, the van provides access to condoms through a ‘safe’ gift with sale strategy where youth purchasing competitively priced soft drink from the van receive a small box of (PSI “OK”) condoms for free, eliminating the embarrassment commonly associated with condom purchasing by youth in Cambodia.

This activity is the focus of the peer education component of Playing Safe, accounting for over 50% of peer to peer contacts with the target group over the life of the project. While it is supported by additional peer led activities and facilities including a youth centre hosting regular health promotion activities, a school and university focused sports link component, as well as outreach activities in snooker halls, it is the Playing Safe van activity that is most visible to and cited by the target group. Thus, while this research does not seek to be a comprehensive evaluation of Playing Safe as an intervention, the results of the study are able to provide insight into the target group perceptions of peer education and outreach models, as well as make some initial observations relating to the impact of the Playing Safe project on the target group.

Methodology

Research Design

The goal of this study is to investigate the following research question:

> *How do young Khmer urban middle class males experience (a) sex and condom use; (b) drug and alcohol use; and (c) access to sexual health information, and services?*

This research was conducted within CARE's Playing Safe project. The purpose of the research was twofold: 1) to contribute to the research literature in general (for the specific topics noted in the above research statement), and 2) to serve as one (of many) tools used to help measure the effectiveness and relevance of the Playing Safe project.

The research began in October 2004 and included several different layers of data collection collected from that time until February 2006. Information was sought about the experiences and behaviours of young men in relation to sex, drugs and accessing information and services. The research employed adapted versions of two distinct but complementary qualitative in-depth, semi-structured interviewing approaches; the Peer Ethnographic Tool, developed by Kristen Hawkins and Neil Price (2000a, 2000b), and the Most Significant Change Technique, developed by Rick Davies and Jess Dart (2005). Brief descriptions of these two methods, and the specific ways in which this research project used them are described below.

Peer Ethnographic Tool

The peer ethnographic tool was designed to assist agencies in developing their understanding of human behaviour 'in relation to sexual and reproductive health, [and in determining] … whether programmes are meeting the needs of users and potential users for accessible, acceptable and quality services, products and information (PSI, 2002).' The approach originates from the anthropological/sociological investigative method of ethnography/participant observation in that the research is undertaken over a period of time in the context of relationships based on familiarity and trust. As outlined by Fletcher & Wilkinson, 'the peer ethnographic approach involves training members of a particular social group to become peer ethnographic researchers' (2002). The logic behind the PER approach is that young people are more likely to speak honestly about their sexual practices within the context of a trusting relationship between interviewer and interviewee. Thus using this qualitative methodology, members or insiders of a particular social group are recruited to the research project. These insiders are then trained in interviewing and hired to interview peers within their social network, asking about the sexual behaviours of their peers.

In the Playing Safe research project, the PER method was used to collect data from a sample of more than more than 60 young, urban Khmer men. Young men from the target group were recruited to become Peer Ethnographic Researchers (a profile of the PERs is provided later in this section). They were seen as "insiders" of this social group and thus, according to the PER method, more likely to elicit honest and "more open" responses from their peers about sexual and drug behaviours. The PERs were trained to introduce all questions in the 3rd person using the following introductions: 'What do guys like you think about…?', 'what do young men from this area do?', 'what do young men you know think about?', and 'what do your friends…?'. Through de-personalising questions, the PER method aims to overcome the embarrassment of asking personal questions about sexual behaviour, and instead seeks to gain youth impressions about the behaviour of their peers.

Two rounds of data collection were conducted. The first round was collected (and analysed) in October – November 2004. The second round of data was collected 15 months later, in January – February 2006. In addition to better understanding the social context (i.e. the behaviours and attitudes of these young men), the data collected from the two intervals also sought to capture evidence of any changes in these young men's sexual practices, drug use, and attitudes about sex and drug use occurring over the fifteen-month time frame. Data from 77 youth was collected and analysed for the PER portion of the study.

Most Significant Change Technique

The second key qualitative data collection technique employed in the Playing Safe project study was a modified version of the Most Significant Change Technique (MSC). The MSC Technique uses a story approach to answer questions about change. It is primarily used as a form of participatory monitoring and evaluation. It focuses on monitoring intermediate outcomes and impact. MSC is done using the "collection and systematic analysis of significant change stories" (p.9). The approach has been compared to Appreciative Inquiry (AI) and other qualitative data methods including Case Studies. However, AI is generally used in a project's planning stage, where as the MSC aims to examine qualitative changes that have taken place within a program and its participants. Furthermore, MSC is also similar to Case Studies in that both methods generate very rich descriptions. Yet MSC differs from Case Studies in that MSC stories are generally collected by those directly involved in the program, and data analysis is done by program staff at various levels within the program, using a participatory process. Thus different project staff and stakeholders may note different aspects or "changes" in the stories that they identify as relevant. The stories, and the participatory data collection and analysis process, can therefore help to identify unexpected changes. The inclusion of various project members in conceptualizing impact makes this technique very powerful.

The MSC technique has several implementation steps to examine significant changes stories collected from the field.[2] The Playing Safe project did not follow all the "full"

[2] See the MSC Guide available at www.mande.co.uk/docs/MSCGuide.html for a detailed exposition of this technique.

implementation of MSC, but adapted it as needed to complement the PER data being collected by the project. While the PER data was intended to provide an overview of the behaviours and attitudes of young, urban Khmer men, the MSC data was meant to provide insights into changes in young men who had participated on some level in Playing Safe project activities.

The qualitative stories (in this report referred to as Change Stories (CS)) collected information from youth known to have interacted with the Playing Safe project. PER data, in comparison, was collected from young men who hung out in the Playing Safe target areas, but did not necessarily participate in any Playing Safe activities. PER data provides an overview of knowledge and visibility of the project and perceptions of peer education and outreach approaches in general, while the CS data offers more specific insights of the impact of Playing Safe on those youth who have had interactions with the project.

The CS data was collected monthly from September 2005 until February 2006. The data collection focused specifically on two distinct sub-groups of the projects target population: 1) peer educators working with the Playing Safe project, and 2) peers (young urban men) selected on the basis of "having knowledge of and observed interaction with Playing Safe project activities". Playing Safe peer educators were responsible for collecting the data. In collecting stories from the target group (peers), they were asked to begin conversations with young men spending time in one of the Playing Safe van outreach locations, to steer the conversation toward SRH issues and determine if the prospective interviewee had had any prior knowledge of Playing Safe and to continue with an interview only if this could be established. The interviews were shaped around the following three questions:

1.) How do you feel about this Playing Safe Activity?
2.) What do you like/not like about it and why?
3.) What have you learned from this activity, and what has this meant for your life?

In collecting stories from peer educators (including themselves), they were asked to reflect on their extended interaction with the project. Specifically, the peer educators were asked the following: "Looking back over your experience working with Playing Safe, describe the *most significant change* in your life, livelihood, work or broader context that you would relate back, in some way to the project, whether big or small, positive or negative. Briefly explain why you chose that change – why was it significant to you? If you were to give your story a headline, what would the headline be?"

They prepared written stories about themselves, their colleagues (interviewing fellow peer educators) and from their peers (young men in the Playing Safe target group population). Data from 20 peer educators and 40 peer youth target group was collected for the CS part of the research. The peer educators, along with other Playing Safe project staff, were also involved directly in the data analysis of the stories. Hence the data collection and analysis techniques used by Playing Safe project with the CS data, sought

to capture the participatory benefits of the MSC approach, by allowing beneficiaries of the program to articulate what they felt to be significant, allowing for unexpected outcomes, rather than defining boundaries of change by prescribed indicators.

Sample

Both the researchers and respondents were recruited from eight different sites within Phnom Penh. These locations are areas in which the Playing Safe van outreach activity has been conducted over the length of the research period, or in the case of the Snooker club location, where Playing Safe peer educators have been conducting 'Snooker Outreach' activity over the same period. These locations were initially identified as target sites for project implementation through a site mapping activity conducted by Playing Safe project staff in early 2004. This mapping comprised staff members being allocated particular sections of the Phnom Penh district which they toured by motor bike, looking for areas where significant (over 25 individuals) numbers of the Playing Safe target group gathered during the scheduled activity time of 4:30-8:00 pm Tuesday to Thursday. This mapping activity resulted in 20 locations being selected as sites for van outreach activity based on popularity with target youth and availability of space for the van itself. Of these sites, the eight most popular were selected for the initial round of interviews: Naga, Toa Pi, Pop Club, Phanashastra University, Royal University of Phnom Penh, Boeng Keng Kang High School, Olympic Stadium and Chroy Chang Var round about.

Over the fifteen month period between rounds of data collection, three of these locations: Pop Club, Phanashastra University and the Royal University of Phnom Penh became unsuitable van outreach/research locations. Thus, the second round of interviews necessitated the inclusion of new locations for research: Capitol Snooker club was selected to replace the closed Pop Club as it was an existing site of Playing Safe activity and the researcher responsible for the original location had begun to spend time in this new location, giving him access to 'friends' from this area. In the case of Phanashastra University, the researcher and his friends had ceased to spend time in that location, but had moved to another Playing Safe van outreach location of the Public Park adjoining the Royal Palace, thus this new location was selected for the second round of interviews. The Royal University of Phnom Penh location had ceased to be a Playing Safe Van outreach activity site as a result of declining target youth numbers spending time in the area, the researcher originally responsible for this site was not contactable for the second round of interviews. The Psar Doem Kor location was selected to replace this site due to its popularity with youth and its longstanding as a Playing Safe van outreach site. A new researcher was recruited to conduct interviews in this location.

Peer Ethnographic Researchers and Respondents

The Peer Ethnographic researchers were hand selected by a Playing Safe staff recruiter spending time in the project areas and approaching young males who appeared to be

middle class in socio-economic status as indicated by social status markers such as clothing, ownership of a mobile phone or motorbike. After identifying a potential candidate who appeared to meet this criteria, a conversation was started during which the recruiter attempted to assess the candidates potential according to the following factors: amount of time spent regularly in the target area; estimated number of friends in the target area; likely amount of time that the candidate will continue to gravitate to the target area; the estimated level of intelligence or capacity to learn and become a researcher; and finally the amount of free time available for the candidate to participate in the training and research.

PERs self selected respondents from their peer group. The PERs were instructed to conduct interviews with their peers or friends, specifically; individuals that they identified as 'guys like them' whom they also knew spent time in the target area they had been allocated. The premise of the PER approach is that the PERs themselves are 'insiders' within the target group; the selection of respondents based on the identification of 'sameness' by the PERs naturally flows from this. Almost all the same PE researchers were used in both rounds of data collection, giving access to the same 'groups' of respondents if not the same individuals over the time period. Efforts were made to interview the same respondents in Round 1 and 2 data collection, however in most cases this was not possible (as briefly explained in the study limitations).

As far as possible the same PE researchers were gathered together to participate in the both rounds of data collection. In two cases the researchers were no longer contactable, or had ceased to spend regular leisure time in the target area, so two new researchers were recruited using the same selection criteria and methodology as employed for the initial selection of the researchers. Eight researchers participated in each round of data collection, with a total of ten researchers conducting interviews over the two rounds of interviews. As shown in the following table, the majority of the PERs were either university or other post secondary students, with one PER attending high school, and one employed in business. All of the PERs were living in Phnom Penh at the time of the data collection, with the majority living close to their target location (hence spending time there).

Table One: Peer Ethnographic Researcher's Profile

Name	**Age at Round Two**	**Occupation**
Choung San	20	Student (Private, Post Secondary)
Pheakdey	24	Student (University)
Sophat	19	Student (High School)
Sarom	24	Business Man

Sany	21	Student (Medical Assistant)
Kim Sros		Student (University)
Chiva	23	Student (University)
Theara	22	Student (University)
Kim Sros (2)	23	NGO Volunteer
Vathana	23	Student (University)

A total of 77 respondents were interviewed over the two data collections, with approximately 40 respondents being interviewed in both rounds. The majority of respondents identified themselves as students, mostly enrolled in one of the many universities in Phnom Penh. Across both rounds of data collection, a total of five respondents identified themselves as employed either in garment factories or small business. The average age of respondents was 21, and they ranged in age from 17 to 24 years old. This respondent profile is consistent with the Playing Safe target group of middle class urban males between the ages of 15 and 25, and is also representative of the youth typically involved in Playing Safe activities as well as the Playing Safe peer educators.

Change Study Researchers and Respondents

CS researchers were selected from active peer educators of the Playing Safe project. The peer educators were selected according to their interest in participating in the research as well as their willingness and ability to devote adequate time both to the collection of stories and attendance at a working group to be formed for analysis and coaching sessions. A total of 14 peer educators participated in the data collection for the CS study. The peer educators selected as researchers included four young women, two of whom were unable to work as researchers for the full length of the study period due to other commitments. The peer educator researchers were all between 20 and 22 years of age, and all were university students working as Playing Safe peer educator volunteers in their spare time. The peer educators were all living in Phnom Penh for the period of the study. Each peer educator researcher collected an average of three stories from the peer youth target group and an additional two stories from peer educators of the project.

The CS respondents included both peer educators and peers from the target group (young, urban Khmer men from Playing Safe target areas) who had varying levels of interaction with the Playing Safe project. Interviews were conducted only with youth who confirmed they had knowledge of the Playing Safe Project, such as seeing or participating in project activities either in the location of the interview or elsewhere. Peer educator respondents

were drawn from both the CS Working Group team (a group formed as part of the research study), and from the wider Playing Safe peer educator population. Some peer educators interviewed their colleagues and prepared the write up, while other peer educators wrote their own change stories about themselves.

Of the peer educators interviewed by their colleagues, 100% were male, between the ages of 19 and 22. The majority of those interviewed were university students, reflecting the make up of the wider peer population. 2 female peer educators, aged 20 and 21 provided their own self written stories; the remaining self written stories were collected from male peer educators aged between 20 and 22. Stories from the peer target group included four stories gathered from young women, with the remainder gathered from young men. The respondents ranged in age from 18 to 23, and the average age of the respondents was 21, many of the respondents identified themselves as university students, with the minority stating that they were employed either by organizations, or in small business.

In total, 20 peer educators and 40 peers from the target group were interviewed or provided self written stories. 90% of the peer educators stories (either self written, or gathered through interview) were collected about male peers from the target group, while 10% were collected about female peers from the target group. While this is not representative of the stated 'middle class urban male youth' target group of the project, it is more reflective of the make-up of the peer educator population of the Playing Safe project, in which the male to female ratio is approximately 4:1.

Training and Data Collection

PER Round One

For the first round of PER data collection, October 2004 to November 2004, the PERs were recruited from 8 geographical project target areas In Phnom Penh as outlined above. and trained as PERs over a 4-day workshop. The training was conducted using participatory learning methods including brainstorming and group discussions as well as structured question and answer time in which the PERs were encouraged to raise questions relating to the training confidentially through the use of a question box. Training sessions were conducted over a four day period, covering topics including: sexual health and drugs; conversations about sex; methodology, interviewing; field notes; and, developing conversational prompts. The fourth day was spent completing a practice interview, receiving further coaching and undertaking role plays. The development of conversational prompts and the practice interview and coaching sessions are the key elements used to ensure successful employment of the tool. Prompts were developed through extensive consultation with the peer researchers so as to ensure they are suitable for use with the target population, of which the PERs are members. Equally important, the practice interview sessions determine the capacity of the PERs to confidently and appropriately use the developed prompts within an interview setting. The role of the trainer/senior researcher in this step is crucial to ensure that there is sound understanding of the methodology by the PERs.

Upon completion of the training, the PERs were sent into the field to conduct five informal semi-structured interviews with peers known to spend time in the target area over a three-week period. The interviews were shaped around the topics of sex and condom use, drug use, and access to information and services and were executed using the prompts developed in the training sessions to guide the direction of the conversations. (See Appendix One) The PERs were required to conduct the conversational interviews using the pre-identified prompts and then, as soon as possible following an interview record the field-notes from memory and submit these notes to the research team for feedback and further coaching. For this purpose, a further 5 – 10 hours of coaching and support, both face to face and via mobile telephone, was provided by the senior researchers responsible for the training sessions over the three week collection period.

PER Round Two

Training for the second round of PER data collection was modelled on the first training sessions with some modifications resulting from lessons learned during the first data collection. The second round of data collection differed from the first in that, as a second phase, it was seeking more specific understandings of behaviour, relationship and in particular, any possible changes perceived by respondents since the first round of data collection 15 months earlier. The PERs required additional support and training to enable them to include appropriate prompt questions and to ensure that they understood the focus on measuring change. This support was provided through the inclusion of a 'test' period followed by supplementary training and mentor interviews, as detailed in both the Fletcher& Wilkinson adaptation of the PER tool and in the Hawkins and Price description of same. In addition, there was particular focus on the development of prompt questions that would elicit descriptions of change as perceived by young men in the target group, allowing for a more participatory assessment of change than would have resulted from researcher analysis of difference in data from one round to the next.

A four-day training was conducted in November 2005, followed by a two week period in which each PER was required to collect one case. These cases were assessed by the research team to define any further training requirements of the PERs. The PERs subsequently participated in an additional one-day training where supplementary interview practice was provided and further modifications of the prompt questions were made. In particular, the input of the PERs was sought in the modification of the prompts so as to elicit both youth perceptions of change and responses comprising adequate detail so as to allow the researchers to analyse the first and second round cases for evidence of change. Given the time constraints of respondents, it was found that the initial prompts were successful in gathering only surface level, contextualising descriptions of target group attitudes, behaviour and knowledge. Through discussion with the PERs, it was determined that providing the respondents with a preliminary context based on the previous years findings would allow them to move beyond this level within the time that they were willing to devote to the interviews. The PERs were instructed in the use of these prompts which were introduced using the following format: 'last year, we learned that young men in this area reported ……about…….is this still the case?, have there

been any changes?' (See Appendix two) Following this second training, the PERs were requested to undertake interviews with an additional four peers over a six week period, re-interviewing the same peers as in the previous year where possible. Again peers were instructed to introduce questions in the third person, so as to avoid embarrassment for the respondents. Throughout this period, the PERs received regular supervision and support. In this round, PERs were required to meet with a with a field mentor (one of the senior researchers responsible for training) as soon as possible after completing each interview. The mentor then reviewed the notes from the interview and guided the PER to recall responses in detail, taking a second level of notes that was combined with the field notes of the PER to form one complete case. The mentor interviews, taking approximately 1- 2 hours each were also used for providing coaching to the PERs for the completion of remaining cases.

PER Group Discussion and Debriefing

A group discussion and debriefing was conducted with PERs subsequent to the completion of the second round of PER interviews. The group discussion was facilitated by two young male Playing Safe staff members previously unconnected with the research project, but possessing strong training and facilitation skills. The group discussion was attended by six of the eight researchers involved in the second round of interviewing. The other two researchers were unavailable at the scheduled time of the group discussion. The goal of the discussion/debriefing was three fold. Firstly; the PERs were asked to give a brief analysis of their feelings about the responses given by their peers throughout the interview process. PERs were asked to describe the responses given in terms of their perceptions of honesty and completeness, giving the team insight into the quality of the data collected. Secondly; the group discussion sought to gain a wider insight into young men's experiences and thinking about sex and reproductive health. To this end a short questionnaire was developed around the initial findings from the research data (Appendix Three). The facilitators introduced these questions with an explanation to the PERs that there were no wrong or right answers to the questions, that what was sought was their own opinions, as researchers, as young men living in Phnom Penh and as members of the Playing Safe target group as to what extent the findings were representative of youth behaviour and experiences. Thirdly; the final portion of the meeting was conducted as a debriefing of the research experience according to the researchers. The purpose of this session was for the core research team to gain knowledge and understanding of the PER process from the perspective of the PERs so as to make necessary adjustments to the implementation of the tool for future research studies conducted by CARE. Throughout all parts of the group discussion and debriefing session, the researchers were assured that their confidentiality would be maintained and that while some responses would be included in both the final report and possibly internal documentation of the PER process neither of these would include the names of the individuals making statements.

Change Stories

The Change Stories data collection was conducted with active peer educators of the Playing Safe project serving as researchers. Ten peers (including 6 males and 4 females)

were selected to participate in a 2-day qualitative evaluation techniques workshop alongside Playing Safe project staff and local NGO counterparts. The workshop introduced the concepts of appreciative inquiry; with a focus on affirmative questioning and attentive listening, as well as the Most Significant Change approach as developed by Rick Davies and Jess Dart (2005); focusing on the role of respondent selection of significant stories to be told. Peer educators participating in the workshop were subsequently invited to form a Story Collection Working Group and undertake an additional two days of training in applying the concepts and techniques already introduced. Peers were coached in the use of probe questions and conducting conversational style interviews as well as recording field notes. In contrast to the PER technique, the peers were *not* instructed to ask questions in the 3rd person. In collecting CS data the peer educators relied on their ability to form a rapport and assurances of confidentiality to encourage honest responses from the interviewees. To further encourage honesty, peer educators were instructed not to identify themselves as working for Playing Safe, *however, it is clear from the stories collected, that in some cases either the interviewee recognised the interviewer as a Playing Safe peer educator from previous activities or, that the peer educators did indeed identify themselves as working for Playing Safe*.

The peer educators were required to conduct conversational interviews with youth in the target area on a monthly basis. They were encouraged to begin conversations with young men spending time in one of the Playing Safe van outreach locations, to steer the conversation toward sexual reproductive health issues and then to determine if the prospective interviewee had had any prior knowledge of Playing Safe and to continue with an interview only if it was established that the respondent had some level of interaction with Playing Safe.

After a few months of collecting and examining stories from target group members, the Playing Safe project also asked the peer educators to reflect on their own significant changes as a result of participating in the Playing Safe project as peer educators. These stories were collected from Playing Safe peer educators using two methods: 1) members of the Working Group were encouraged to write stories of their own involvement with Playing Safe using an MSC based prompt question as a guide, and, 2) Working Group members were instructed to interview other peers using a CS prompt question developed by the group for this purpose and the techniques developed in their interviewing of the target group.

The function of this level of data collection was to collect specific accounts of interaction with Playing Safe and the impact thereof. The interview guide/prompts for both groups (peer educators and target group peers) were focused on stories of change, identified as significant by the respondent that could be attributed to their involvement with the Playing Safe project. In MSC terminology, the ‘domain’ of change was open, in that it could relate to any aspect of the respondents’ life, with the only boundary that the change had to relate to Playing Safe, according to the respondent.

Data Analysis

The data collected for both the PER and the CS was recorded in Khmer and subsequently translated into English by both externally paid independent translators, and Khmer senior researchers involved in the research study. The researchers sought to engage in extended conversations with the principle researchers about the literal Khmer terms and the appropriate English words that could be used to translate the meanings of the responses. Popular or commonly repeated Khmer words and phrases were also collected and have been included in the Glossary & Acronyms section.

PER data

While most of what was recorded by the PERs was based upon verbal responses, the PERs were further encouraged to record body language, hand gestures and researcher intuitions about the information they were being given. The research analysis was conducted around the three themes of sex and condom use, drug use and youth access to services, products and information. The data analysis team consisted of five researchers. The team categorized and coded each of the interviews, noting patterns and emergent themes. Responses were further analysed for inadvertent admissions, omissions and inconsistencies in order to gain insight into hidden areas of thought, attitude or practice. Through these processes the researchers sought to identify common knowledge, attitudes and behaviours amongst the interviewees, as well as evidence of changes over the 15-month period over which the research was conducted. Secondly the researchers and authors of this report undertook to develop theoretical explanations/propositions and link these to the findings of previous research studies, developments in the social environment and/or larger bodies of theory.

CS data

Throughout the CS data collection period, the Working Group, which consisted of 14 peer educators, 2 Playing Safe implementing partner organization staff members, and the Playing Safe project manager, participated in monthly meetings to read and analyse the stories in an adaptation of the MSC ‘most significant’ selection process. In a departure from MSC however, the stories were not ‘culled’ through this process, rather the relative strengths and weaknesses of the stories relating to content, collection and writing were discussed and techniques for improving story quality through strengthening interview technique were developed, resulting in a total of 60 progressively stronger stories collected over the seven month period.

Throughout the analysis sessions the Working Group team sought to divide the stories into domains of change, identifying behaviour, attitude or knowledge changes amongst both peer educators and the wider peer target group. Stories were discussed according to level of change (domain), links to the project and significance in terms of the demonstrated roles of peer educators. These insights gained from the data were then used to provide the story collectors direction for gathering additional stories.

Supplementary to this analysis, the stories were further analysed by the Project Manager and two senior foreign researchers to examine the results in terms of key messages of project impact. The stories were categorized and coded according to emergent themes and patterns as well as levels of change, using the same process as for the PER interview cases. Only those results that relate to the specific topics and themes of the PER level of data collection are included in this report. A full analysis of the Change Story Data will be documented in a forthcoming report to be produced by CARE International in Cambodia.

Limitations of the Study

Sample Considerations:

Firstly, it is acknowledged that the sample size of this study, at a total of 137 individuals is small. Thus the results and conclusions drawn from them are not presented as necessarily representative of the entire population of middle class, urban Khmer men aged between 15 and 25 years living in Phnom Penh. However, one of the key strengths of the PER approach is the way that it draws deeply upon the experiences of 'groups' of individuals through the use of multiple third person interviews rather than more shallowly from a larger number of respondents. While most commonly cited as a positive factor in terms of gaining honest and candid answers from respondents, this 'group' narrative characteristic of the third person interviews allows for a relatively small sample to capture the experiences of a much larger number of individuals. Thus, it is felt that the results and conclusions of this research, while not definitive, are certainly able to point toward areas for action and further study.

In addition, in the case of the PER component of the study it was largely impossible to adhere to the initial research design by interviewing the same individuals in both rounds of data collection. As noted in the methodology section, in the majority of cases PERs were unable to access the same individuals interviewed in the first round of interviews for the second phase. This was the result of two factors: A number of PERs were unavailable for the second round of data collection, necessitating new respondents drawn from the peer group of these new researchers, and, secondly; Most of the PERs retained from the first round of data collection reported that that many of their friends interviewed in the first round were no longer contactable, had ceased to spend time in the target areas, or were no longer living in Phnom Penh. This clearly limits the ability of the study to measure change across time in particular individuals. However, by retaining the same PERs (as possible) in both rounds of data collection it was possible to access the same *groups* of young men. Given the 'group narrative' characteristic of PER data, it is felt that this provides an adequate level of consistency in sample across time. Of the 77 respondents interviewed for the PER component of the study, approximately 40 were interviewed in both rounds of data collection.

The Process:

Working with youth PERs provides a researcher access to places where s/he otherwise could not go. However this benefit is accompanied by the draw back that interviewing is undertaken by newly trained and inexperienced researchers. The field notes from both rounds of interviews indicated varying standards in the execution of interviews and the appropriate application of conversational prompts. Building on the lessons of the first round of data collection, additional training and a test interview period were introduced in the second phase, resulting in more consistency in the quality of findings across PERs; however in some cases from each round of interviews findings were limited in terms of describing the knowledge and attitudes that underlie youth behaviour.

The capacity of the PERs to perform as effective key informants is based largely on the capacity of the senior researchers to provide quality training, coaching and mentoring throughout the data collection process. This is particularly applicable to the 'mentor interview' component of the methodology employed in phase two. In conducting this study, it was felt that this aspect could have been strengthened, but was constrained both by the time available to the PER volunteers and the senior researchers as well as the relative experience level of these key figures. While it is felt that this constraint limited the depth of responses obtained from the PERs, it is also recognised that the second round of interviews produced results of greater consistency and richness than the initial round of data collection.

Objectivity:

Another factor to be considered is that young men are widely considered a group that may be likely to exaggerate their own sexual exploits, or those of their friends. Other subtle factors may have led some young men to exaggerate their stories, such as a desire amongst interviewees to be able to provide answers to their Peer Interviewers and 'keep face'. Perhaps other interviewees shaped their responses out of a desire for acceptance from their peer who was undertaking the interviewing. Of course it should also be remembered that when the PERs record their field-notes they are themselves condensing and prioritising pieces of information, reporting on some findings and leaving out other information. Similar decisions are further made of course by the principle researchers/report authors that must look for patterns and seek to include some quotes in the final report considered pertinent and relevant, whilst excluding other statements thought to be peripheral. These factors acknowledged, it should be remembered that an ethnographic approach is less concerned with gaining objective facts, and more interested in uncovering people's perceptions, and examining their stories about reality.

Translation:

It is acknowledged that in all processes of translation, depth and richness of data and subtler meanings are often lost or can be misinterpreted. We have sought to carefully translate meanings into English using the time and financial resources available. However, it should also be remembered that whilst this study has drawn on the anthropological tradition of ethnography, the first round of data collection and analysis occurred within a 6 week period and the second over a total of 9 weeks during which the senior researchers (key figures on translation of meanings) had many other commitments. Therefore, both time and financial constraints have impacted upon the translation undertaken and the conclusions rendered.

Results

First Sex

Young men were asked when 'guys like them' first started having sex, what type of sexual relationships young men were involved in, and why they felt 'guys like them' began having sex at the identified age. While several respondents stated that first sexual experiences for these guys was at age 13 or 14, the more common responses in both rounds of data collection suggested first sex occurred around 18 years of age. Dara, a 21 year old student, explains:

> They started having sex around 18 and it's usually because their friends invite them to a party. After they get drunk they always go to the brothel and other times they just feel horny so they go. They always go with three or four friends when they go to the brothel. (PER29, 04)

Akhla, another 21 year old student agrees:

> Sexual relationships that young men like me have had is mostly having sex with prostitutes, and less with girlfriends. Young men at about my age start having sex at around 18 because they are overwhelmed by their friends and want to be happy. Most of the time they go to Bun Pao or Toul Kork, they go at about 8-9 o'clock at night. (PER16, 04)

The same typical response was repeated in the second round of interviews:

> youth often start sexual intercourse from 17 to 18 years old. And for their sexual activities, they still do the same things because it makes them happy. The youth in my age start having sex at 18 years old because of wanting to be happy and test. Anyway watching pornographic film makes them feel more sexual urges. The reason they start having sex at that age is because they get carried away with their friends, being drunk, being tempted by their friends and also because they choose to. (PER14, 06)

In addition to identifying the age of sexual debut, responses to the questions around first sex also provided insight into the type of sex that constitutes a young man's first sexual experience. As in the first two cases above; the first round of data collection pointed to a tendency for first sex to revolve around commercial services. In the second round of data collection, while there were still frequent references to commercial sex, there was also a marked increase in references to sex with sweethearts, girlfriends and even wives within the context of first sex.

> Young people like me start having sex at the age of 16-17 because they follow other friends and they have girl friends or Sangsar at that age. Example: They

> have Sangsar and they want to follow the elder because elders can have sex so they can also have sex as well. (PER 38, 06)
>
> My friends practice sexual relationships with their girlfriends and most of their girlfriends are students at high school because girls like guys who have money and are fashionable [while] on the other hand the guys want to find virgins so that they can make them not use condoms (PER 9, 04).

Young men were additionally asked to discuss why they felt 'guys like them' began having sex at the identified age. Again, there was a significant element of consistency across data collection periods, with a handful of reasons being commonly given across both rounds of interviews. The majority of young men spoke about curiosity and a desire to be happy. Chen, a 19 year old high school student explained that his peers 'have been having sex since they were around 17 years old because they want to be happy, are curious and have sexual desires'(PER5, 04). In a strikingly similar statement, Kosul, interviewed 15 months later describes that his friends 'start having sex around18-19 years old because they need joy. Also, they think they are old enough to have sex. Moreover, they want to experience having sex, they want to know what it is like' (PER 15, 06).

Added to this curiosity is a seemingly growing exposure to sexualised 'culture'. This is primarily evident through references to pornography, but can also be seen in comments relating to 'sexy clothes' worn by girls and 'sexy' or 'bad' foreign influences. Present in the first round of interviews, but significantly more pronounced within the second round is the stated influence of pornography on the sexual desires and aspirations of this group of youth. Throughout both rounds of data collection, youth referred to 'pornographic', 'sex' and 'obscene' movies, books and pictures as prompting sexual desire and thus sexual initiation. The following comments are representative of a significant majority of the statements made within the PER interviews across both time periods. Recalling that the 76 youth interviewed were not expressly relating their own experiences, but those of their friends and peers, these statements give a clear indication as to the popularity and availability of pornography amongst this group.

> Youth are starting having sex from 16 to 17 because they think that at their age it is normal to feel like sex. It is seeing pornographic books and seeing sex films that make them feel sexual desire. (PER9, 06)
>
> They still continue, and begin to have sex at 16 to17 years old because they often see sex Videos and books or magazines which have sex pictures. The sex pictures make them want to have sex. (PER10, 06)
>
> Sexual playing that young guys do involves going to see a sex worker. Young people my age start to have sex around 17 because of watching too many pornographic movies. (PER19, 04)
>
> Many young people start having sex around 17-18 years old. This has not changed. And young people like me start having sex because they want to know

> about it, some were forced by friends and led by pornographic film. This activity still continues now, some times young people like me find sex services to relax stress, especially sexual relationships with beer girl promoters in restaurants. (PER16, 06)
>
> Youth lose their virginity when they are 18 to 23 years old. Because they are overjoyed with their peers and they feel sexual, they watch phonographic films or through phones. In their phones, they insert sexy karaoke programs and it makes their sexual pleasure feeling more passionate (increase). (PER 38, 06)

These statements clearly suggest that a significant proportion of youth have access to pornography within Phnom Penh. The ready availability of pornography, specifically to minors, has been documented by O'Shea in "A Preliminary Study into the Accessibility by Minors of Pornography in Cambodia", a Briefing paper produced for the Child Welfare Group in 2003. (O'Shea, 2003) This is of particular interest in the Cambodian context in which there is typically limited discussion of sexuality and sexual relationships. This means that youth are not generally taught about sex or 'good sex', leaving pornography to form the only exposure to sexual acts, and thus to constitute the entire sexual script of young people. This is of particular concern in terms of the potential impact on sexual behaviour when one considers the often 'hard' and violent nature of pornography available. (O'Shea, 2003)

In addition to pornography, a few respondents identified other 'sexualised' aspects of culture and society that prompted young men to seek sexual relationships. Responses indicating an awareness and perceived influence of foreign culture occurred more in the 2nd round of data collection in 2006. Most identified general concepts such as "Modern youth mostly have sexual intercourse because it is a new era and the adopting [of] foreign culture.(PER4, 06)" but in some cases, detailed explanations were provided as follows.

> There has been a change from the last year because of the rapid development of Society: the girls grow up fast now, [and they] follow other friends. For example: They see young boys driving a motor with his girlfriend or Sangsar and they want to do [the] same as [they have] seen. (PER38, 06)
>
> Mostly, they want to do like foreign society and Khmer youth like my friend, he likes American and French society to talk about and also [to] practice, such as his sweetheart lived with him and they called each other "wife" or "husband" but they weren't married yet. He lived in foreign style. (PER20, 06)
>
> …this sexual behaviour is dependent on seeing other, foreign, cultures, such as obscene movie and the locations [to] buy sex disc (PER31, 06)

There appears to be a perception amongst young men that society is changing, influenced by 'other', 'foreign' cultures, in a way that pushes them toward sex. However, the descriptions of these changes, the 'reasons' for engaging in sex such as viewing pornography, and things from abroad are in fact not new. Similar explanations were

provided almost ten years ago in the then groundbreaking "Cambodians Don't Talk About Sex , They Just Do It" study prepared for UNAIDS (Tarr,1997). In this study, respondents variously identified a "foreign journal on sex" and pornographic films as driving sexual desires that could not be denied, ending with the individual visiting a brothel. Nor do they represent new ideas about male sexuality in Cambodia; the understanding of sex as a 'natural' and thus uncontrollable force once awakened. Further, young men continue to identify that these messages are reinforced by their peers in the form of peer pressure. Many respondents made reference to the expectations, interests and judgments of their peers as impacting on their decisions to engage in sex.

> They start to have sex around 18 years old because they feel like having sex and sometimes young men are pressured by their friends to have sex when they go out drinking (PER10, 04).
>
> The result is that they have sex at this age because they are young and irresponsible, go out to drink beer, want [to have] happiness, and especially, they are dragged by their friends. (PER 31, 06)

In a concise articulation of the role and impact of peer pressure, one young man explained that 'some say that if they don't play around, they feel ashamed so [then] they start to play around' (PER23, 04)[3]. It is here that the role of the peer group in defining masculine norms of behaviour becomes apparent. Most males experience puberty and have full sexual capacity approximately four to six years earlier than eighteen years of age. Therefore it is unlikely that young men become sexually active at age 18 simply because of reaching physical maturity. Similarly, as stated, the availability of pornography to minors throughout Phnom Penh in particular has been documented, and the impact of 'changing society and culture' is no more visible to youth at eighteen than at an earlier age. It is likely then, that young men are more likely to engage in sexual activity at 18 because of social expectations to 'become a man' and demonstrate their adult status at about this age. The link between being sexually active and manhood was supported by several references to 'being completed' and proving adulthood and is further demonstrated in the following statements:

> As my friends tell me about 10 to 15 of them had sex for the first time around 18 – 20 years old. They don't want their friends to look down on them, [or think] that they are impotent in sex and [they] also want to show that they are completed men. (PER36, 04)
> They started to have sex at age 18 years old. They started to have sex at this time because they wanted to show that they are adult, and wanted to know [and] test love. (PER7, 06)

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3 The use of this description of sexual activity as 'Play' is common within Khmer youth discourse. The planned new phase of the project will involve a change of project name; from 'Playing Safe' with its 'fun/recreational sex' connotations to a name more reflective of the goal of the intervention in terms of encouraging young people to place a value on sex and sexual partners.

> The youth start having sex from age 16 to 17 years because they want to show their friends that they are adults. Sometime they come to see sex film or want to know the taste of having sex because they are persuaded by their friends. (PER12, 06)
>
> …because they want to show they [are] mature enough to have sex and they want to test of love [that they] don't know (PER 19, 06)

Amongst those stories from peer educators of the Playing Safe Project which dealt with first sex, there was an increased tendency for respondents to describe the decision making process, indicating awareness of the choices available to them and the possible repercussions of early sex. A key message of the Playing Safe project is developing skills to negotiate peer pressure and make choices that demonstrate youth's ownership of their choices, bodies and lives. The internalisation of this message is evident from such comments as those that follow:

> So far, I rarely go out with them (my friends), and when I have free time from my studying I always do house work and go to visit the Youth Centre of Playing Safe Project because there is a library and other sport to do there, and also I thought that it is better not to do something illegally. Moreover, a woman can keep her virginity for her future husband, and I, men, should do as she does. I will keep it until I meet someone whom I love and marry her in order to show my loyalty to the person whom I adore. The reason I decided to choose like this is because it makes me feel better, have happiness in my family and not feel afraid of going out when ever. (CS 39)
>
> …now I know that finding sex service and having sex with a sex worker can make me face danger. I think that it makes us happy for a short time, but that we will be afraid if we do it wrong. When we go to sex service, I think that we spend money for no benefit, and the possibility of danger. I think that I am too young. Although my friends call me to do it, I don't join them. Sometimes they pressure me, but I trick them to avoid having sex. I think my first sex should give to someone I love. (CS 42)
>
> I admit that all people would find it difficult to avoid being involved in sex because it is biological and we can not change that, especially because it is because of nature that having sex was the way to produce a new life. As for me, I had known a woman, and we loved each other so much, and we promised to marry each other in the future as well. I went with her to a quiet place when we started to become intimate with each other. And I felt sexual desire; however, she managed it by telling me the consequences of having sex at a young age, especially being an unmarried couple. She told me, with a look of sadness on her face, that having sex could lead to unwanted pregnancy, and if she were pregnant, what would she do? Also, she said that if she went for an abortion, she would be at high risk and "spoiled", especially, her family's reputation, she said. I said

> sorry to her, and we turned to talk about studying and future plans… etc. Then we went away from that place. In the circumstance, if both of us were not aware of life skill, we could not have avoided having sex and we would be at risk of having a sexual health problem. After this, we stopped going out to quiet places just the two of us. We go to sit in a park that has many people there. (CS 40)

Each of these stories provides insight into the way that these young men have been affected by their involvement with the Playing Safe Project. Each story is different, showing shifts in gender concept, negotiation skills and communication practices. However, they all demonstrate an increased sense of personal agency and responsibility to complement improved reproductive and sexual health knowledge, leading to a delay in sexual debut. It must be noted, that while these stories reveal positive impact of the project on these particular individuals, these stories represent the minority. Across both the PER rounds of interviews, the Change Stories collected from Peer educators, and those stories describing the wider target group, it appears that the expected 'normal' age of sexual debut is close to eighteen.

First Sex: Summary

In summary, the findings indicate that sexual debut is an overtly socially negotiated and influenced occurrence. Young men perceive the biological changes associated with adolescence *in concert* with the messages they receive from their social environment about what sexuality, masculinity and adulthood mean. In general, the messages being received seem to circle around 'natural' male sexuality, changes in 'modern' society and sexual activity defining adulthood. The group discussion conducted at the conclusion of the second round of interviews gave clear support to this, stating that

> Having sex shows that you are adult and can do what ever you want. It is a way to show that you are in control- that no one can stop you (FGD 02.03.06)

Young males appear to confirm their 'completion' as men who have 'entered into society' through becoming sexually active, and by proving their masculinity to their peers through peer group supported involvement in commercial sex. The stories from peer educators of Playing Safe suggest that these social constructions may be renegotiated on an individual level, though there is little evidence of this type of change on a wider scale. The challenge for CARE, and for future SRH interventions is to harness these 'individual' changes and scale up impact across the wider target group, both in reference to sexual debut and other 'negotiated' behaviours.

Relationships and Condom use

In the first round of PER interviews young middle class urban men described 'guys like them' being involved in a variety of sexual relationships including commercial and non-commercial sex. For the second round of interviews, respondents were probed about these relationships in detail, and asked to identify any changes they perceived in the sexual behaviour of their peers. From this second round of descriptions it is clear that amongst this

group, the commonly used categories of 'sweetheart' and 'commercial' relationships displays only part of the picture. A significant number of youth identified their involvement in casual, but unpaid sex with 'girls met by chance' in addition to the relationships identified in the first round. These findings indicate an additional dynamic to be considered within the context of addressing the spread of HIV/AIDS within this age group (both men and women). Further, both rounds of interviews provided evidence of knowledge of and some experience with same sex relations, particularly amongst men. The second phase of data collection, including PER interviews and MSC story collection (CS) revealed some changes in sexual behaviour, relating both to frequency of engagement and actual practice. These changes, identified by respondents, were largely the result of messages relating to HIV/AIDS as well as access to money. Both phases of data collection identified that condom use varies across different types of relationships and tends not to reflect the stated knowledge of the respondents.

Sweethearts

As identified in the previous discussion on first sex, engaging in commercial sex appears to be standard masculinity-affirming behaviour for young, urban males. However, the role of sweethearts (sangsar) within youth male culture also appeared to be of prime importance across both data collection periods. A significant number of respondents stated that 'young men like them' prefer this sort of sexual relationship to relationships with sex workers. Sweetheart relationships serve a dual role; often regarded as a prelude to marriage, the relationships are seen to provide affection and fulfill emotional needs. Additionally, young men seem to derive increased peer status from 'wooing' 'sweet talking' and attracting sweethearts as demonstrated by the following comment collected in the first round of interviews:

> I used to hear them all the time sitting altogether and bragging telling stories to each other, about this and that. They're proud of having sex and wooing girls. When guys get together, what else do they talk about…girlfriends, girls, making friends, prostitutes, bad girls, promotion girls and karaoke girls. (PER 22, 04)

A number of respondents described how men 'use beauty, handsome looks and talent in sweet talking to attract those girls'. (PER25, 04) Similar sentiments were expressed throughout the second round of interviews with one respondent explaining that youth like him discuss sex with their friends because:

> they want to let their friends know that they are great and can use [various] sex styles. For example: they boast to each other, saying that they [have] wooed girls successfully to have sex without spending money. Moreover, it makes them happy when gathering together. I know because they have told me. (PER12, 06)

With respect to fulfilling emotional needs, a number of respondents identified their preferences for sweethearts due to the 'closeness' of the relationship. Again, responses across time were consistent. In round one, one youth explained that while men have many different sexual relationships, 'their girlfriend is the most important person…sex workers

need money from us when we have sex with them…a sex worker doesn't love us, doesn't kiss us'. (PER 7, 04) In support of this, one youth in round two responded that young men have various relationships involving sex, but that:

> Having sex with their girlfriends, is more thrilling because those girlfriends are beautiful, not containing HIV and [sex] feels better because they dare to kiss using lips and are closer than sex workers. It is normal for modern youth. It's not strange because everyone does that. Everybody has had sex by that age. It is so simple that the youth have sex with the girls they satisfy and it is common now days. (PER15, 06)

The role of sweethearts in providing affection and love is captured in the following statement:

> The sexual intercourse that the youth normally have is with girlfriends, and [they] caress those girls tenderly. The reason that the youth would like to have sex intercourse with girlfriends is being not afraid of HIV and pregnancy. This kind of sexual intercourse makes them feel comfortable, boiling (aroused), and confident and loved. (PER21, 06)

This final statement reflects an additional perceived benefit of sweetheart relationships identified by numerous respondents; a reduction in HIV risk in the context of these encounters. Almost all responses indicated that the interviewees were aware of HIV/AIDS and were aware of 'unsafe' sex as a principle mode of transmission. However, this knowledge did not always translate into practicing safe sex. Consistent condom use within sweetheart relationships was not common; rather their fears of HIV often led them to seek 'virgin sweethearts'. Indeed, as demonstrated by the following quotes, a large proportion of respondents across both time periods reflected a belief that having sex with sweethearts, particularly those that were virgins, was a way to engage in sex without the need for using a condom.

> Before they have sex they woo their girlfriends and [then] they have sex four or five times and then they break-up and get a new girlfriend. When they have sex with their girlfriends they don't normally use condoms because it's difficult to use them. Sometimes they use condoms because they are afraid of STI's or HIV/AIDS and also protect from pregnancy. Before they have sex with their girlfriend they use condoms because they don't know if their partner is a virgin. After they know that she is/was a virgin, then they normally stop using condoms (PER 3, 04).

> They've had sex with sweethearts, promotion girls, karaoke girls, and prostitutes. They don't use condom with sweetheart when she's virgin and they use condoms after if she isn't virgin (PER 28, 04).

> For sex workers they use condoms but with girlfriends sometimes they use and sometimes they don't. Because they think that their girlfriends are virgins. When

> they use a condom it doesn't seem natural, on the other hand the young men would like to woo the students at high school to become their girlfriend because they are curious to have sex with a virgin. They don't use condoms with their girlfriends… if they use with their girlfriend she will think that they are not faithful with her. (PER 8, 04)
>
> For me I never forget to use condoms with the sex worker, but I don't use with my sweetheart because as all men know, it can't provide convenient sex for her and it's also because I trust my sweetheart 100% that she has no infected disease (PER 36, 04).
>
> When they have sex with their sweetheart, they don't use condoms at all because think that their sweethearts are still virgins and have never had sex with men and so don't have any disease. In short, they use condoms to have sex with prostitute because they are afraid of becoming infected by diseases, but when having sex with their sweetheart they are not afraid of becoming infected with diseases, so they don't need to use condom. (PER19, 06)
>
> My friend, once he had wooed a girl to become his sweetheart already, he took her to have sex. To begin, he used a condom, but when he began to have sex, there was blood run down from her vagina, and she also shouted. Suddenly, my friend thought that she was a virgin because of the blood, and he pulled the condom off from his penis. Then he continued to have sex without the condom. After, she told him that it was her menstrual blood. My friend was very afraid that he would be infected with AIDS disease. (PER30, 06)

These descriptions give a clear image of the relative consistency of sex and condom use within sweetheart relationships across both rounds of data collection. The data revealed that many young men desire sex with girlfriends, and prefer sex with virgin girlfriends when possible, principally as a way to avoid using condoms, but also to gain status amongst their peers. While it should be noted that a few of the young men professed 100% condom use in all acts of sex, overall from this data, condom use within sweetheart relationships may be described as inconsistent at best.

Changes in Condom Use with Sweethearts

Some perceptions of changes in condom use among this group were recorded in the second round of interviews however. A significant numbers of respondents reported an increase in the use of condoms by their peers within the context of sweetheart relationships, primarily as a result of increased concern for contracting HIV/AIDS or other diseases and to a lesser degree, an increased desire to prevent pregnancy. The following quotes, drawn from the second round of interviews represent this increase:

> Anyway, when they are not using a condom, they feel more faithful each other and do not [feel] shy. But now it has absolutely changed. Because not using condoms with girlfriends has caused pregnancy and meant they had to have an

abortion one time. Now even though having sex with girlfriends, we must use condom because we are afraid of needing an abortion again. Anyway it can [also] prevent from HIV. They learned [about this] from TV, organizations and English study programs.' (PER13, 06)

My friends wooed a female student at school into becoming a girl friend. They were always getting along and then they wanted to have sex. My friend said that [they] "do not need to use condom because it make difficult and we are not trust each other". He tried to speak to her again and again until she agreed to have sex without condoms. The reason that he did not want to use it is because that girl was a student and pretty and it's clear she is a virgin and has not had sex in the past. After receiving the information about AIDS on TV; that we can not prejudge whether someone is carrying AIDS or not, he has had sex all the times with condom, even with our sangsars because we can not look at someone and prejudge as a person living with AIDS or not. (PER16, 06)

For this thing, it's changed because they know some thing about HIV/AIDS disease. So for their sexual intercourse, they should use condoms; even with sweetheart because we can't conclude if someone have HIV/AIDS diseases, we have to test blood, that makes us know [if] someone has or not. We get information about HIV/AIDS diseases from advertisement on TV and radio. This action scares people to prevent [HIV/AIDS] before making decision to have sex with either partner or prostitute, and sometimes it also makes them afraid to have sex with prostitute. (PER 32, 06)

The youth always use condom with sex workers while having sex. But this activity is also with their girlfriends because they have understood a lot such as HIV, condom use and it can prevent from having pregnancy. (PER 15, 06)

As I have known, it is not like before because last time they were confident in their girlfriends but now [they are] not. Among my friends, there is change because they do not know who else their girlfriends have had sex with so it (their behaviour) is changed. This is information I got from my friends. (PER25, 06)

I think that they use condom with prostitutes as well as with their girlfriends. There is change because they are not confident in their girlfriends and they are [also] afraid of having pregnancy before getting married. The reason that makes them change is that sometime their girlfriends have done something which is bad such as having sex with others and they don't know about it. They get this information from their friends. (PER28, 06)

These comments identify a number of factors surrounding the changes in condom use within sweetheart relationships. Firstly, and positively, there appears to be an increased correlation between understanding amongst young men of the dual protection of condoms in preventing both unwanted pregnancy and transmission of diseases such as HIV/AIDS

and health seeking behaviour. Secondly, there is evidence of increased understanding of the nature of HIV/AIDS as a disease, as demonstrated by the acknowledgement that only a blood test can identify HIV/AIDS status. Thirdly, the majority of respondents identifying changes in the knowledge and behaviour of their peers identified hearing about these things from either their friends or, more often, through the media. However, it is also noteworthy that most of the young men who used condoms primarily thought about consequences to themselves – the fear that they could contract HIV. They seemed far less concerned about the possibility of them infecting others with HIV or 'getting a girl pregnant.' The young men were mainly focused on what could happen to their own bodies.

An additional theme emerging from respondents in the second round of interviews, is changing perceptions of young women and their sexual practices. A number of respondents, including the two cases last quoted above identified young men 'like them' using condoms within the sweetheart context as a result of declining confidence in their girlfriends, their 'purity' and their subsequent faithfulness. In particular, the final comment identifies the possibility that girlfriends have been involved in "something bad such as having sex with others". This comment defines two aspects of condom use decision making; firstly, it asserts the fact that condom use is a decision made on the basis of the male partners perception of own risk, and secondly, it identifies that problematic social perceptions, such as those addressed by Population Services International (PSI) through their OK condom campaign are still prevalent within Cambodian youth social discourse[4].
Comments made by one respondent within the second round of interviews relating to a young women negotiating condom use within a sweetheart relationship further demonstrates this perception:

> One of my friends, when he woos a girl he tries to console her in order want to be in sexual with her only and he don't want to use condom for his sexuality. But she wanted him to use condom to avoid pregnancy; he agreed with her and told me that she is maybe not a fresh girl. (PER2, 06)

Also emerging from the second round of interviews was increasing evidence of young women successfully negotiating condom use within sweetheart relationships:

[4]Commencing in April 2004; PSI has been working in collaboration with the MoH to increase condom use within sweetheart relationships within Cambodia in response to findings indicating that prevailing social attitudes were discouraging the use of condoms within this context. Aiming to address the perception that using condoms discriminates against ones partner, suggesting she is unclean or impure, PSI has introduced the Ok condoms as an adjunct to their successful Ok birth spacing product line. Promoting Ok condoms as a mark of caring within the relationship, the campaign has acted as a complement to the Number One condoms originally introduced to Cambodia and successfully marketed for use within commercial sex. Ok condoms have been marketed as the condom of choice within romantic sweetheart relationships, with a particular emphasis on pregnancy prevention. The marketing effort has been considerable, including the production of IEC and BCC tools such as posters, leaflets, radio and television campaigns. PSI estimates that 2.6 million OK condoms were sold in 2004. (PSI, 2004:7)

> For instance, one of my friends, he has had sex with prostitutes by using a condom but when having sex with his girlfriend, at first he does not want to use a condom as it makes him not feel close and not feel good. But then his girlfriend argued against having sex unless using a condom as [she was] afraid of pregnancy, he finally decided to use a condom to have sex. It's changed because girlfriends do not agree (to sex without a condom). Also he has received information of sexual reproductive health for a long time through promotion on radio, TV, Organisations, papers, magazines and other promotion services'. (PER 15, 06)

> We used to always use a condom with sex workers but rarely used with girlfriends, but that is changing now. One of my friends, after wooing and going out together with a girl, he introduced his girlfriend to his other friends. Some time later they started to have sex without condoms, since he thought she was a virgin. But later she persuaded him to use a condom because she was afraid of getting pregnant, otherwise their parents would completely blame her and she would be embarrassed. Anyway (he has heard about this) through promoting by TV, Spots and peer educators about the advantages of condom using, so there is change to use condom during having sex instead of not. (PER 14, 06)

While examples like these two above that display evidence of condom negotiation were few, they are an important development as there has been stated concern regarding the ability of young women to make safe choices for themselves. (Wilkinson and Fletcher 2002) The examples above demonstrate how increased awareness of sexual and reproductive health amongst young men increases the ability of young women to negotiate safe sex as the messages heard elsewhere by young men reinforce the requests and arguments of their partners.

Overall, the PER interviews provided an insight into sweetheart relationships and condom use that identifies the former as common and often preferred amongst young urban middle class men and the latter as increasing, but still relatively inconsistent. This finding was supported by the focus group discussion conducted after the second round of interviews in which use of condoms with sweethearts was identified as a "sometimes" occurrence, with a number of participants voicing their opinion that 'guys like them' were concerned that they would "feel regret" if they used a condom with a sweetheart who turned out to be a virgin. It was claimed that this would be to "waste the golden time" and that sex with a condom is not "good, natural sex". Unlike in the data collected through the interviews, the participants further noted that "Girls will blame them and say 'you don't love me' or 'you must have other partners' if the boy wants to use a condom ". This is possibly a reflection of the stigma that remains attached to condom use within sweetheart relationships, but it is also possible that it is an excuse used by young men unwilling to use condoms with 'low risk' partners as within the FGD there were numerous mentions of sweethearts being virgins and unlikely to "contain HIV"; As interviews were not conducted with any young women, it is impossible to know for certain. The focus group participants again revealed the level of HIV/AIDS, sexual reproductive health knowledge of their peers by identifying that "they know about the

role of condoms on preventing HIV/AIDS and pregnancy through advertising through the mass media". It should be noted that the FGD participants neither identified the use of alternate forms of birth control, nor concern for transmitting HIV/AIDS to their partner in the cases where condoms were not used, even when questioned directly about this issue.

Within the context of Playing Safe, particularly in those stories gathered from peer educators, there was an appreciable difference in respondent's approach to using condoms with sweetheart partners. Peer educators tended to speak of making choices about condoms and contraception *with* their partners, as in the following example:

> He said that he had stopped finding sexual services, or participating in bauk, but that he still has sex with his girlfriend. (He says) "We both have the same Sexual and Reproductive Health knowledge". He ensures that his behaviour is safe, because "we love each other, one to one, so that we always discussed using condoms". The knowledge that he has from the project is condom use; using one or two safely, that can help him to avoid danger (CS 49)

In addition, a number of peer educators felt that through their participation in Playing Safe they were able to make choices for themselves and their partners about sex that would safe guard their futures.

> Because I find a person that I love, and we get on so well, so I have sex with her. When we have sex, I always use methods which I studied to help both of us stay safe such as using condoms. Another reason which pressures me to change my behaviour (to have sex now) is that to be a human, I have to run according to nature, so we can have sex. I think I was mature to have sex, and I have knowledge about reproductive health so I think that I have the ability to protect myself from getting AIDS and other dangers. (CS 42)

> We observed that having knowledge can't make him stop from having sweethearts because it is natural. There is life, there is sex. What is important to me is safety and responsibility. Finally, I really want to educate all people, but especially youth, to protect themselves. (CS 48)

Overall, condom use within sweetheart relationships within the context of peer educators of Playing Safe was not only more consistent than within the rest of the target population, but also more negotiated and based on mutual decision making.

Commercial Sex

In addition to having sexual relationships with sweethearts, almost all of the young men interviewed spoke about peer involvement in purchasing commercial sex. The following accounts provide typical examples of this, demonstrating the variety of 'commercial' sexual engagements:

Sexual relationships for young people about my age are usually found by paying money and doing it in a red light district (PER 34, 04).

Sexual-relationships that all youth have are with their girlfriends and other, with bar girls because they think all prostitutes at bars or other beer girls need money so if they have money they can have sex with her. For our girl friends, we can discuss with her about this thing. I think it is normally for being sexual in-group. Most of them who have with sex are students because they think they are gangster, handsome and it is the happy age for them. (PER2, 06)

Sexual relationships that the youth have are with sex workers such as prostitutes at brothels, schoolgirls, and karaoke girls. Now they are still doing this often. For example: one of my friends goes to have sex with sex workers every Sunday. It is one time a week at Toul Kok area. There is no change because they are still doing as often as before. (PER9, 06)

I heard from them that they have relationships with sex workers and beer girls near where they live as well as *srey kalip* from schools or snooker places. Mostly when they have a girl they go together (PER 23, 04).

They go to sex workers because they think that it is easy to have sex with them. Whenever they have money, they can go for the sex service, but with girlfriends it is not easy because sometimes they allow sex and sometimes they do not. (PER9, 06)

Most of them have sweethearts because they are handsome and rich and have a modern motorbike. For the people who don't have sweetheart it is because they are not handsome, have no modern motorbike like the others, so when they want to sex they go to have sex with external prostitutes. We know also that they said they go to have sex with their sweetheart at guesthouse. They have similar feelings [no strong preferences] between these things, because [both of] these activities make them happy. The relationship that they most like is to go to have sex with prostitute outside and they rarely have sex with their sweetheart because when they have sex many times, it can make their sweetheart become less beautiful. They like commercial sex because it is easy. It means that when they need it, they get it quickly. (PER10, 06)

Sexual relationships that youth have had or like to have is [sex with] prostitute they like that because it is easy to find sexual service and prostitutes are easy to have sex [with] such as we can change different style to have sex with her. For sex in different styles they (sex workers) think that it's a normal thing but if having sex with sweetheart perhaps they do more happily. They think like this because having sex with their sweetheart, they do not worry about AIDS and STD diseases. (PER22, 06)

> They think it is easy because it is not necessary to spend much money on the guest house and to be involved with a sex worker is easy because they don't have to woo the girl (wooing a girl is difficult). It is easier than having sex with girlfriends because we need much money to invite her (girlfriend) to eat something and go somewhere. (PER 25, 06)

> Youth have various sexual relations with prostitutes, factory girls and students. Moreover, they seek outside sex services (that they pay for). It is easy (comfortable) for us, not to be involved, and we don't have to think about pregnancy or other difficulties. (PER 30, 06)

From these results, it appears that commercial sex is a frequent and normalised sexual behaviour of young men in Phnom Penh. The results also show that the arrangements for sex and payment vary from 'formal' brothel based commercial sex to individually negotiated sex in return for some money or gifts. It should be noted at this point that relationships being identified as 'commercial' in these descriptions have been defined as such on the basis of the perceptions of the young men involved. Sexual encounters which the men feel are reliant on payment are thus defined as commercial. This does not immediately identify either the individual women or 'type' of women involved as a commercial sex worker. Nor does it suggest that she/they would identify herself/themselves as such.

Changes in Sexual Behaviour relating to Commercial Sex

Results from the second round of PER interviews revealed some changes in sexual behaviour relating to commercial sex. A number of respondents identified that their friends, and 'guys like them' have reduced the frequency of commercial sex encounters as a result of increased perceptions of HIV/AIDS risk relating to this practice. The following comments have been selected as representative of this trend:

> Now it has changed especially in the city for outside sexual service, they cut down doing this because they are concerned about being infected with HIV/AIDS and STDs. Sometimes this is [also] due to lack of money. I think that it (using commercial sex services) has been cut down because I use to go out together with my friend, after leaving a karaoke shop my friend asked me to go to a brothel, I agreed but I didn't enter and my friend decided to enter alone. I told him that I'm afraid to contract HIV/AIDS and that because at that time, we were drunk, we can forget [about] using condom, or use condom incorrectly. So he felt afraid because he thought like me. It happens, but a little bit because they are aware of sexual health and care for [their] honour and future. (PER 18, 06)

> Today young people are less likely to go to find sexual services because they are afraid of HIV infections and many of them understand about the danger of AIDS. In the past one of my friends always used to go to brothels 5 times per week but now he has heard and knows about the problems related to commercial sex worker. The factor is AIDS. There are changes because he is afraid of sexually

> transmitted diseases which he could transmit to his wife and children without knowing it. (PER1, 06)
>
> Recently, outside sex contact has decreased much, as only occasionally they come to have sex (as they told me). They come to have outside sex when there is a party until late at night and they are drunk and are insulted by their friends so they always come to have outside sex whenever having a party. This is the fact of my friend who likes going out to have "fun" and has many girlfriends. When he told me as if he was skilled in sex because he said he has had sex since he was in grade 12. Until now he is still doing it but he has decreased having sex outside because he has studied and understood much about sexual reproductive health. He stops having sex with prostitution because he is recognized information about HIV and STIs through organizations, TV and radio. (PER13, 06)

It is interesting to note that very few of the PER respondents identified that either they or their friends had ceased using commercial sexual services in response to these HIV/AIDS fears, preferring instead to 'better their odds' by reducing the frequency of the behaviour recognised as risky.

The change stories recorded by peer educators, about themselves, other peer educators and their peers within the target group gave some deeper insight into these risk assessments, providing concrete examples of the role Playing Safe and other education has played in encouraging young men not to engage in commercial sex.

> In the previous time, I used to be sexually active with sex workers, and I frequently visited there alone, but sometimes my friends came and invited me. I had never known about sexual and reproductive health before, and whenever I had sexual passion, I went there immediately to relive my desire. I used number one condom every time I had intercourse…Then I met one of my friends who was a peer educator…He invited me to study life skills. Now I am a peer educator and I stop visiting commercial sex services any more. I promote on it and advise other friends to be aware of Sexual and Reproductive health. (CS, 03)
>
> For me, another behaviour change is that I used to make bad friends who liked to eat and drink out at night, and called me to find a sex worker at the garden. Firstly I did not want to do this, but they blamed me a lot, and mocked me that 'you were a bad man if you had never tasted it'… a long time ago, I tried having sex and it was so comfortable, so [after that] when my friends called, I went every time with them…I always used condom because I was afraid of AIDS, if I don't want to wear it myself, the girls would put it on for me when we had sex. Now, I stopped [doing this] after I studied SRH at the youth centre of Playing Safe project because I am an educator about AIDS/HIV so I should stop first, to be an example for others to learn from…another reason I stopped is because I think that even though we use condom correctly every time, one day we might make a mistake and [it could] lead to having AIDS. (CS, 50)

> He and several of his friends made an appointment to sing karaoke, and not only did they sing, but they also drank alcohol. There were five or six women waiting for us to select (he said), then we chose one of those women, each one of us, and then went into the rooms. He added that he did not use condoms…After he knew van outreach of Playing Safe, has gained some leaflets on STIs and when he read some of those leaflets, he began to suspect that he had an STI because he when he urinated, he had a clear/creamy discharge from his penis each time, and he seemed not interested in anything because he did not know what type of illness he had, or not…When I met him a second time, he said that the doctor had told him he had Gonorrhoea. He was very happy to know van outreach of Playing Safe…he did not dare to visit commercial sex worker anymore…he added that even if we knew about the ways of prevention, it was better not to be involved in it. (CS 14)

As well as showing an increase in understanding of the risks associated with commercial sex, these stories also demonstrate an increased understanding of the fallibility of condoms. While the best available protection against STIs including HIV/AIDS, condoms are not 100% effective and vulnerable to user error. The recognition of this allows for individuals to make realistic and informed decisions about their sexual behaviour. It is interesting to note that this understanding was not demonstrated by youth outside of the Playing Safe peer educator group. Again, as within the wider target group, there was a tendency within a number of cases to reduce possible HIV/AIDS, STI exposure by reducing frequency of access to commercial sex services.

The perceived 'riskyness' of commercial sex, in terms of HIV/AIDS fears was reflected by an apparently more consistent use of condoms within commercial sex than sweetheart relationships across both rounds of data collection. Results indicate that this is based largely on the perception that 'those women', being sex workers, are likely to carry disease. This is arguably the result of successful social marketing and education campaigns focusing on sex workers and their clients. Statements from the second round of PER interviews demonstrate this clearly:

> If they do not change to use condom with that girl they will be faced with other diseases especially AIDS. Nowadays most of them are always going outside for their lust even [though] they knew that they would [get] infected from that girl. One of my friends would like go for a walk outside very much. Sometimes he had a sex with the prostitute without using condoms, but fortunately, he did not contract the disease from her. After that, he learned clearly about the benefits of condom usage from advertisement. Since that time he is not careless like before and when he has sex he always uses condoms –every time. (PER 3, 06)

> Because they think a girlfriend is different from sex workers. A girlfriend is virgin and has no diseases ... Unlike girlfriends; prostitutes sleep with many men a day and can transmit many kinds of diseases. (PER18, 06)

> [When] they have sex with prostitute they never forget to use condom when they have sex, but when they have sex with their sweetheart, they don't use a condom at all because [they] think that their sweethearts are still virgins, and never have sex with men and don't have diseases. They use condoms to have sex with prostitutes because they feel afraid to be infected with diseases (PER19, 06)

This was supported by the change stories, as seen in the following quote selected as representative of the attitudes demonstrated across change stories:

> he never thought about being infected with AIDS whenever he had sex with the one whom he loved so much (his sweetheart), but when his friends invited him to sing karaoke and find sexual service, he felt that he was highly afraid of AIDS (CS 29)

From an education and Behaviour Change Communication (BCC) perspective, the use of condoms within the context of commercial sex is a significant success. Within the Cambodian social context however, there is a risk that by promoting HIV/AIDS fears linked to commercial sex, these campaigns may inadvertently reinforce existing attitudes which polarize good women and bad women, ultimately contributing to gender inequality. While it is recognised that possible translation issues exist, the following comments are particular cause for concern:

> They use number one condoms with prostitutes and I think that they use OK condoms with *normal people*… Condoms are used with prostitutes only because those girls can carry AIDS or STIs (PER 22, 04).

> Normally Number One condoms are used for having sex with prostitutes and OK condoms are used for having sex with *normal people* because most prostitutes carry AIDS…I always wear condoms when having sex, but some people don't use with their wives (PER 20, 04).

In Cambodian social discourse the separation of woman into categories of 'normal' and 'abnormal' or 'good' and 'bad/broken' contributes to social exclusion, violence and exploitation against 'abnormal' women who may include: sex workers; trafficked children; sexually active women outside of marriage; and survivors of rape, incest and abuse. In addition such categories reinforce Cambodian social controls for 'normal' women. Through such categories pressure is placed on women to follow oppressive rules as outlined in the Chbap Srei[5] and take all necessary precautions to avoid being labelled a 'bad' women and being ostracised from family and community life. Thus, while the relative consistency of condom use within commercial sex is a positive signal from a public health perspective, it is necessary to consider the wider implications of this behaviour and its contrast with condom use within sweetheart relationships in terms of wider social issues and future social marketing campaigns.

[5] The Chbap Srei is a traditional code of conduct for Cambodian women. Translated directly, the term means 'Womens law'. A 17th century rhyming verse, the code stipulates ideals of the virtuous women's conduct within marriage, family and the community.

However, returning to a strictly public health perspective, there is evidence of young men becoming informed consumers of condoms. Both of the PSI branded products OK and Number One condoms were mentioned within the first round as condoms of choice due to their high quality and break resistance. The second round of interviews further revealed young men demonstrating good buying skills including buying from reputable sellers, and checking the packaging of the condom both for signs of damage and the expiration date.

Casual, non-paid partners

The second round of PER interviews explicitly probed respondents answers around the types of sexual relationships that 'men like them' were involved in. The result of this probing was the emergence of an additional category of relationship outside either commercial sex or sweetheart relationships. A significant number of young men identified being engaged in sexual activity with young women that they neither paid, nor had extended relationships with. These 'meet by chance' girls seem to provide another option for sexually active young men,

> Sometime they woo garden girls successfully, and then take those girls to have sex at guesthouses, [at] Kep Thmei. Sometime they spend [money] on her but sometimes they do not because garden girls are available to woo successfully. It depends on us to give money or not because garden girls and ski girls don't ask [for] money from us. (PER 15, 06)

> Most of them have sex with ski girls, and garden girls. After wooing them successfully, they bring them to guesthouses. Sometimes the guys give money and sometime they don't because those girls want to have sex too. While having sex, they say Great! "Ous Tous Mong!" especially [during the] second time (in one session), out of power. While having sex, they are changing styles, spread the legs apart, penetrate in and out in order to make those girls joyful and satisfied (PER 5, 06)

> For sexual relationships, we feel very happy after having sex and feel relaxed, and we want to try again with Srei Karaoke (waitress in Karaoke club) and Srei Lansée (beer girl promoter) because those young women are easy to communicate with, just pay a little bit and they follow us and sometimes, we do not need to pay for them. When we have free time we go and have sex. (PER 16, 06)

> The youth of my age feel so excited and surprised while talking about the various kinds of sexual intercourses such as with Karaoke girls at the restaurants. And sexual intercourse that the youth like [to have] is with girls at restaurants and Karaoke girls because for those girls, whenever seeing [the young men are] a little bit handsome, have money and modern motors, those girls [will] absolutely come to meet them. They like having sexual intercourse with those girls because [they

> do] not need to spend much money and not have problem after having sex (the girls will not sue them) and it's easy when they want to stop seeing her. (PER14, 06)
>
> They can contact girls at schools or factories and especially when those girls are free from working and studying, so they take the time to woo those girls- just spend 1 or 2 days. Then I see them riding [their] motor [bike] with those girls (on the back) together because they are good at doing such things. Anyway, they are good-looking and have expensive motor [bikes]. Whenever they have driven their motor [bike] with girls, it absolutely means that they have had sex with those girls already because they never come to anything, and they are not just taking those girls around. Because they think they don't need to spend much money for those girls but just to persuade them with some words is ok. Anyway, as I said above they specialize in wooing so rarely can the girls escape from them. (PER 17, 06)

These cases appear to be describing a type of sexual interaction distinct from either commercial sex or sweetheart relationships as they are commonly understood. There is no expectation of relationship, certainly on the part of the young men involved, or ties of affection between partners, nor is there necessarily payment. This could be characterised simply as 'casual sex', which to some extent exists in western cultures, however, there appears to be a difference when considering the status and power differentials between the individuals involved. In most of the reported cases, the males involved are middle class, relatively privileged individuals, while the women are from groups generally perceived as of lower status within Cambodian society. The apparent 'casualness' of the interaction, at least on the part of the women involved, is also undermined by the need for young men to "woo" and "persuade" their prospective partners.

This data emerged unexpectedly in the second round of interviews and was thus a topic of the focus group discussion conducted after this data collection. The participants of the focus group identified that these 'ski' girls (young women spending time at a popular club in Phnom Penh) and 'garden' girls (young women spending 'free time' in public parks and gardens throughout the city, as opposed to in their homes) were available for sex without payment because "they want to have sex too." (FGD 02.03.06) Further, the FGD participants suggested that these women were seen to have multiple partners, thus were "women you would use a condom with." (FGD 02.03.06) The participants of the FGD also indicated that this 'meet by chance' sex was "not new". Irrespective of this assertion, this appears to be an emerging factor within Phnom Penh youth culture which should be further examined in terms of potential public health impacts.

Group Sex

When asked what types of sexual relationships 'guys like them' were involved in a large majority of young men indicated that there is peer pressure to join in commercial sex as a group. As identified in the statements around accessing commercial sexual services, going out to have sex often involves 'going together' as a social activity between friends. This theme was apparent throughout most of the interviews as many of the young people

interviewed spoke of peer involvement in group sex. The following accounts outline numerous examples of what has become known as *bauk* [6] amongst young men. Perhaps some of the following examples of group sex appear consensual however others are clear and explicit examples of group rape.

> My friends always come here [the Japanese Bridge area] and I know about sex from my friends because they all tell me that they have sex with prostitutes. They go to the brothel as a group because they like it and think that its fun. They want to introduce their friends to know different methods of having sex, like how to use condoms etc. My friend's team which has three or four people take one girl to have sex together. They told me that it's okay for her because it is her job and they never use violence with sex workers and they have never had a sex worker who says no either (PER2, 04).

> My friend used to go and have sex with a sex worker at New Park Bun Poa Brothel. He also used to have sex with three or four guys with one girl. He did it like this because it was fun and also sometimes used violence when the girl didn't agree to have sex with so many men even though they used condoms. Its easy to use condoms because he is skilful at it. They prefer to have sex one-on-one but because they don't have enough money they have to have sex as a group (PER1, 04).

> [My friend] used to have friend who was a sex worker when he rented her to have sex as a team, 3 or 4 people, and always rent the same girl. He rents her from near Super Centre Soreya he likes to have sex as a team because it is fun. Sometimes she doesn't agree because his team adds more than four people but he doesn't use violence because they don't want to use it because he pities her and always pays money to her. He always uses condoms with that girl but his friends who have sex don't always use a condom because they don't know how to use it (PER4, 04).

> My friends know about sexual relationships through having sex with sex workers using condoms, through renting sex workers from Bon Poa, Lee Meng, Chop Dep (Magic Lotus), to have sex as a team 3 or 4 guys for fun. If the prostitute is clean then they will hire her, but if not then they won't have sex with her, because [when] she gets undressed for sex they look at her body. Sometimes they use violence, sometimes not. If she doesn't agree to have sex with them then they will use violence. She knows that they have a lot of guys to have sex with her. She goes with their team because her boss forces her to go (PER5, 04).

> …we have sex one-on-one with sweethearts or spouse but not for sex workers. We have sex with many friends because sex workers earn money and we don't have enough money on our own (PER13, 04).

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6 Literally, 'plus', in slang idiom, *bauk* refers to multiple males having sex with one woman, with or without her consent

> If they are sweetheart, they go to have sex alone, but if with sex worker or a girl from a snooker place they go as a group with 7 to 10 guys and 2 or 3 girls. Many have sex one on one but they don't feel very much so that's why they have sex in a group (PER23, 04).
>
> Having sex by forcing or using violence is because there are a lot of people when having sex, it makes prostitutes feel shy and disagree to have sex. Sometimes we hit them or force them to have sex with violence. It's because it is so passionate that this happens (PER31, 04).
>
> Some of my friends like having sex as a group of many people, normally hire one or two sex workers to go with them (5 – 7 guys) to a quiet place such as a hotel, guesthouse, Kiensvay and quiet resorts. They never play without condoms in that kind of sex because they don't trust each other, maybe anyone of them has HIV especially that sex worker (PER36, 04).

These are merely a few examples of the numerous accounts of *bauk* recorded in Round One data collection. In Round Two data collection, the respondents were told that researchers had knowledge of 'guys like them' participating in group sex as a result of last years research. Thus respondents were asked to identify any changes in this activity that they had perceived over the intervening period. The vast majority of respondents were able to confirm that group sex or group rape remained common amongst peers, and they also offered very graphic stories of *bauk* incidents. However, a closer look at the language the respondents used when talking about *bauk* or group sex indicates that these young men saw *bauk* as even more 'normal' or 'simple' (largely interchangeable terms in Khmer language) among young people now, pointing to a normalization of the practice within youth male sexual culture. The following examples provide further evidence of this normalization. They also highlight the fact that this phenomenon is viewed by young men as a 'fun' bonding activity amongst young males seeking cheap sexual services.

> It is a simple fact because modern youth want to have joy in a team. They like having sex with sex workers. They have never brought their girlfriends to have sex in a group. They said making sex in team makes them joyful and gives varied feelings. There is no change because still bring girl to make sex in team. Until now they bring one girl to have sex in a team of 3-4 because they think that this way they do not spend much money. I think it is still simple; For instance last month, my friends brought one girl to sleep with 3-4 of them. (PER 9, 06)
>
> It is so simple for modern youth as it was last year. They have sex in a team with girls they bring for *bauk*. It makes them joyful. It does not cost much. Moreover, it gives them variation. Anyway, it happens from being persuaded by their friends. There is no change because having sex in a team makes them happy and not spend much money. For instance, a group of my friends shared money to bring girl to have sex. When arriving at the brothel, they each had sex 2-3 times a night. They did that; as a result, they did not spend much. (PER 12, 06)

> Many youth have sex in a team because it is convenient and [makes them] happy together. For instance one of my friends brought one Karaoke girl to make sex. Though they told her there were many members in-group, she still agreed to go with them at the price of $30. During sex, the first three men had sex easily. But when reaching the fourth one to the seventh, this made her gesture and groan and said that Pain! Please softly! Among my friends, three made sex three times and the other four did 2 times over that night and spent $40 including guesthouse. The reason for having sex in a team is that we can know who is the strongest and who has more sexual experience to satisfy her. Though those girls are so beautiful, we always use condom because we can't know if any one contains HIV or not by observing their appearance. (PER 14, 06)

> (talking about who 'guys like him' engage in *bauk* with) Most girls are sex workers and prostitutes and so on. No one dare gang rape (*bauk*) a good and accurate girl because unfortunately if she died, they would have a serious problem. New style makes us feel varied. (PER17, 06)

> Having felt thrilled and happy with a prostitute, one to one, or in a group, it's a normal thing because it is a common activity that youth practice today. Group sex is a group, many boys that have sex with only one girl, or, sometimes, 5 boys to 6 boys with one or two girls. Before and now are the same. I think it's simple because they like to have sex, so it's good to have fun with friends. (PER 19, 06)

Engaging in *bauk* appears to fulfill these young men's needs for proving their masculinity, gaining sexual experience and the approval of their peers. The necessary coercion, humiliation, intimidation and/or physical violence that accompany these group-rapes are arguably understated in many of these accounts. There is no doubt that those women who have had the misfortune to be involved in *bauk* would describe their experiences very differently (Grant; 2004).

The violent nature of bauk was also described in some detail by several respondents, with seemingly little or no regard to their actions as being cruel to women or criminal. And although respondents were not asked specifically about their own personal sexual experiences, some young men chose to describe their personal involvement in *bauk*, thus providing very detailed and graphic descriptions:

> Last night we went to Spark (a Phnom Penh nightclub) to drink maybe for 2 hours at night. There were 5 men and 1 woman. After that, we took her to Bun Pav guesthouse. The first person told her to put his penis to her mouth while the others had sex with her one by one until they had all finished. But I was the last one who had sex with her, so while I was having sex, I had a special action like getting her to raise her legs and change styles a lot. After we finished, we think that we will give her small money but when we had sex with her, she cried and shouted because her vulva was hurt. My friend, who is a rich man gave her $50 including

> guesthouse. During sex, some of them spent a long time and some maybe after 2 minutes were finished. (PER 29, 06)
>
> They always have sex one-on-one with girlfriend and with sex worker one with four or five and sometimes up to 12 guys with one girl. When they go to hire a sex worker, they go with only 2 or 3 guys and they convince her to come and tell her that it is just them, but when they arrive at the guesthouse they have their friends waiting, nine or ten more guys. They always use violence because the sex workers don't want to have sex with that many people. After they have all finished having sex sometimes the girl is unconscious. After she becomes conscious they start to have sex all over again. (PER8, 04).

The following description by one young man about his idea of a "good guesthouse" is also disturbing and shows the total control the men have over the women in these situations:

> …If it is later (at night), she (prostitute) is cheap and nervous because she is afraid to have no customers. They took her to the Spring guest house that is in the intersection of Orrussey Road. Spring is a good guest house compared to the others because it is safe because if a prostitute wants to leave at night or before us, the safety guard will be stop her and then come to ask us if we allow her to leave or not. If we say it is okay, only then will the safety guard allow her to go, because they are afraid those girls will steal the customer's money. And, it costs only $6 but has 2 beds, when we are at Spring guest house they have sex one by one. Sometimes they do the strong sex, such as rape her to make her shout, because it is one style to increase their sexual feeling. They continue until morning, and then they will go back, and those girls ride moto-taxi back. (PER 30, 06)

In addition to numerous accounts of involvement in *bauk* found in the PER data from both rounds of data collection, a high proportion of the Change Stories also included references to and descriptions of *bauk* and participating in group sex with sex workers. Again, the language and style of reference indicates *bauk* to be a common and 'normal' event. Furthermore, these findings are consistent with previous studies undertaken as participants openly admit personal or peer involvement in group rape, have failed to recognise their behaviour as criminal, and have demonstrated little regard for the lives and dignity of the women who they abuse. Much has been written (Fletcher & Wilkinson, 2002; Bearup, 2003; Wilkinson, 2003; Grant 2004; Soprach, 2004) about the underlying causes for this male, youth pattern of sexual behaviour and it is outside the scope of this study to deeply examine underlying causes for group rape.

As disturbing as these findings are, it is notable that there were a significant minority amongst the young men interviewed in the first round of data collection who either expressed preference for consensual sex or expressed distaste for the practice of group-rape:

> Don’t like abusive sex, never did…They [My friends] like sex one-on-one because it’s easy, the female partner likes it and feels satisfying (PER21, 04).
>
> They like having sex one with one because they feel good, no one is forcing and it’s not too noisy. When they have sex as a group they don’t feel good, sometimes they use violence or force and have unsafe sexual intercourse (PER29, 04).
>
> My friend doesn’t like having sex in a group because he thinks it has not feeling, no order/noisy and also it makes him shy with his friends. Sometimes, one of his friends doesn’t finish his mission [doesn’t climax and], another one forces [or interrupts], so it’s difficult and not happy (PER32, 04).
>
> Most of my friends have sex with women and also with only one partner because they think that they reach orgasm when they have sex one on one. Sex with many guys - I don’t think its very fun and I pity those sex workers (PER34, 04).
>
> They said they like having sex one on one because no bothering and no waiting because they pay full price for service. They don’t like that kind of sex too because they say it is unacceptable for human beings, just like animals or other things. (PER36, 04).
>
> Sex is agreement between both sides and with emotional feelings - without abuse...That’s my idea, sex one on one because there is no bothering from friends, sex with strong feelings and not feeling shy (PER35, 04)

In addition, the second round of interviews also displayed some evidence of changes in attitudes and practices around *bauk*. While the majority of respondents noted that *bauk* is common, normal behaviour for young men, a minority of respondents reported that they felt that their friends, peers or ‘guys like them’ had reduced their involvement with *bauk*. The following quotations have been selected to represent the various reasons given for these changes:

> For me, I think having sexual intercourse in group is not simple, but that it is extreme strangeness because having sexual intercourse in group can transmit disease if they don’t use condoms. On the other hand, it also violates reproductive rights. (PER 18, 06).
>
> There are others such as having sex violently and by using drugs, which are illegal. There is change because before, the youth were not much afraid of laws and wanted to have sex violently and by using drugs. As I have heard, [now] it is not usual because now people are not supposed to have sex in team, as it is illegal. There is change because now the youth are not brave, they are afraid of police. (PER 27, 06)

> Most of my friends have sex with women and also with only one partner because they think that they reach orgasm when they have sex one on one. Sex with many guys…I don't think it is very fun and I pity those sex workers. (PER 34, 04)
>
> Only a minority have sex by force with many people. I think it is not simple because making sex in team is not supposed to be done now. And the guesthouse is not allowed to rent a room with many people, now guesthouses are banned by the law from renting rooms for having sex in a team. It has changed but not much if compared to last year. Having sex in a team is mostly with sex workers. They think it is happy but some do not. It is enjoyable as it does not cost much money. Some don't like because it is not good because having [sex] in a team is easy to be infected by HIV and other diseases. (PER25, 06)
>
> Before, it was so normal to bring girls to make sex in team. But now it has changed because we have more knowledge and are more considerate because of being afraid of HIV, not daring to have blood test and not having much money. (PER 13, 06)
>
> Last year they often had sex four to one girl because they lacked much money or much time. But now they rarely do that even one to one because of widespread dissemination (of information) so they are afraid of HIV. (PER 13, 06)

What is clear from these accounts is that young men understand that group sex, *bauk*, is a high risk activity in terms of the transmission of HIV/AIDS due to the involvement of what they perceive to be 'high risk' women – sex workers, and that some are adjusting their behaviour accordingly. It appears that some young men are receiving and heeding public health messages relating to HIV, and as a result, reducing their participation in group rape. While this is unequivocally a positive step, what is equally clear is that few young men recognise group rape as either illegal or a violation of human rights. Instead, the noted changes in behaviour are primarily driven entirely by self interest in terms of HIV/AIDS fears and changing sexual desires, with only a handful of young men speaking of reproductive rights, 'pity' and a fear of prosecution, indicating some understanding of *bauk* as a criminal act. This is of significance when placed against other findings of this research such as differences in perceptions of HIV/AIDS risk between sex workers and 'other, normal' women. Evidence already exists that *bauk* occurs outside of a commercial context (Bearup, 2003; Soprach, 2004) , suggesting that women perceived to be 'low risk' in terms of HIV/AIDS transmission are already vulnerable to bauk, thus it is unlikely that the practice can be eradicated through public health approaches alone.

The limited understanding of bauk as rape was supported by the change stories collected by peer educators of Playing Safe, a number of which related to participation in *bauk*:

> (Peer educator story about an encounter with a target youth)
> There was a youth among them who dared to ask me first. He asked me whether, if there were many men involved in sex with only one woman, and while the last man was having sexual intercourse she was bleeding, could he catch any

diseases? I asked them if they used condoms? And he answered that all of them used it (his friends sitting with him said 'tell her it was us') After I listened to them, I firstly told them about the problem that they were at risk for HIV and STI if they had not used the condom properly. Secondly, they could kill the woman they took to *bauk*, and thirdly, that they had violated the human and sexual rights of that woman, even if she was a sex worker. One youth among them said that 'yes, the woman who we had sex with, she was a sex worker (CS 31)

Before he was never interested in SRH. Before he had studied at Playing Safe, his behaviour made him face dangers because not only did he enjoy finding sexual services, but also doing *bauk* rape. His friends and he went to have sex often, he added that when finding sex service and doing bauk, no one forced anyone, they all agreed. He liked other men who wanted to be happy, ate and drank and had a girlfriend. It was normal for men, he said. His behaviour was dangerous and was useless but he never thought about SRH because he thought that it wasn't important and didn't apply to him. At that time, his walking, joining sex and bauk rape didn't effect his studying because he did in his free time… He told that he knew clearly about SRH after he studied (at Playing Safe) It was really important…Since then, he never did as before. He added that studying at Playing Safe made him be awake and afraid of doing as he had before. He advocated to his friends that they stop, they agreed. (CS 49)

(Peer educator recounting the story of another peer educator) His friends and he found sex service at Toul Kork. At that time, he knew to use a condom, but was not sure if it is correct or not. They also joined *bauk* rape he said, because "we haven't enough money." Another reason, he said, was that "we wanted to share experience". Two years later, he had passed into university and he stopped it because he said he was afraid of someone's eyes. Moreover, he was bored with those girls because sometimes, he hadn't had sex feeling, and it wasn't suitable to go there. At university, he had many friends; they always found guest house girls, karaoke girls and the girls that serve beer at restaurants. After they drank and contacted the girls to go to the guest house (with); they had sex. One to one sometimes, but most of the time, they had bauk…After he studied (with Playing Safe), he knew that what his friends and he had done was at risk for transmitting HIV and STI strongly…he thought ladies will suffer when we are cheating her, having bauk rape with her. We shouldn't commit it with ladies. To end, the title is 'Remorsefulness' (CS53)

Each of these change stories documents a different group rape/bauk scenario and individual response. The first demonstrates the knowledge and capacity of the peer educator collecting the story. The peer educator listens to the story of the young men and is able to provide them with health information as well as advocate for behaviour change on the grounds of human rights violation. The two subsequent stories recount stories of increased knowledge leading to behaviour change amongst the peer educators of the project themselves. Similar to the PER discussions of change, HIV/AIDS fears are

fundamental in the decision to stop participating in *bauk*, but in these stories there is also a nascent understanding that *bauk* causes the women involved to 'suffer' and that it shouldn't be committed. Nonetheless, these stories fall short of clearly articulating that *bauk* is more than a public health concern, but also a violation of women. It should be recalled however, that the change stories were self selected by respondents on the basis of their significance to the story teller. Thus, the inclusion of a number of *bauk* stories can be seen to indicate that it is considered an important issue amongst Peer educators of the project. The recognition of bauk as an 'issue' by peer educators is in clear contrast to the 'normalised' conception of the practice identified by the wider target group. This raised awareness can be seen as a crucial step towards changing attitudes around bauk within this peer educator group.

Group Sex: Summary

Overall, these findings support those of earlier studies (Bearup, Soprach, Wilkinson) and suggest that group sexual violence is a normalised part of youth male sexual experience in Phnom Penh. The findings also illustrate the limited utility of a public health based approach in addressing the constructs that contribute to sexual violence. While self interest based messages focusing on HIV/AIDS and STI risks appear to be impacting on young men, and in some cases reducing their involvement in *bauk*, overwhelmingly, this is not the case, as the 'safe' message of condom use competes with avoidance as a strategy for keeping oneself safe. In addition, different perceptions of risk among different categories of women could simply see *bauk* shift from a crime predominantly committed against sex workers to one targeting other vulnerable or 'available' but lower risk groups of women.

Men who have Sex with Men

A significant number of young men reported knowing men who have sex with men (MSM). In the first round of interviews, when asked if young men like them were involved in MSM, the minority of respondents reported that young men like them never have MSM, with one respondent reporting that his peers were never involved because 'they hate that activity'. Another respondent conceded that 'most men' don't have sex with men allowing the possibility for some Khmer men who have sex with men. The following quotes provide an indication of some knowledge about MSM as documented in the first round of interviews.

> Young people like me have sex with females but they cannot have sex with males. If it is male and male we call *khteuy*, because we don't desire to have sex with men (PER12, 04).

> I have heard of sex between men but I have never seen… they call this gay? I hear that there are gays at this park or male sex workers but I have never seen them. I don't want to meet them either! (PER25, 04).

> Some young people have same sex with the opposite sex and some with the same sex (PER31, 04).
>
> As I have heard from friends there is both heterosexual and homosexual sex. However, heterosexual sex is natural and passionate because nobody criticizes you like friends and neighbours because we were born in different sex and to complete each others passionate needs. Homosexual sex is always very secret because their ashamed and afraid of being gossiped about. Anyway there are not many people like this too, we can say that homosexuals are a minority in Cambodia and are because of foreign influences. There is also a lack of homosexual services, there are some but they are so secret and can't be public and also expensive, from $20, $50 up to $100 or maybe more depending on the area. My friends say there are mostly gays and almost no lesbians in Cambodia because women have strong ancient tradition (PER36, 04).

In addition to these examples of knowledge of MSM, the following quotations from the first round of data collection provide examples of young people who report that young people like them are involved in MSM, express interest in MSM, or claim personal involvement themselves.

> The young guys start to have sex around 17 years old because they see sex videos, which cause them to have sexual desires, because of peer pressure. Most young guys have sex with the opposite sex, and some of them have sex with the same sex, like with *khteuy* because *khteuy* give guys money to encourage them to have sex with them without condoms (PER8, 04).
>
> I observe that young guys like me have sex with both girls and guys because it is natural and can be productive but of course sex with men cannot be productive [make a baby] (PER11, 04).
>
> Man and man I've never heard but I have seen on the internet and other websites. If I see homo-sex (man with man) it looks unusual, strange feeling, and it's not natural but it looks more passionate and better than hetero-sex! (PER22, 04).
>
> …as I know at the traffic lights area, there are some men who have sex with men (whisper in my ear). I don't know what but it is strange. I want to try too, just kidding. But man with man, if it's true, there is no damage too because there is no losing of virginity or pregnancy at all. If we know how to protect against it, we also don't get AIDS…I am not really interested in sex between man and woman, but between man and man (PER24, 04).
>
> I know through another, if they have homo-sex, they call [it] 72. Guys who have money come to buy sex from my friends and foreign people too. Some gays we can know, but some we can't [tell they are gay by the way they act]. They look like the normal men (PER32, 04).

A significant minority of the young men interviewed in the first round of data collection reported that young guys like them are involved in male – male sex. There appears to be knowledge that some young men prefer sex with men, or seek money for sex with men and were identified using the derogatory terms *kheutey* or *paeday*. However it appears that young men who engage in sex with men do not view themselves in an exclusive sexual category and engage in sex with men in addition to involvement in both girlfriend relationships and commercial sex with women. This supports the finding of Teodoro, Sovanarna and Mourik that 56% percent of MSM respondents reported having had sex with both male and female partners (2003:45).

The second round of interviews did not specifically seek information relating to MSM, the question respondents were asked in this section was more open ended, asking what sorts of sexual relationships young men have, and whether they had seen any changes in the types of relationships over the past year. A number of responses included reference to MSM, with a minority of respondents indicating that 'young men like them' could engage in sex with men.

> Sexual relationships that young people have are man with man, man with woman and woman with woman (PER1, 06)

> Some have sexual intercourse with the same sex like women having sexual intercourse with women and men having sexual intercourse with men. I have known one person that had sexual intercourse with the same sex. I asked them about that; "how can we have sex, if they are both men" They said that they have many positions such as oral sex, and sex, and to do with hands, and so on. I'm not sure but I just think that when they were changed their health was good, they had good feeling, were brave, and come to study all the time, especially they did not care about women. (PER 20, 06)

As in the first round of interviews, there was an understanding that men having sex with men did not preclude the individual from sexual relationships with women, nor identify them exclusively as homosexual. This study, which did not seek an MSM sample group, or specifically attempt to target known MSM locations, provides supporting evidence to the Teodoro, Sovanarna and Mourik report that sex with men is practiced by young men who do not define themselves as homosexual or gay, having necessary implications for the design of sexual and reproductive health interventions targeting this group of men in the future.

Drug Use

‘Guys like us’ who use drugs

Young men were asked about the drug use of their peers over both rounds of data collection. The first round clearly established the use of illicit drugs within this group as common place with a vast majority of respondents identifying either peers or acquaintances that had previously, or continued to use drugs while others admitted personal experience. Very few respondents stated that they had no knowledge of drugs through their peers. Whether they knew drug users personally or not, most young people identified *yama* (amphetamines) as the *neehyom prah,* or the most popular drug of choice and many were further able to identify the cost of *yama* or the street locations at which it could be purchased. This finding was used to tailor the second round of data collection to seek evidence of any changes in drug use habits over the intervening seventeen month period as perceived by young men themselves; responses to the second round of questioning provided a vision of drug consumption habits similar to those in the first round. The following quotations have been selected as typically representative across both time periods. The data reveals that the majority of the youth interviewed know a great deal about the various kinds of drugs available, different methods of ingesting drugs, and where and how to buy drugs.

> My friends know about *yama*, *guncha* and glue through my friends that use drugs. They start using drugs at around 18 years old and my friends started using around 2 years ago. They use only one type, *yama*. *Yama* is easy to buy because it is sold everywhere near Phsar Kandarl,Tuol Kork, Bang Kak, near Sra Chork pagoda because it is cool for young guys. I used to tell them about the disadvantageous of using drugs but they don’t listen to me because they haven’t stopped using (PER2, 04).

> There are many kinds of drugs such as *yama*, heroin, poppy, marijuana, opium, opiate, methamphetamine, cocaine and morphine and so on. For example; they use a kind of injected drug. They inject into their body one by one. After injection they feel as in the paradise and can see everything are beautiful (PER3, 06)

> The kinds of drug such as *yama* and the one called ice *(Toek kok*). The reason that they use is that they use new drug such as just-done drug. For instance: one of my friends first used *yama* and then could use another called Ice (*Toek kok*). (PER27, 06)

> They know drugs like *yama*, glue, heroin and opium. They use drugs since 1998 at quiet places like at a friends house, at guesthouse. They sniff, smell, smoke, or inject depending upon the type of drug (PER19, 04).

> They have some knowledge about drugs and there are many kinds, like *yama*, heroin, cocaine and *yama*. *Yama* is used to smoke, heroin is used to inject. They use the kind of drugs that help them have power… There are many types of drugs but they don't know all of them, just *yama* because its cheap and easy to buy. The kind of drug that makes people die is heroin. It's the most addictive drug but we have never tried it (PER31,04).

As several of the quotes above indicate, *yama* is seen as a "very easy to buy" drug. Several respondents highlighted the fact that *yama* is so easy to obtain, and that it is cheap, and that there are 'systems' in place for buying this drug easily. The last four quotes in this section below also reveal that *yama* has doubled in price from October 2004 (first data collection period) to February 2006 (second data collection period), but that it is still known as the cheap, available drug of choice.

> I don't know exactly what kind of drugs they use, but I have tried with them. It smells beautiful and they told me it is *yama*. They smoke it with a bottle of mineral water, pipes, and a lighter. They like *yama* the best. They have their students' network [for buying]. They buy it around Kandal market and around ball betting, and Tapang market (PER33, 04).

> I don't know the drugs they are using, just know that it's like grey powder. They like using grey pills, I have seen them many times. About buying I've heard my friend say that it's not difficult so long as we know their *mote* (password) and have money. Buying is from places like nightclubs. At phsar Kandal they buy most of the time, pshar Clha etc, and most nightclubs in Phnom Penh. Sometimes they don't sell them for money but exchange them for other drugs [eg. drug a swapped for drug b] (PER35, 04)

> They use only one kind, *yama*. The material that they use includes a bong, lighter and cigarettes. They always use drugs during the daytime because at night they cannot go out. They use drugs at karaoke or guesthouse. *Yama* is cool and easy to find to buying from Tuol Kork, near Srah Chork pagoda, and the throughout all the provinces in Cambodia. One pill costs 4500 – 5000 riel depending on the location. (PER5, 04)

> None of my friends are addicted to drugs. I heard from TV and newspapers and other broadcasts…Drug addicts are everywhere around Phnom Penh, people using *yama*, glue and white powder. *Yama* and glue are used because they are so easy to buy at places like Casa [nightclub] karaoke bars, at the car crashing game place at the riverside and in front of the national assembly. One pill of *yama* costs between 4500 and 5000 riel (PER23, 04).

> As I know, the price of *yama* for one tablet is 10,000 Riel. I also knew that there are many kinds of drugs besides *yama* just like opium, poppy, cocain, heroin and so on. The drugs mostly used by them are *yama* because it is not strong as heroin. (PER 2, 06)

> The type of drugs they use are *yama*. Now the price of *yama* is increasing to 10,000R per tablet. (PER16, 06)

These PER findings, drawn from more than 70 respondents represent the combined experiences of a much larger group due to the use of the PER methodology which seeks respondents accounts and perceptions of the behaviour of their peers. As such, the responses suggest that illicit drugs are very accessible to young people, especially *yama*. This is consistent with the RHIYA baseline study, in which 99.2% of urban youth had heard of drugs, and 64.7% of the CARE (Playing Safe) sample stating that they knew someone who uses drugs. (RHIYA, 2004) The prevalence of drug use amongst this group was further supported by the change stories (CS) collected by peer educators of the Playing Safe project. A number of cases recount individual's experiences of drug use, or the experiences of their friends and peers. Given that the MSC methodology involves the selection of stories by youth on the basis of significance to them, the inclusion of stories of drug use in this data suggests that drug use is common and an important issue amongst young men.

Indeed, drug use appears to be common enough that even non-users were able to identify the market price of *yama* and locations at which it can be purchased. In addition to knowledge of *yama*, the following drugs were identified as being available or used by peers in both periods '*guncha* (marijuana), k (ketamine a veterinary tranquilizer), heroin, opium, as well as glue, with 'icey', methamphetamine, cocaine and morphine being newly identified in the second round of data collection, indicating a possible proliferation of drugs available to this group of youth in Phnom Penh.

Across all levels of data collection, amphetamine, namely *yama*, was consistently found to be the most popular drug. The effects of amphetamine use were articulated by a significant number of respondents as including 'have energy and think that they are strong, brave and fearless of others. After that [using drugs] they do bad things like fighting, go to have sex, and [the drug] can make them have sex for a long time'. (PER 7, 04) Whilst not all respondents identified 'doing bad thing like fighting' as a result of drug use, feeling power and aggression does appear to be a common theme as to why young men reported using drugs. One youth succinctly explains that 'Young men like me like using drugs because they can help us have strong power/help us be strong and be happy'. (PER15,04). Being brave, or gaining strength, power, daring or fearlessness was identified by a majority of young people within the first round of interviews as reasons for using drugs or the result of taking them. This was largely repeated in the second round of data collection where being brave to have sex and fearlessness were commonly related impacts of drug use. These findings are interesting set against Cambodia's socio-cultural political context. Power and strength is everything in a society in which access to most employment, or legal justice for example, is linked to one's level of power and strength attained through good *knong* (patron)[7]. Considered in this context there is little wonder that the most popular drug amongst Cambodian young men is amphetamines.

[7] For further reading on patronage system in Cambodia see O'Leary & Nee, Learning For Transformation, 2001.

An area of growing concern is the apparent availability of heroin and its popularity as a drug used intravenously. The use of heroin was mentioned in a significant minority of cases throughout the first interviews in addition to multiple direct references to injecting heroin. The second round of interviews, in which the questions referred directly to *Yama*, and did not ask for a listing of available drugs, still included a number of references to heroin and opiates as well as additional references to injecting. This suggests a significant increase in the reported accessing of heroin by this particular cohort. In 2002, intravenous heroin use was identified as a problem limited to 'male street children 15 years and older' (Mith Samlanh, 2002, p.38). Similarly, in the Paupers and Princelings study (Bearup, 2003) no evidence was found for use of heroin amongst middle class gang members. However, concern has been expressed by some observers about the potential for an increase in numbers of intravenous drug users given the 'injecting culture that exists within Cambodia' (Bearup, 2002:10). The results from this study indicates that heroin use in Cambodia is no longer limited to street children and is evidently in the early stages of being marketed to the middle class demographic of young men.

Changes in Drug use

The second round of data collection explicitly sought to capture youth perceptions of change around all aspects of drug use. To this end, the respondents were asked if they noted increase or decrease, or other changes in the drug use of their peers. Responses varied substantially with almost equal numbers claiming, no change, increased use or decreased use, with the overall outcome of answers 'cancelling out' and an apparently unchanged sample wide level of drug use. However, through this questioning, insight was gained into exogenous factors influencing drug habits. Firstly, and unsurprisingly, youth reported that access to money is a strongly determinant factor in drug use. From an economic perspective, this data shows that drugs are seen to be strictly normal goods; their consumption is positively related to income, and they have both complements (including commercial sex) and substitutes (such as cheaper drugs or alcohol), and the price of either can impact on the quantity of drugs purchased and consumed. As the following quotes reveal, one of the main reasons cited by respondents for changes in drug use by guys like them were economic changes.

> It has changed a little bit because now it has changed to use more than the one kind of drug, such as: glue, ketamine, and Yama. A new reason for using drugs is because they have much money. Example: In past, one youth sometimes used drugs a little bit because he didn't have much money but when he got more, he used drugs much more. I know this because my friend told me. Drug use will change if he has a lot of money and it won't change if he doesn't have money. (PER7, 06)

> But I still see a few more newcomers (to using drugs). The amount they are using is reduced when their members increased as they have no money to buy more, so they have a few to share with each other. When they have much money they use

> *yama* but when they have not much, they buy glue to sniff. Dog-Head glue can be bought at motor-part shops. (PER17, 06)
>
> It has changed… now they use (drugs) a lot because now they have a lot of money; [they use drugs] such as glue amphetamine *yama,* ketamine and so on. For example, my friend goes out in a group and now they use many drugs because my friend for awhile has much money and now he has new friends, and these 2 to 3 new friends all use drugs.PER19, 06)

Secondly, youth perceive a change in the legal environment surrounding drug use. When asked about changes in drug habits, a number of respondents in the second round of interviews stated that there was a reduction in drug use due to increased pressure through new laws, new understanding of laws, or a changed perception of drug law enforcement. The following statements give an overview of young men's perceptions of change within the legal environment.

> Now the government has taken measures to close the drug selling places and arrest the drug users so that it doesn't happen a lot like before. For example, now drug users and drug sellers are arrested by the government so the young people don't use drugs a lot and they rarely go out at night at the moment. I know this from my friends because they have heard about it. (PER 38, 06)
>
> It has changed and is different from before because now a law has been issued, and, they are afraid of HIV. (PER25, 06)
>
> It has changed because he is afraid to commit a crime by 'doing drugs.' Taking, selling, or trafficking drugs are all crimes. (PER18, 06)
>
> It is not as easy to buy, even if they know where to go it is very difficult because when they go to buy, there is another person waiting to get them sometimes they are caught by police and go to prison for one to two days. (PER10, 06)
>
> Drug is not easy to buy because even if you know the drug place, it is still difficult because when you enter and exit, sometimes you are caught by police. They would like to buy at Beong Kok area. There is no change in their behaviour when using drugs as they are still making sex improperly and sometime not use condom just as before. Can I give an example? It is clear because a group of my friends were caught by police when buying drugs. After being caught, their parents come to buy them out from being detained with $100-300 (PER9, 06)

It is clear that there is awareness amongst this group that the use of illicit drugs is illegal and disposes them to action by the police and judiciary. However, the final statement identifies a previously documented challenge within the Cambodian context, a culture of corruption within the police and judicial system, whereby those with the means to 'buy out' do not face the full extent of the law. This was supported by the findings of the focus group discussion session conducted following the second round of interviews; the PER

participants were quick to identify that fear of legal repercussions would not, in their opinion alter drug use habits, the PERs commented

> Young people are not so afraid of being arrested; firstly, the chance of this happening is very small – there are not so many police. And, secondly; if they are arrested they will get out of trouble by paying a small fine (FGD, 02.03.06)

While this issue, of corruption and adequate judicial process is beyond the scope of this research, it is relevant to note that there seems to be an understanding amongst middle class young men that while laws may exist regarding their behaviour; their actions do not necessarily place them within the reach of those laws.

The stories collected by Playing Safe peer educators about their peers included a number of stories of change from being a drug user; these stories suggest that education; both through Playing Safe and other organisations is influencing the behaviour of some youth in relation to drug use. The following example is a clear demonstration of the Playing Safe model in action:

> (Peer educator talking about a target group youth he interviewed) …he added that he had gained much knowledge from the Van Outreach, especially, he now knew about the consequences of drug abuse which always happen to many young people in our society. Moreover, he said that in the past, he had not known about using drugs, but then a group of his friends asked him to test it saying it would make him feel relaxed, happy and study well. He didn't use it the first time, but finally he began to use it because they forced him to do so. At that time, he just got a headache, nausea and felt stronger than before; however, after he listened to me (peer educator) tell him the consequences which were related to health, he felt highly shocked from hearing that after abusing drugs for a long time, it could cause stroke or heart attack. He said that he had seen the van several times, and that he did not really want to die. Later, he decided to quit abusing drugs, it was very difficult for him to quit the first time, eventually he was successful, and it took him three months. He now stops seeing his previous friends because he is afraid of them asking him to abuse drugs again. (CS 22)

This story documents a behaviour change directly attributed to the Playing Safe project by the individual involved. Through the information he has gained from the project over a number of interactions with the Playing Safe van, this young man has made a change in his life in order to protect his health. Further, he has also developed a strategy for sustaining this behaviour change, through avoiding contact with his old friends. Several similar stories were collected, some explicitly identifying the activities of Playing Safe as a factor in the change, others simply identifying the shift from user to non-user through some sort of increased understanding and awareness. While these stories do not appear to translate into a sample wide decline in drug use, they do provide support for the impact of the Playing Safe intervention on youth participating in activities.

The Impact of Drug Use on Sexual Behaviour

Findings in this report have already suggested that heroin and intravenous drug use appears to be on the rise in Phnom Penh, potentially leading to a greater number of young men sharing needles and being exposed to HIV and Hepatitis. This presents the possibility of changing the dynamic and profile of the HIV/AIDS epidemic in Cambodia, thereby eroding the acknowledged 'success' of the response thus far unless adequate and proactive harm reduction strategies are developed and implemented quickly. Beyond this, continued increasing popularity of this depressant (as opposed to the stimulant *yama*) will conceivably impact on the profile of drug related sexual behaviour and the concomitant public health factors in the future. However, in the interim, *yama* and other 'new' amphetamines such as 'Icey' continue as the drugs of choice for this group, thus their characteristics dominate the currently observed links between drugs and sexual practice.

When asked about the impact of drug use on sexual behaviour, a few young men responded by suggesting that drug use decreases sexual desires or capacity. A 19 year old high school student explains that when guys he know 'use drugs they have no desire to have sex … they don't know why'(PER2, 04). Furthermore, another student notes that: 'Some people want [sex], [and] some don't want because it makes our penis not work' (PER20, 04). This was also documented in the second round of interviews, with one respondent noting; 'when they use drugs they feel forgetful and vague especially, they find their penis doesn't become erect. (PER5, 06)

These responses, however, deviated from the norm as most young men interviewed spoke of increased sexual desire. These contradictory responses are consistent with the findings of other local research initiatives such as the Mith Samlanh publication, *Drug Use and HIV Vulnerability* (2002). Different capacities or desire for sex can be attributed to differing peer group expectations around behaviour after drug use, or alternatively could be caused by differing levels of addiction. High levels of addiction are seen to produce both behavioural and physical impacts reducing the ability and desire of the individual to engage in sex as part of their drug experience. High levels of substance addiction lead users to prioritise purchasing that drug above all else, leaving little room for the pursuit of other needs or pleasures such as sex. Physically; strong or long term addiction to substances such as *yama* and heroin is known to cause impotence or a decrease in sexual libido amongst some men.

Increased Access to Commercial Sex

The majority of young men reported heightened sexual desires and many referred to accessing commercial sex after taking drugs. Socially, it appears that for many young men, sex appears to be a normal group activity that occurs after using drugs. One youth, speaking about his peers, explained that the 'drug makes him strong and happy and increases sexual desire. After my friends take drugs they go to the brothel like Svay Pak, Toul Kork, Bun Poh'. (PER1, 04). Another youth similarly noted that after using drugs 'they have a feeling like being very happy and have energy and have increased sexual desires. After they use drugs they go to the place that sells sexual services Bon Poa, Stun

Mean Chey, Svay Pak' (PER4, 04). And another 20 year old university student explains further:

> After they use drugs they go to hire a girl to have sex from night time until the morning…and have the energy to have sex for a long time. If they don't use drugs when they have sex they last maybe 10 minutes , but if they use drugs then they go for more than half and hour. (PER8, 04)

References to increased sexual desires were made in a significant number of respondents in both rounds of interviews as well as in the change stories gathered from peers and non-peers of Playing Safe. Specific references to accessing commercial sex after using drugs were made by almost half of all respondents over both rounds of PER interviews. This example, part of a change story gathered by a Playing Safe peer educator, further demonstrates this link:

> They inhaled drugs together, and the type they used was *Yama*. Every time after they abused drugs, they always went to bargain a girl to have sex together. (CS 27)

'Longer Sex

While findings around sex and drug use were consistent over both time and sample group, the second round of PER interviews revealed an increase in the expressed link between drug use and longer sex. A majority of youth identified 'having sex for longer' as a principle reason for drug taking as opposed to an unplanned by-product. The following examples represent this finding:

> While using drugs, we feel sexual desires strongly. For example when not using, we can have sex only one time but while using, we can have sex three to four times, and for a long time for each. (PER9, 06)

> After smoking drugs, it makes them happy, relaxed, feel able to make immediate decision, easily angered, and feel like having sex. When using drugs, it make them have sex longer and not become exhausted. (PER12, 06)

> For instance some youth use drug and then come to have sex with prostitute because after using drug, they feel like having sex and they think that [using] drugs make them able to have sex for longer. The reason that they do not change this is that modern youth like to use drugs and having sex after using drugs. (PER26, 06)

> Most of them use while they have sexual relations because usually, if we don't use drug, we can have sex for short time, but when we are using drug, we spend long time, about 30 minutes to have sex. (PER29, 06)

Again, these findings were supported by the focus group discussion with the PERs. On the subject of impacts of drugs on sexual behaviours, the researchers all agreed that 'many people believed in using drugs to have sex for a longer time' (FGD 02.03.06) and further stated that young people like them feel that "if they use commercial sex without using drugs, they feel they are spending their money for nothing as they can have sex only for a short time when they do not use drugs." (FGD 02.03.06)

This is a development in the culture of sex and drugs within this group; rather than an experienced result of drug use, increased sexual capacity is being listed as a reason for taking drugs. This serves to firmly establish links between drug use and accessing commercial sexual services, and indicates an emerging drug domination of the culture of 'recreational' sex within this group of youth. This development is of particular concern in terms of both public health impacts around ineffective or non-use of condoms as a result of drug use, and in terms of the *type* of sex youth engage in when under the influence of these 'passionate' drugs, which will be addressed in the following section.

Inconsistent Condom Use

As noted above, the evidence suggests that drug use is explicitly linked to sex, primarily the accessing of commercial sexual services. Given this, the following section seeks to briefly explore the impact of drug use upon risk taking behaviour during sex. Furthermore as the data reveals, amphetamines, such as *yama*, are the drug of choice amongst young urban middle class men in Phnom Penh. Within the context of sexual behaviour, the feelings of courage, strength, power, daring and fearlessness provided by these drugs are considered likely to cause young men to act aggressively and with decreased regard for their own, and their partner's sexual health or well being. In particular, drug use is expected to reduce both the frequency and quality of condom use.

The majority of young men, across both rounds of interviews, made statements that indicate inconsistent condom use following drug taking;

> They use a kind of injected drug. They inject into their body one by one. After injection they feel as they are in paradise and can see that everything is beautiful. This is what causes them to have sex without condom, and makes them face AIDS infection easily. Drug using has effected strongly the youth's action, especially in sexual issues. When the drugs go into their body they don't fear anything. As a result, they will have sex without using condoms. (PER3, 06)

> Because modern youth mostly use drugs and then have sex, they sometimes have sex without using condoms – they are drunk on drugs and cannot control themselves. (PER 4, 06)

> After using drugs, during sex sometimes he will use condoms and other times he doesn't (PER1, 04).

> When they use drugs they would never use a condom when they were having sex because drugs affected their thinking, changing the way they normally felt. (PER5, 04).
>
> … they actually have sex with the girls in their group because they use drugs together then they have sex together in a group also. Maybe they don't use condoms because they are strongly passionate while using drugs…but I saw many boxes of condoms in their room (PER25, 04).

However, the second round of interviews did suggest an increased understanding of the importance of condom use within the context of using drugs, especially in relation to HIV/AIDS risks and sex with sex workers. The following comments demonstrate this growing knowledge:

> Though using drugs while having sex, they still use condoms as they are afraid of HIV. Sometimes this fear is caused by the fact that they have seen a lot of their friends die from HIV. (PER25, 06)
>
> Though using drugs, while having sex, we still use condoms as we are afraid of STIs. (PER12, 06)
>
> They have sex by force because drugs makes them want to have sex by force. They use condoms sometimes because they are sure those ladies (sex workers) transmit disease to them (PER 10, 06).

This increased awareness was reflective of a shift within the second round of interviews more generally. Responses relating to drugs within this second round tended to demonstrate a deeper understanding of the wider impacts of drug use on themselves, their peers, their families and society than responses recorded in the first round of interviews. A number of youth recounted stories of tragedy or rehabilitation and made normative statements regarding the 'falling down of society' resulting from drug use. There was also increased mention of family interventions in drug habits, and of support and rehabilitation facilities as well as learning about drugs and drug issues, primarily through the mass media, but also through 'organisations' and peer educators. This learning and increasing awareness will be more closely examined in reference to youth access to information and services.

This increased knowledge relating to safe sexual practice was similarly represented within the change stories collected by peer educators, both from themselves and their peers. A small number of these stories demonstrate peer educators questioning their peers about their drug use as it relates to sex, as well as a small number of respondents claiming they use condoms during sex, irrespective of using drugs. Further, a number of Change Stories from Peer Educators of Playing Safe included specific stories of reduced drug and

alcohol use as a result of learning about the relationship between this and unsafe sexual practice through project activities and life skill training;

> (Peer educator talking about a target group youth) He educated his other friends to use condoms correctly and safely, especially to warn them to avoid finding sex services when they were drunk because they might be less careful, leading to transmitting HIV/AIDS or STI. Next, he told his friends, if you decide to find sex service, don't drink to become drunk and always be sure to use condom safely. (CS, 51)

It is notable that peers tend to reference drug and alcohol use together, while members of the wider target population (the PER sample) tend to either ignore alcohol entirely in the drug section of the interview, despite frequent references to drinking with friends in other sections, or to draw distinctions such as

> For using drugs I do not know because in the group of my friends, no one uses drugs. We just [go] drinking to cut down stresses and sometimes it can help use to be brave enough for sexual intercourse (PER32, 06)

Increased Aggressive Sexual Practices

In addition to failing to wear condoms consistently when taking drugs, additional statements made by the youth suggest that a drug induced increased sense of power may contribute to the rape and abuse of sex workers.

> In their group when they use drugs their tempers become weak, they lose their memory and also for get to use condoms. Sometimes they force them (sex workers) to have sex. (PER 19, 06)

> Drugs make them feel like having sex strongly; but even so, they also use condom. For instance, a group of my friends, after using drugs, brought girls to make sex in team (*Bauk*) by using many sexual styles and very strongly and forcefully.(PER11, 06)

> They have sex by force because drugs make them want to have sex by force. They use condoms sometimes because they are sure those ladies (sex workers) transmit disease to them.(PER10, 06)

The results provide some evidence that amphetamine use may be a factor leading to involvement in violence and group rape. Young men frequently speak of inconsistent condom use during drug influenced encounters of group sex with sex workers, suggesting at the least a level of intimidation and implied force within these interaction as it is unlikely that sex workers, with all the education that has been directed towards them, would be agreeable to sex without condoms.

The following quotes were chosen as examples of involvement in group sex after using drugs, or indications of aggressive sexual tendencies and/or a desire to inflict trouble on others.

> They will go to brothel, hit people and do not respect the law. The problem that causes danger to their own sexual health is that when they get high on drugs, they'll have sex with their partner without condoms and after using and they don't have money, they will steal and rob as examples we have so far in our society (PER33, 04)

> they think that having sex violently makes them feel strong and excited; anyway they also use condom. For instance a group of my friends, after using [drugs], brought girls to have sex in team (*Bauk*) using many sex styles and forcefully. …having sex improperly makes them much more aroused. (PER11, 06)

> When using drugs they feel happy, addicted, hot tempered, want to fight and want to have sex. When they use it they feel like they want to have sex strongly because it can release feelings (PER21, 04).

> When they go to hire a sex worker, they go with only 2 or 3 guys and they convince her to come and tell her that it is just them, but when they arrive at the guesthouse they have their friends waiting, nine or ten more guys. They always use violence because the sex workers don't want to have sex with that many people. After they have all finished having sex sometimes the girl is unconscious. After she becomes conscious they start to have sex all over again. The reason that they want to have sex like this is because it is fun and because they use drugs… and have the energy to have sex for a long time. If they don't use drugs when they have sex they last maybe 10 minutes, but if they use drugs then they go for more than half and hour (PER8, 04).

> They have sex by force because drugs leads them to want sex by force. They use condom, sometimes because they think clearly that those ladies [sex workers] transmit disease to them. They never have sex by force with their sweetheart because they don't want to force the person who they love. They don't change because they think that when they have sex by force it can make them excited and happy. One of my friends told me that after he uses drugs, he takes a lady to sleep [with him]. If the lady doesn't agree, he stabs (hits) her badly. (PER10, 06)

> My friends always use violence with sex workers because they are drug addicted. Sometimes they don't wear condoms…, they want to have fun and after they use drugs they want to smoke and *daeleng* (play) until the morning. (PER36, 04).

In addition, there is evidence of forcing sex workers to engage in drug use as part of the drug influenced sex scenario, as described by one youth in the second round of interviews;

> Sometimes they don't use drug alone, they push the prostitute to use with them, if they disagree with they will fight her and push her to use too, so if wants to be safety, she must use drug. (PER 30, 06)

These final four comments not only display 'high risk' and violent behaviour, but also give additional insight into young men's attitudes towards sex workers and their rights that underlie this data and support the findings throughout other sections of the report and pre-existing research around male youth sexual behaviour and attitudes. (Bearup, 2003; Soprach, 2004; Wilkinson and Fletcher, 2002) Two of the statements clearly articulate the respondents acknowledgment of the impact of drug use on his sexual behaviour, (i.e. increased violence), and the youth are suggesting that this is acceptable for sex workers, but not for girlfriends because they are loved and they do "not want to hurt her." The lack of concern for hurting the sex workers involved is evident, as it is in the remaining two comments where violence is threatened against prostitutes unwilling to perform unwanted sexual acts or use drugs at the will of her 'clients'.

In addition to contributing to involvement in sexual violence, the study further found numerous references to involvement in theft, robberies, fighting and gangs. These findings have not been included in detail within this report given that they are outside the parameters of this study.

Drug Use: Summary

The findings have provided evidence of a wide availability and knowledge of drugs amongst young men. Indications have further been gained that young men view drug use as a 'cool' group activity and of benefit in increasing a sense of happiness and power. Most of the young people interviewed knew peers involved in drug use, and many of them reported that peer pressure was a factor in the decision to use drugs. That alcohol is not widely thought of as a drug is clear, this may be the result of the actual terms used when conducting the interviews, it is possible that the PERs referred to 'illicit' drugs, or it may be reflective of the actual perception of alcohol within Cambodian youth culture. Either way, it is noteworthy when one considers the impacts of alcohol use on risk taking behaviour and the extremely high level of availability of alcohol to youth. Cambodia has no legislation relating to a legal drinking age, and the price of alcohol places it well within the financial reach of young men within the Playing Safe target group.

Further, the stories and descriptions collected suggest that drug (including alcohol) use amongst young men is contributing to their involvement in high risk sexual activity involving infrequent and/or ineffective condom use and violent, coercive sexual behaviour. While responses were largely consistent over time, there is some evidence of changes around drug use behaviour over the seventeen month study period: There appears to be an increased understanding of the impacts of drug use overall, with respondents in the second round of interviews more likely to provide stories of drug death, or of rehabilitation than in the first round of interviews. This increased recognition of drug risks failed to translate into a clear reduction in drug use. Learning through media and other sources did seem to translate into an increase in the number of respondents

asserting that they use condoms irrespective of drug use however, an arguably positive development, though the quality of use while intoxicated remains an issue. This quality issue was explicitly recognised by a number of peers of the Playing Safe project who articulated the danger of ‘drunken sex’.

The links between sex and drug use seem similarly well understood amongst the sample group as a whole, as shown by the increasingly recognised links between drug use and sexual capacity, and the reporting of this as a prime reason for using drugs. This indicates a significant development in the culture of drug use within young middle class men in Phnom Penh, reinforcing the social norms that encourage ‘recreational sex and drug use’. Apparent changes within the legal structure surrounding drugs within Cambodia are seemingly inconsequential in changing drug use habits, predominantly as a result of limited respect for the capacity of the legal system to enforce punitive measures.

Information & Services

Access to Condoms

Playing Safe is a component of The European Union (EU)/United Nations Population Fund (UNFPA) Reproductive Health Initiative for Youth in Asia (RHIYA). RHIYA funds a total of seven youth sexual and reproductive health projects in Cambodia. The umbrella project has chosen the phrase 'Don't let Shyness Harm your Health' as the main message being spread to young people. Access to condoms is impacted by shyness; with embarrassment or being ashamed featuring as a strong theme throughout young people's responses to questions about purchasing condoms.

Across both rounds of data collection, shyness and feelings of embarrassment and shame were the primary factors inhibiting the purchase of condoms. A typical response explains that young people are

> shy to buy condoms because the sellers always have a quick look and a laugh and ask them what do they buy them for? When they go for walks, they always have condoms with them in places such as under the motorbike seat, or in their wallet (PER28, 04)

A number of respondents describe similar scenarios. Apart from being embarrassed in front of shopkeepers, several young people also explained that there is embarrassment when purchasing condoms because of being viewed as 'bad' for carrying them around, or because the sellers are female.

> Always buy condoms at guesthouses or clinics and they are shy because they think that they are so young and the people around them think they are bad guys because young men should not put the condoms in their pocket. (PER2, 04)

> They don't want to use or buy condoms; first because they are afraid the sellers think that they are bad, second, they are afraid other people who see them buy it will judge them as bad boys, third, they are afraid to meet someone who knows them, especially prostitute who know each other and when they see we are buying condoms, they will think that we are bad and have many girls (PER22, 06)

The Change Stories collected by peer educators provides further evidence of this perception that young people should not carry condoms. A number of these stories document a reluctance to touch or carry condoms, with most mentioning that to touch condoms was 'brave' or 'daring.' Further, some youth reported watching condom demonstrations at the Playing Safe outreach van activity and being surprised and encouraged by the courage of the demonstrators, particularly female peer educators of the project, as explained by one youth:

> When a girl passed a condom to me for the first time, I felt shocked and did not dare to take it. I only took a Coke because I was a student, and I felt shy…Then, after I sang several songs, they showed a spot on the use of condoms at the van. I watched it from the beginning to the end of the show with a group of girls who dared to demonstrate the use of condoms amongst many people without any shyness. Therefore, it made me realise that I was a coward about not taking a condom like this, I thought, that even though they were girls, they dared to do so, so how about me? And, I decided that the next time I bought a Coke, I would also take the condom and put it in my pocket. (CS 23)

A small number of CS cases report similar situations where the promotion of condoms through the Playing Safe van outreach activity has led to an increased confidence and feeling of 'normalcy' relating to carrying and using condoms. Feelings of shame and embarrassment around condom use are significant to youth. Thus the individual changes recorded by the change stories can be seen as demonstrating one element of the dynamics of changes as seen within the larger sample population.

Changes in accessing condoms

As in the previous sections, respondents in the second round of interviews were asked to identify any changes they had seen in the attitudes and habits of their friends around buying condoms. A significant minority identified no change, explaining that young guys like them were embarrassed or shy about buying condoms one year ago, and were embarrassed about buying condoms now:

> Feel embarrassed because when they buy condom the sellers always looked [at] their face, today, it is still embarrassing (PER 19, 06)

> Youth when they buy condom they always feel shy because they are shy with the other people near to them such as women or old person. In this case nothing has changed because they are still shy about buying condom and don't know reason why they feel shy (PER22, 06).

> When they go to buy condoms they feel very ashamed. Sometimes they want to have sex so they must go to buy, but no one will volunteer to buy. They all always push each other, but sometimes they must play 'so luck so bad' (a game similar to "paper, scissors, rock") the loser must go to buy the condoms. (PER29, 06)

The majority of respondents felt there had been a change however, and identified this change as a reduction in shyness and a feeling that buying condoms was now 'normal' or 'ordinary':

> The youth are not very shy because now it is advertised on TV and they think buying is about money. This is a change because before they were shy to buy but now they are not.(PER25, 06)

> Having shyness because he goes back with condom, others think that he has sexual intercourse with prostitute, but right now they have changed because are extremely aware of reproductive health and information about disease transmission. When someone has a condom in their bag or under the seat (of their motorcycle), others think that he has sexual intercourse with prostitute, but that he knows how to protect himself from HIV/AIDS infection and also realizes clearly about sexual health. (PER18, 06)

> Because we are young, when we come to buy, they absolutely think that we are bad, but now we seem not so shy because everywhere there is talk about condoms and HIV so it is normal. Also we well understand and know that only condoms can protect us from HIV. When we see one of our friends keeping condom with him; before I thought they are bad and cunning with girls, but now I do not think so. Instead I think they are so good and brave to protect themselves as they have much knowledge about HIV and think that HIV can not be cured successfully. When getting it, it must be dead, so they are afraid of HIV (PER17, 06)

When asked about the reasons for this change, most youth responded that their friends had gained extra information about the importance of condoms, or, felt that using condoms was now so publicised that there was no need for embarrassment. Several respondents, like this one below, noted that media promotion, in particular on television, has been especially effective in influencing the attitude of young men toward buying condoms.

> Now there is much change because the youth are now brave to buy condoms at clinics because of widespread dissemination about HIV on TV. This is good. Before, the youth were not clear where they could buy safe condoms so they usually bought condoms at quiet places to avoid feeling shame. (PER13, 06)

These changes combine with evidence of ‘normalisation’ of condom purchase recorded in the first round of interviews to present an image of increasingly ‘shyness free’ access to condoms:

> As far as I know it’s not shameful because it’s the right thing to do. If the sellers see us buying condoms they think we are people who are very responsible (PER35, 04)
>
> .
>
> They aren’t shy when they buy condoms because it’s just like buying chewing gum (PER38, 04).

> They are not shy when they go to buy condoms because it is very important for sexual relationships and can protect from STI’s or AIDS. Condoms are easy to buy, available everywhere like pharmacies, on the street at night, and at guesthouses (PER8, 04).

In addition to these responses, there were a number of young men from both rounds of data collection who explained that despite shyness, purchasing condoms was a necessary action given the risk of contracting HIV or STI's. Some of the comments that emphasize the need to overcome embarrassment are included below:

> I think that they [people who wear condoms] are good people who take responsibility for what they have done, I mean they play and they also wear [condoms] and know how to protect themselves. [Young men feel] A little bit ashamed, but I think if we get AIDS we feel ashamed and we are also dead (PER22, 06)

> For people who decide to buy condoms it doesn't mean that they aren't ashamed, but that they are braver than other friends (PER34, 04)

> For buying condoms, there is nothing to be embarrassed about because we do it for others and ourselves mainly. If we did not buy it, and have become infected with AIDS into your body, you will be the most ashamed. When we are infected with AIDS disease, our relatives and neighbours will be ashamed and will not want to talk with you, they will hate you, so at that time I just think that you feel more ashamed than if buying condoms. (PER2, 06)

This particular response was strongly supported by the participants of the focus group discussion; all participants agreed that buying condoms was now a 'social norm'. They felt that while sometimes embarrassed, most young men understood that it is necessary to buy condoms if you want to have sex, and that in most cases this understanding is enough to overcome embarrassment. Even so, when asked about whether they felt that services providing condoms in a non-confronting manner, such as the 'safe soft drink' component of the Playing Safe Van, were useful, participants said that they 'liked this very much' because it was 'not difficult' for them. (FGD 02.03.06)

In summary, young people reported that condoms were widely available at pharmacies, hospitals, health clinics, guesthouses, hotels, shops and on the streets at night. No young people reported that finding condoms to purchase was difficult, or that condoms were inaccessible due to price. Most respondents in the first round of interviews found purchasing condoms to be an embarrassing experience, but generally recognised the importance of overcoming their embarrassment and the stigma around using condoms in order to protect themselves. Seventeen months later, there were fewer respondents identifying buying condoms as prohibitively embarrassing, with many citing advertising and awareness campaigns as the source of this shift. Nonetheless, both interview respondents and participants in the focus group discussion stated that they still felt some embarrassment with both female sellers and 'mean' clinic or pharmacy staff whom they felt were judging them. Focus group participants further identified that the access to condoms provided through the Playing Safe van outreach activity was valuable as it made overcoming residual embarrassment easier for them. The change stories gave further insight into the role of Playing Safe activities in the normalisation of condom use,

demonstrating that peer educators were seen as an example for other youth, and worked to support the messages youth are receiving through media campaigns.

Access to Sexual and Reproductive Health Services

In the first round of interviews it was seen that most young men knew vaguely about potential places for seeking medical assistance and reported preferring to visit clinics or services located conveniently close to their home. A number of young men also explained that visiting sexual health services or talking about such personal matters to a doctor was a very difficult and embarrassing experience. There further appeared to be a perception that sexual health clinics or services are not places where young men should go.

> They go to the place that provides service for treatment near Depot market [perhaps a RHAC clinic] and also Preak Ketmealea Hospital. They are shy because they think that they are young and should not be seen in that place. They caught STI's from their partners because they didn't want to wear condoms. About six months ago a couple of friends had STI's but now, after treatment they don't have them anymore (PER1, 04)

> They mostly go to clinics, National Clinic against Skin Diseases, STI Pasteur and they also go to RHAC clinics. At clinics they don't get much information because the sellers are busy selling (PER25, 04)

> Young men should go for treatment when they infected. They always go to private doctors because it's easy [and] not noisy as public doctor when they check. I don't know that doctor, I just heard (PER32, 04)

> As far as I know, some young people go to the doctor near *phsar* Depot when they have STI's. I don't know his name. Getting information about sexual health is also in that area or there is a treatment service which is closer to where we live (PER35, 04)

The second round of interviews provided a similar image of health service access, with the majority of young men identifying NGO clinics, health centres and hospitals as their health service options. The majority of cases reported accessing services for either the treatment of STIs, learning about condoms, or contraceptive advice.

> At hospital, private clinic, and health centre they go there because they wanted to know about other disease in their body and especially wanted to know condom usage and prevent to disease. (PER7, 06)

> They receive daily services at Ser Sbak (skin) clinic near Depot market. I only know [about] that one. [They went there] because they had STIs. They had syphilis and [went there] for treatment. And now they are recovered. If my friends had that disease, I would bring them to the Ser Sbak clinic because there are skilled doctors there. (PER11, 06)

> At all hospital clinics such as at Depot market. But, I don't know names of clinics. I have heard that NGOs also have [clinics] but I am not interested in [the] names of NGOs, I don't know too much, but for me, I used to go at Depot market. Because this belongs to the state, the cost is suitable, when we have examination (consultation) we can pay only a little bit [of] money, only 5000 riels. And they have [a] document for us to meet [with the] doctor and the doctor will ask us about our situation and ask to examine [us]. I had [a] skin rash such as sun allergy disease around my penis I allowed doctor to examine and he told me about diseases and wrote for the medical doctor to buy medicine such as take medicine (oral) and paint medicine. (PER20, 06)

In addition, a large proportion of respondents identified HIV Blood testing as a service they were seeking and accessing:

> The youth also have talked about receiving sexual health service, for example if one of our friends want to test blood, we can bring him to the place with logo "test voluntarily and free". The main things that we talk [about] are HIV, condom using and blood testing. (PER14, 06)

> They go there because they are taken by their friends to test blood.....etc. (PER24, 06)

> They go to do blood test and the result shown that it's Negative. Then they keep that to talk with their friends and explain to them about how blood test is, sometime they can go to test blood too. (PER38, 06)

This was a significant change from the first round of interviews in which the primary reason given for accessing services was symptomatic STD infection and contraception. There appears to be an increased understanding of both the nature of HIV and the availability of VCCT, with an increase in the number of cases referring at some point to the fact that it is impossible to determine HIV status through observation, and the availability and usefulness of blood testing.

In another progression from the first round of responses, a high proportion of round two respondents identified that they talk about accessing sexual and reproductive health services with their friends. As with the reasons for accessing the services themselves, the most common topics of these discussions included HIV/AIDS, condom use, contraception and abortion. The following are typical descriptions of discussions young men reported having about using health services:

> The youth talk about sexual health by insulting that the one [guy] is so thin, like [a] person living with HIV, so [he] should go to have [a] blood test, and some talk about abortion services. For example one of my friends has had made sex with his girlfriend and many sex workers and then he has symptom of losing weight so his

> friends persuade him to have HIV blood test in order to be sure [if] he has HIV or not.(PER13, 06)

> Getting everyday service and information at RHAC organization at Phsa Depot or Toul Tompong, the Men's health organisation in front of the Cambodiana (hotel), The National Authority Against HIV/AIDS and STD diseases hospital private clinic such as Vishal Sok Chhoun Ming and so on. For example [they tell] such as at the Men's Health Organization they have free consultation and keep secret and so on. They speak about here is cheaper than there, or that [it is] easy to find, [and] the doctor works hard at [helping] clients. (PER19, 06)

A number of respondents further articulated that they actively refer their peers to health services they know about and that they consider are good value and effective:

> Youth like me talk about reproductive health with friends, too. And we have talked about getting reproductive health services. Something that we talk about is AIDS disease and health services at RHAC organisation Centre at Tum Nup. For example: One day, one of my friends had [a] problem with [his] health such as painful urination, maybe he had [a] venereal disease, and after that I took him to RHAC health Centre at Tum Nup. While he [was] there, [it was] good service because they [were] helpful and so friendly to youth that need their help. (PER32, 06)

> [Youth] receive daily services by retelling from one to another and at the hospitals, for example they go there because they want to get the information and blood test. The youth often talk about receiving some information from their friends for wanting their friends knowing sexual reproductive health. The youth rarely talk with their friends about receiving health service but they say in case their friends raise the topic related to sexual reproductive health.(PER21, 06)

> For example, the youth, after getting sex health services, they got advice and explanation from doctors. And then they retell the advice above to their friends. There is tactic, for example, [some] people, who have known sexual health services before, guide the others to get sexual health services too. (PER26, 06)

However, overall, few respondents in the second round of PER interviews provided very much in the way of specific details about either location or quality of services, with a small number of young men reporting having "no ideas" about where they or their friends should go to seek sexual and reproductive health services.

> I and my friends never know that where we can get information because we don't know NGOs or doctor that can help and also get service. Example: If my friends have problems related to reproductive health, I don't know where to take them to. (PER20, 06)

This demonstrates a continuing need within the community for the promotion of quality youth friendly services such as are available throughout Phnom Penh. In recognition of this need, the overall objective of the Playing Safe project (and the RHIYA initiative) is to '*contribute to enabling safer sexual and reproductive health behaviour, including increased utilisation of quality youth friendly services among target adolescents and youth in program intervention areas'*(RHIYA,2004,p5) to meet this objective, Playing Safe actively promotes available SRH services through a peer educator based referral network comprised of seventeen health service providers throughout Phnom Penh, including both NGO clinics and health centres. The Change Stories documenting target youths' interactions with the peer educators of the project demonstrate the way in which Playing Safe is advocating for the adoption of health seeking behaviour amongst the project target group and facilitating access to services:

> One of my friends who was a Peer Educator came to visit me, and he asked me to take a blood test for AIDS. He promised to accompany me. I told him I would not go, even if he gave me a lot of money, because if the result was positive, my mother would kill me. Moreover, I also felt very embarrassed. After he explained to me a lot about the advantages of taking a blood test and that the information was kept confidential, I decided to take a blood test. The result was that I had typhoid…my friend who accompanied me to take a blood test was a peer educator at Playing Safe. (CS4)

> In this case, I told him that he should consult with a consultant about having a blood test for AIDS, thus you would know whether you were positive or negative. Where could I have consulting? He asked. I answered to him that "you should go to the Youth Centre because there is a consulting room there, or you should call through the counselling number (provided)"…I told him to take a blood test for AIDS at Pasteur clinic because it did not charge any money and he turned to ask me where the Pasteur clinic is (CS24)

> I also discussed (SRH) with my friend who used to have sex with karaoke girls. He used a condom, but it broke while he was having sex. He was afraid and had lost 5kg, so I asked him to go to have an HIV blood test. At first, he disagreed, but I explained to him many times the benefits of having a blood test; if the result was positive or negative, we still can make plans and live longer into the future, like other people. Then he agreed to go to Pasteur clinic. The result was negative. (CS45)

In addition to accessing these 'modern' services a significant number of young men within the first round of interviews reported peers turning to *Krou Khmer*, (a traditional Khmer doctor) when faced with a sexual or reproductive health issue, particularly for STI's.

> Anyway they often take their sweetheart to see the doctor at clinic now because there is Pasteur with modern material so they can do blood testing [for HIV prior to marriage]. Some of my friends ask me to go to *Krou Khmer* to buy herbs to

> drink to cure because it costs less. I used to believe in *Krou Khmer* but after from friends from CARE, Red Cross, and other organisations explained to me I decided to stop believing in *Krou Khmer* and believe in science because it's obvious and based on evidence (PER36, 04)

> Young men don't go for these services because they don't know about them. They are ashamed of being asked by the doctor about these issues. When my friends have an STI they prefer going to *Krou Khmer* rather than a modern doctor. They went to ask a doctor at a health care centre but because they were shy they weren't able to ask all the questions they were wondering about (PER34, 04)

> If the young guys catch STI's they always go to a public hospital, NGO hospital that provides service on reproductive health or skin problems, or some of them go to meet with *Krou Khmer* because they are cheaper and they think that Khmer traditional doctors have stronger medicine than the doctors at the hospital (PER37, 04)

> If they have an STI they go to the hospital or Krou Khmer because they don't want to spend a lot of money. They access information about sexual and reproductive health, AIDS, at RHAC Hospital or health centre that provides the service on reproductive health (PER8, 04)

These findings seemed to indicate that there were significant numbers of young men turning to traditional medicine for treatment of sexual and reproductive health issues, STIs in particular. These young men preferred the Krou Khmer over hospitals or clinics which they felt to be overly expensive and embarrassing to visit. However, in the second phase of the research, conducted approximately 17 months later, there was almost no mention of seeking traditional Khmer medicine. Only two cases mentioned the use of traditional medicine. In both of these cases, the services of the Krou Khmer were sought for abortion, possibly indicating that abortion is a particular case in which traditional medicine is preferred:

> We asked our neighbours how to abort, using Khmer medicine, or Chinese medicine. So I bought Chinese medicine.(CS41)

> There was a teenage boy who rented a house in Psar Deom Kor commune to live with his girlfriend and they were involved in sex, but they had never considered starting a family. They had sex occasionally, until the teenage girl was pregnant. She did not want the pregnancy because it made her feel ashamed, thus, she decided to have an abortion by drinking Khmer herbs. (CS)

It is uncertain whether this overall shift away from Krou Khmer amongst the youth interviewed is reflective of a wider trend away from traditional medicine, or indeed whether this well reflects this group of men as a whole. However, participants in the FGD similarly failed to mention traditional medicine as an option for dealing with sexual and reproductive health problems.

Access to Sexual & Reproductive Health Information

Young men were asked where they could access information about sexual health. The findings suggest that young men are most commonly learning about sex outside of the home and through sources other than family. Across both time periods only very few young people referred to learning about sex or reproductive health issues through older people or relatives:

> If we want information about sexual health, we get from old people near our house who know (PER17, 04)

> At clinics, health centres, hospitals, STI clinics and reproductive health centres such as the National clinic, RHAC, PSI, health centre, through some relatives, through STI doctors and reproductive health doctors we can get more information (PER26, 04)

> I think that they talk with their close friends. About sexual health services, they talk with their friends and also people they are very close [to] such as [their] parents. The thing they talk [about] is [information] got from health centres and organizations. (PER26, 06)

Similarly, the focus group discussion participants identified that young people 'like them' would approach "older people, like uncles and grandparents, not so much parents" (FGD 02.03.06) if they had a sexual or reproductive health question.

There appears to be a correlation between asking older family members for information about sex and accessing services based on cultural traditions and beliefs. One respondent who reported using traditional medicine for the treatment of an STI (PER33, 04) identified the medicine as coming from relatives in Battambang. Another young person, explained that he used to believe in traditional medicine but, that this had changed after speaking with friends from NGO's, at which point he had 'decided to stop believing in *Krou Khmer* and believe in science because it's obvious and based on evidence'. (PER36, 04) Based on the apparent shift away from the use of traditional medicine, and the high number of references to NGOs as health service providers evident in the second round of interviews, it seems that this may not be an uncommon occurrence. While there is a clear need to ensure that accurate information is made available to young men to reduce the rate of HIV infection and improve sexual health, there is also a need to recognise the importance of seeking advice from elders within the Khmer cultural tradition. An approach that is felt to bypass elders may be disempowering to parents and detrimental to the family unit. A significant message emerging from the Change Stories is the influence held by the family over the reproductive health status of young people, with stories from Playing Safe Peer Educators in particular identifying that only through the support of their parents, siblings and extended families, including grandparents, could their participation with the project continue:

> One day I was reading an AIDS book, my Mum blamed me, "there is no benefit to reading it" she said. I thought my Mum was too shy to talk about it, so I explained to her that it did have benefit to reading it, that it (SRH) was a problem that youth need to know about. So she understood and stopped blaming me (CS 46)
>
> When I got home, my brother saw my (Playing Safe) T-Shirt in my hand, and he asked me where did I bring it from? I told him I was involved in the Small Health Promotion at the Youth Centre, and that I had answered the question correctly, so therefore they had given me the Playing Safe T-Shirt as a reward. Moreover, I had registered to be a participant in a three day Life Skill training. He did not prohibit me, that's why I could go to take part in the Life Skill Training (CS40)
>
> I was pleased to receive good news from one [staff member] asking if I had enough free time to participate in the training, and I answered happily OK immediately. I was permitted by my Father. He never forbade me from taking part in the activities of organisations (CS47)

This signals a strong need for adolescent sexual and reproductive health initiatives to work with parents and other family/community based gatekeepers primarily to provide support for youth participating in programs, but also to maintain traditional structures and hierarchies of knowledge within the family and community. Change Stories from Peer educators (as above), as well as the RHIYA baseline survey[8] indicate that these gatekeepers are receptive to SRH knowledge and understand the importance of this for their children, thus they are a potentially important and valuable resource in the improvement of youth sexual and reproductive health.

Sites identified by young people as places to get information about sexual and reproductive health were similarly consistent over time; in the first round of interviews the most common responses were; firstly through NGO's, secondly through clinics and thirdly through the media. A typical response from the first round of interviews has been selected from each of the target areas:

> They access information about sexual and reproductive health, AIDS, at RHAC Hospital or health centre that provides the service on reproductive health. RHAC NGO have been here before to spread information and do public education about AIDS and show them how to use condoms on the path near the riverside and they also do concerts that attract young guys to join and show them the consequences of living with AIDS' (PER8, 04)
>
> They access to get information through TV 9 that educates about HIV/AIDS maybe 3 or 4 months ago now and also through some peer educators that came here maybe a month ago, their name Play Safe. Play Safe came here to educate

[8] Qualitative results from the RHIYA baseline indicated that parents felt SRH education was important for their children. In particular they expressed fear for their children contracting HIV/AIDS(RHIYA: 2004:pp 84-7)

about sexual and reproductive health, how to use condoms and (avoid) drugs' (PER2, 04)

Young people like me get information about HIV/AIDS and STI's through TV radio, broadcasts of role plays in their target area. Some of my friends have met peer educators but not in Tou Pi. Peer educators come from RHAC or other NGO's (PER11, 04)

We get information about sexual health services AIDS on radio, TV magazines, Radio 103 MHZ, TV9 and Pop Magazine…I have met peer educators or social workers along this way [who taught] about sexual health and AIDS. I have met [them] in public and in school in the classroom and people who work for the Cambodian society. They want us to be good and help announce to people to get to know about sexual health practice (PER15, 04)

They ask information from health centre, hospital, NGO's. They have never met peer educators, [they] know by TV, newspaper and magazines (PER21, 04)

National clinic against skin diseases near Psar Depot, RHAC. Going to these places they will explain to us. I saw PSI, they told us how to use condoms near this area (PER24, 04)

Young men like us get information about sexual health/AIDS through advertisements like radio, TV, or the NGO that's against AIDS. Other young men that I know have met friends who are peer educators or people who work for society and those areas. We got information about sexual health and AIDS. They come from Against AIDS organisation. They educate about the understanding of STIs and AIDS in order to prevent the spread of diseases and help us to know how to use condoms understand STIs and AIDS clearly (PER31, 04)

The second round of interviews provided a similar account of accessing information, with young people indicating that NGOs, clinics, hospitals and health centres were primary sources of information about sexual and reproductive health.

They get information at RHAC, Marie Stopes, Maryknoll and Family Health International clinic because the service there is cheaper than [at] private hospitals. Counselling is free of charge. (PER8, 06)

Young people like me get information about sexual health such as AIDS/HIV, non-consensual sex, STIs, contraception, condom use and accessing services at hospital, clinic, Health centre, and RHAC. (PER5, 06)

Young people like me receive information on sexual health such as HIV/AIDS, Non-consensual sex, STIs, contraception and condom use and take daily services at health centre, people who disseminate (information) in public places, TV and the places which have reproductive health services where health providers explain

> how to prevent diseases, [as well as] contraception methods (condom use and contraception pills). (PER1, 06)
>
> Young people like me receive information of services from RHAC clinic which is located near Psar Depot. I heard [about it in] that area, I heard one times when I talked to some of my friends and one of them ask [if] there [is a] place for abortion? And his friend told that [X Place provides abortions]. How much does it cost? He said I don't know. (PER9, 06)
>
> Young people like me get information about sexual and Reproductive Health for their daily life such as condom use, HIV/AIDS and contraceptive method at organization or public hospitals: Red Cross, Calemet and other private clinics. For that information I got it from my friends through leaflets on HIV/AIDS and drugs. Whey they go to RHAC [they go] because they want to know that what kind of services RHAC provides in order to [access] them easily when they have health issues. (PER16, 06)

These findings can be seen to confirm that NGO's are playing a vital role in spreading information about sexual health and HIV as NGO's appear to be getting out and reaching the young people in their own environment. RHAC, Playing Safe, Marie Stopes International, Family Health International, Maryknoll, CARE, World Vision, PSI and Friends were all mentioned by young people as providing information about sexual health, HIV, condom use or drugs. In the second round of interviews, RHAC clinics in particular were frequently mentioned and it appears that the services offered are both well known and largely well regarded.[9] Further, across both rounds of data collection a significant number of the young people interviewed had met peer educators from NGO's who were spreading information. This topic of access to peer educators and knowledge of NGO's will be discussed in the coming section.

Young people further spoke of being able to access information at sexual health service providers such as health centres, hospitals, clinics and centres. However, as previously reported, these services have been identified as places young people are typically uncomfortable to attend, and thus it seems they are unlikely to be regularly accessed sources of information, in fact, it is most common for these types of locations to be accessed only once an illness or infection is assumed. The participants in the focus group discussion further suggested that young guys like them, in their opinion, "Do not go to health centres or clinics to talk about sex or ask questions- these are places for treatment, you need to be sick to go there." (FGD 02.03.06) Arguably additional training or coaching with the PERs would have assisted the process of questioning responses and probing more deeply, thereby gaining additional insight into these seemingly contradictory answers.

TV and Radio

[9] See: www.rhac.org.kh for more information.

The final major source of information mentioned by young people across both rounds of interviews was TV and radio stations. The use of TV and radio is a very effective means of spreading information as information may be targeted and packaged towards reaching young men, but is simultaneously able to be consumed by young women, parents and older people, allowing for the building of community support and knowledge around adolescent sexual and reproductive health.

Friends

Round One - 2004

Surprisingly, in the first round of interviews, when young people were asked where peers gained access to information about sexual health, apart from references to peer educators, only one person mentioned gaining information through their friends. While this was seen to be a potential source of concern, given the number of NGO's employing peer educator programs as tools for reaching young people in Cambodia, it was also felt that the phrasing of the question and interviewing techniques could be responsible for the result. When asked about the sexual behaviour of their peers, young men were able to give detailed accounts as well as provide examples of peer involvement in both decision making processes and actual activities. Therefore despite some information to the contrary, it was concluded that young men do gain access to information about sexual health through their peers.

It was hypothesised that the formalised usage of the medical words sexual reproductive health caused young people to respond by stating formal channels through which information may be gained about sexual health. This theory would also explain why a large number of young men claimed that guys like them gained information through clinics and health centres despite having previously explained that young men are often too shy to visit such services.

Round Two - 2006

As a result of these particular findings, the prompt questions in this section were carefully assessed during the second round of PER training prior to the final round of data collection. It was agreed that worded differently, this prompt may be able to provide more useful and representative information. As a result, the second round of interviews was conducted using a prompt shaped around "where guys get information about sex and HIV on an everyday basis" This resulted in answers around sharing information with friends that were significantly different from those given in the first round. A typical response in round two cases was that 'youth usually talk about health affairs and reproduction with their friends. They talk about reproductive health services. Mostly, they talk about the spread of sexual diseases.' (PER3, 06) This statement was echoed in the majority of cases from round two of the PER interviews, with most young men identifying that their friends are important sources of information and advice on health services and sexual and reproductive health:

> [Friends] often talk because sometimes, they say they have also had sex. It can be said that it is absolutely comfortable [to talk to friends]. They can explain to their friends [how] to use condom to prevent various diseases. (PER4, 06)
>
> They talk about how to prevent unwanted pregnancy and other epidemical diseases. Yes, [they talk to their friends] such as cajole to make them soft-hearted and persuade them to see the doctor or go to get information at different health centers. (PER5, 06)
>
> Young people like me often talk about getting information on Sexual and Reproductive Health with their friends when we meet each other. We play cards while talking about girls and about going to have sex. Some of them tease each other about becoming HIV/AIDS positive, carefulness of getting HIV. Some of them said it doesn't matter if we have sex with virginal girls, for example. (PER16, 06)
>
> The place the youth receive information of sexual reproductive health is at the drinking shops. (Where they gather with their friends)…the youth often talk about receiving some information from their friends or wanting their friends [to] know [about] sexual reproductive health…The things that the youth often talk [about] with their friends are HIV and condom use. For instance when one youth were chatting at one garage, he raised HIV problem to talk to their friends that "be careful" and tell more about condom use. (PER21, 06)

These comments indicate that youth talk extensively amongst their peer groups about sexual and reproductive health issues and gain information from each other. This finding provides support for peer education as an implementation model in adolescent sexual and reproductive health initiatives, and is consistent with both common understandings of youth behaviour and other findings within this study.

Information and Services: Summary

In summary; young men access sexual and reproductive health information and services from a variety of sources. Services are typically sought at Health centres, hospitals, NGO clinics and private clinics despite some feelings of embarrassment associated with attending these locations. This embarrassment appears to be on the decline, with feelings of shame and being inappropriate more frequently expressed in the first round of interviews than in the second. Service were most frequently sought for symptomatic STI infection in the initial round of data collection, with a marked increase in access to HIV blood testing (VCCT) being visible fifteen months later, indicating growing awareness of the nature of HIV and available services. Consistent across time, contraception, abortion and learning about condom use were the other most frequently discussed services.

Round two responses demonstrated that young men talk with their peers about accessing sexual and reproductive health services. HIV/AIDS, STIs, contraception, condom use and abortion were the service topics mostly discussed amongst friends, with a number of

cases identifying friends directing friends to access services as needed, VCCT in particular. Across both rounds of PER interviews, and supported by the Change Stories, it seems that the majority of young men have an abstract understanding of appropriate health services to access, but have limited knowledge of the actual locations or services offered by particular providers, or of a variety of options. Informal referral, through more experienced friends, as mentioned above, in addition to formal referrals through projects such as Playing Safe appear to be contributing to overcoming this issue.

Access to information about sexual and reproductive health appears to be a little more problematic than access to services, with a majority of respondents identifying service providers such as clinics, hospitals and health centres as sources of information despite admitting to feeling uncomfortable to go to these places, and the FGD participants identifying that these are places for sick people, only to be accessed for treatment services. However, a number of alternative sites of information were listed; including NGOs, people disseminating, the media and, most importantly, given the prevalence of peer education based programming in Phnom Penh, friends. While the availability of peer educators will be discussed in the following section, it is noted here that young men themselves are frequently acting as sources of information, regularly reporting that they 'retell' what they have learned about sex and sexual health to their friends. Young men are typically seeking information outside of their homes and families, and are most commonly seeking information about HIV/AIDS, STIs, contraception, using condoms, and less frequently, abortion services.

Finally, it appears that young men may be turning away from the use of traditional Khmer medical practice, and the access of Krou Khmer, with a significant reduction in mention of these services apparent over the fifteen months of the research project.

Playing Safe Project: A look at Peer Educators and Van Outreach Activities

The primary goal of this research, as stated earlier in the report, was to gain a qualitative understanding of the way that young, urban, middle class Khmer men experience (a) sex and condom use; (b) drug and alcohol use; and (c) access to sexual health information and services. As a reproductive health project working with young men in Phnom Penh, Playing Safe clearly hopes to impact the way that young men experience all of these things. Of particular interest to the project is improving access to sexual and reproductive health information and services for this target group. Contact with the project is clearly the strongest determinant of impact upon individual youth. Routine project data collection indicates that more than 50,000 youth have been contacted through project activities to date. This research sought to measure the level of contact with the project by measuring knowledge of Playing Safe and exposure to Peer Educators amongst young men within the target areas[10]. An initial measurement was undertaken within the first round of PER data collection to gain an initial assessment of knowledge of the Playing

[10] Playing Safe 2005 Annual Report UNFPA/ RHIYA

Safe project in the project target areas and also an indication of whether or not the target young people had ever spoken with peer educators in their specific geographical areas.

Awareness of Playing Safe: Name and Activities

It should be noted that the Playing Safe (Playing Safe) mobile health promotion van, staffed with male and female peer educators, had only just commenced outreach work approximately one to two months prior to the initial data collection. As the van had just commenced operation at the time of the initial round of data collection, it was not expected that the Playing Safe project would be familiar to many young people in the target areas. Considerable care was taken to ensure that the peer ethnographic researchers (PERs) recruited and trained for the study were not aware that they were undertaking a study on behalf of Playing Safe during this initial round of data collection. No mention was made of Playing Safe in the trainings or in the interview questions and all of the training was conducted at the CARE international office. These steps were taken to prevent any bias entering into the interviews. Young people were simply asked if they had ever met a peer educator in this area before.

Despite the project just starting out, there was some knowledge of the project in one area, where each of the five respondents interviewed knew of both the Playing Safe project and peer educators.

> My friends also know about Playing Safe. Playing Safe has activities to spread information about sexual reproductive health and how to use condoms (PER1, 04)
>
> …and also through some peer educators that came here maybe a month ago, their name is Playing Safe. Playing Safe came here to educate about sexual and reproductive health, how to use condoms and drugs (PER2, 04)
>
> Peer educators have been here before, they are from AIDS NGO Playing Safe that have the objective to educate on reproductive health and drugs (PER3, 04)
>
> Peer educators come here one time per month for educating about sexual relationships and using condoms. The group that came here was called Playing Safe (PER4, 04)
>
> Peer educators have been here before. They came from NGO such as Intervention HIV/AIDS & STI's and the group educators from Playing Safe (PER5, 04)

These findings provide strong evidence that the Playing Safe peer educators in the Chroy Chang Var round about location were seen and remembered by the target group. However, apart from this location, no other specific references were made to the Playing Safe name. Numerous other references were made to peer educators, including peer educators identified as RHAC, CARE, World Vision and Friends/Mith Samlanh Peers. In addition to these instances there were numerous occasions on which young men referred

to peer educators from *Oncar* AIDS/AIDS NGO. The following provide some examples that may or may not refer to Playing Safe peer educators.

> Young people like me receive information about STI and HIV through NGO workers who train their target group in the city and provinces. We have also met with peer educators who disseminate information about how to have sex and about HIV infections (PER10, 04)

> I have met peer educators or social workers along this way about sexual health and AIDS. I have met in public and in school in the classroom and people who work for the Cambodian society. They want us to be good and help announce to people to get to know about sexual health practice (PER18, 04)

> I saw that they crowded around the traffic light area I asked them what they were doing and they said that had come to teach how to protect against AIDS and wear condoms. I walked out 'cause I wasn't very interested (PER25, 04)

> They get information about sexual health AIDS through advertisements by cars that announce on the road…They have social workers and peer educators in this area who talked about sexual health and AIDS. They come from Against AIDS organisation. They educate about sexual health and drugs and told us about the consequences and influence very clearly (PER29, 04)

These examples suggest that a considerable number of young people in the target areas had had some exposure to peer educators at the commencement of the research project.
It was expected that the level of Playing Safe peer educator contact, and thus recognition of the Playing Safe project would increase over time, and that as a result more respondents in the second round of interviews would be able to identify Playing Safe by name, describe some activities and identify any impact of the project on themselves or their peers. As in the first round of interviews, knowledge of Playing Safe was stronger in some areas than others. In particular, the Boeng Keng Kang High School (BKK) and Olympic Stadium areas showed high levels of knowledge with more than sixty percent of youth interviewed in these locations identifying Playing Safe activities and/or peer educators by name.

> Yes, I used to see them (peer educators). They heard about sexual reproductive health and drugs. They come from Youth Centre or Playing Safe. I don't know who they work with because I never join the activities of the Youth Centre. (PER5, 06) (BKK)

> Have met peer educators and mobile car to advertise about sexual health and drugs. Have met them at the riverside at 7 o'clock. They (his friends) have learned, and heard about sexual health and drugs . Peer educators come from Playing Safe. They come by car. [We] have seen the mobile advertisement car at handicap show at 6:30pm. (Botum Pagoda) (PER6, 06) (BKK)

> One of my friends has STI and I told him about the clinic which is near Depole Market have different ways (of treatment) because I have seen one group with a car and wear clothes signed Playing Safe. (PER10, 06) (CCV)

> But I have seen [a] mobile van here... I did not know where those peer educators came from. Those peer educators did not tell, but I just know [that] those peer educators wore white T-shirst with logo “Playing Safe” and rode in the van with logo “Playing Safe”. I didn’t know whom they worked with. (PER11, 06) (CCV)

> Mostly, like my friends I have seen Playing Safe van at garden near Hang but [we have] rarely seen [it] at Olympic stadium. It is not strange to see Playing Safe van because [the] Van comes to promote about health, singing karaoke, HIV, sells condoms at a cheap price, and specially playing short spots. (PER13, 06) (Olympic)

> I [have] never met peer educators in this area, but a few day ago there was a Playing Safe mobile Van disseminate in this area with peer educators delivering many leaflets on Drugs, STIs and condoms to us with explanations on how to prevent STIs, and at the van they were selling soft drinks and playing Karaoke. (PER16, 06) (Olympic)

> I have met ‘friends educate friends’ a few times at Phsa Dumkor and in front of the Royal Palace. I and my friends got information about using drugs, disadvantages of using drugs and protecting ourselves from AIDS/HIV by using a condom. Those peer educators wore white T-Shirts with a Playing Safe design on the back (PER31, 06) (Naga)

In addition to these descriptions that mention Playing Safe or Playing Safe by name there were numerous additional cases where youth may be assumed to be describing the project. The Playing Safe van is unique in Phnom Penh, being the only mobile health promotion vehicle outfitted with karaoke equipment and staffed by peer educators wearing specially designed white, football style T-Shirts. While it is possible that the following comments could be referring to another of the multiple peer educator based projects operating within Phnom Penh, it is believed that the following descriptions are most likely identifying Playing Safe activities.

> Peer educators are from [an] Organization but I did not know which organization. They work with young people…They knew about the van outreach activities such as Karaoke song, leaflets providing, and short Spot display. (PER8, 06) (BKK)

> Peer educators disseminated STIs/HIV/AIDS by talking face to face and [through] spots on TV. It is comfortable for young people in this area; watching and accompanied by karaoke to sing for fun and [it is] free as well. But I don’t know where they [come] from because I didn’t ask them. My friends and I used to see and we feel happy, and we know the way how to used condom. (PER9, 06)(CCV)

> Never met peer educators. But have seen [a] van with 5-6 members promoting about sexual reproductive health and HIV and distributing leaflet with the pictures of symptom of STIs. My friends and I have known the consequence of HIV, how to use condom clearly. When [we are] standing, that group (peer educators) with girls and boys came to explain. For example one of my friends, after learning that having anal sex can transmit HIV, now stops doing that. First I did not recognize where they came from but after they spoke to me and introduced them that from the van of CARE organisation. (PER12, 06) (CCV)

> My friends and I have not directly met with those promoters but I was curious so I asked 2 or 3 of those promoters coming from speaking to another group and then they walked past my group so I called them to ask something; for instance: "What do they work for? Where from? How much for singing one song? Are you giving out something or not?" He replied "we promote about HIV, Drug and Reproductive Health", what organization?… they told me but [I] forgot, [it is] free to sing, or just buy a coke and be able to sing and get a free condom. Those promoters [have] more understanding than me and my group who haven't joined with them before. Those promoters looked so happy when asked. I didn't know what else they have known because they just told me something [like I said] above but at least they could tell us what my friends and I never know before because we were just looking from far away and we did not dare to come close- we are not afraid, but shy. (PER17, 06) Royal Palace

Combining these descriptions with those above identifying Playing Safe by name, it is clear that some locations recorded higher levels of project knowledge, in particular the Boeng Keng Khong high school (BKK), Olympic Stadium (Olympic) and Chroy Chang Var round about (CCV) locations, possibly reflecting the confined nature of these spaces. Overall, few respondents in the second round of PER interviews reported that they had not met either an outreach van or a peer educator. This suggests that access to peer educators (from Playing Safe or otherwise) is widespread across the target sites.

In addition, the number of respondents identifying that they or their friends had seen either the van or peer educators in an area other than the one they were interviewed in demonstrates the mobility of young people within Phnom Penh, providing support for the use of a mobile service, targeting young people in their chosen leisure areas. Thus, given the structure of the PER sample and the way that it can be seen to be drawing on the experiences of a wide group of young men, it can be assumed that many young men in Phnom Penh have access to peer educators, and that a significant number of these young men have been exposed to either Playing Safe peer educators, or the Playing Safe van outreach activity.

Perceptions of Playing Safe Peer Educators and Van Outreach Activities

The secondary purpose of this research is to contribute to the measurement of the effectiveness and relevance of the Playing Safe project. To this end, youth participating in the second round of PER interviews were asked a number of questions relating to their

own, or their peers' interactions with peer educators or a van outreach service. As in the first round of interviews, no specific reference was made to Playing Safe in any of the questions asked by Peer Researchers, thus avoiding undue bias. However, given the prevalence of projects using peer education models in Phnom Penh, there is an element of uncertainty in attributing many comments made by respondents directly to Playing Safe.

The Change Stories form an additional layer of data, collected from youth *known* to have been involved with the project in some way, thus providing examples of the functioning of the Playing Safe model and its' impact on individuals participating in project activities. The following discussion does not seek to be a comprehensive evaluation of either Playing Safe as a project or of outreach or peer education as intervention models. However, as Playing Safe is a pilot project, it is useful to examine both the target groups' perceptions of the project activities and the impact of these activities on members of the group and draw from this some initial lessons learned to inform the implementation of similarly targeted interventions in the future.

Peer Educators: Source of 'good information'

Young men reporting that they or their friends had either met peer educators or seen an outreach van in the target area in which they were interviewed (or elsewhere) were asked what they felt about the meeting and whether they thought the peer educator or van outreach was a good way to get information about sex, drugs and HIV. The responses to questions around peer educators in particular were very positive, with respondents articulating some of the foundational reasons for the employment of peer education models. Most commonly, young men interviewed expressed that peer educators were a good way for them to get information as they perceived that peer educators were well informed and provided information that was both relevant to them and accurate. As the following quotations indicate, young men feel that peer educators are able to provide them with information to help them care for their health and to make good decisions. This is clearly a message for agencies implementing peer education programs that the information given by peer educators must be of high quality to match the expectations of the stakeholders.

> Friends Educate friends (peer educators) is the best way of getting sexual information, drugs, AIDS(HIV) because they (young people) think that when they hear or get information from friends educate friends or other advertisement, then they will know clearly about condom usage to avoid from AIDS infection because it cannot be cured. (PER3, 06)

> When they ride their motorbike or go for a walk, they meet friend educate friend (peer educators) at those areas and they feel so happy to get information about condom usage and health care. They used the information that [they] get from friend educate friend and they think that they (the peer educators) have good knowledge about health and sexuality. The main point is that they always obey things introduced from friend educate friend, especially they take the information to practice. (PER6, 06)

> Some of my friends also followed peer educators. They said that peer educators is a good thing because they explain to young people to help them understand many problems about sex and AIDS, and what is good, and what is not good for young people. (PER8, 06)
>
> They think sometimes peer educators give good information about sexual reproductive health, drug and HIV but sometimes, [they think] it is not good. The good thing is that peer educators try their best to explain to them about STIs and condom use, but the bad thing is that peer educators explain about drugs- I think that if peers tell them the impact of drugs and how to use [them] then sometimes they (young people) can (know how to) use as well as want to test it. (PER13, 06)
>
> Meeting those peer educators at new Naga, my friends felt happy because if [they] know/learn [about] sexual reproductive health, drug, condom use, how to prevent from HIV, then 're-promote' that information to their relatives and friends. Peer educators is a good way of receiving sexual reproductive health information because those peer educators help us, share their knowledge and give us good advice to protect ourselves. (PER15, 06)
>
> For me and my group, I think those peer educators are so good because they can make youth aware of the problems such as HIV, Drugs, and it is a disadvantage because compared to public school, they are not as detailed about those points. Anyway, it is important because those problems have been destroying our society; especially most youth fall into bad situations and cannot stand it. (PER17, 06))

Also arising from the discussion of peer educators as a source of information was the way that the young men felt that this information was naturally shared amongst other friends. From these comments it seems that information delivered by peer educators is perceived to be particularly suitable for 'retelling', and this appears to be an organic part of the process of learning through peer educators. This supports the efficacy of the 'ripple' effect on which peer education programs necessarily depend.

> When they met peer educators they felt that the peer educator came to provide information to young people and people who don't know. They know about sexual health and drugs. They got information from Peer Educator and kept it to tell other friends like me. According to what I've known, they found that it is good that peer educators came to provide this information. I think they get information and provide it to others in order to make other youth and people understand. (PER38, 04)
>
> They think it is good and they are interested because their explanations make the youth know about things such as drug, sexual reproductive health, and HIV. After getting that information, they retell it to their friends such as my other friends and me who do not know about this stuff. (PER28, 06)

Similar themes emerged from the discussion of young men's perceptions of Van outreach activities. Primarily, young men identified the van outreach as a positive activity as they felt they were being provided with relevant and high quality information that can be used to positively change their lives and their society. As in the case of peer education, this puts the onus on project implementers to ensure that the quality of information available through outreach facilities (peer educators in the case of Playing Safe) is of an adequate standard.

> After seeing the van and receiving information about HIV, drugs [and] how to use condoms, they said it is so good there is disseminating van like that and [that it] can protect the youth from HIV and, especially, [that] they can ask the questions there. (PER13, 06)

> When they saw the advertisement car they feel comfortable, and they think that they may have no way to know about health matters and reproductive health if they do not have the advertisement car...We are youth, we want to have mobile car to share more and more about health matters for all the youth. Through this way, if they understand about condom usage, and reproductive health and drugs clearly, our country will not have AIDS anymore in the future. (PER2, 06)

> The advantage of the mobile car is that it makes teenagers understand clearly about sex problems and STIs. There is no disadvantage. They want the mobile car to have a lot of good programs, and they especially want teenagers to understand about them. (PER10, 06)

Van Outreach: Fun Activities and Easy Access to Information

Young men also responded that the outreach van was a good thing as it has activities and features that are specifically designed to attract and accommodate youth. A number of respondents reported that the activities of the van, such as karaoke and games and quizzes offering interaction and small gifts were ways to get young people interested in the important issues of sexual and reproductive health.

> What is good is that they put their information into practice by themselves, (happy to answer) they feel fun and happy with the outreach van by singing Karaoke songs…etc, they take this information to provide to their friends or family. It is a good way to make young people interested in such things by singing and providing information about health, drugs and how to effectively use condom. They (my friends) want them (the peer educators) to create more fun and blissful activities besides singing. (PER5, 06)

> Their feeling was very happy and happy whey they see the mobile advertisement car. They knew about some activities such as: singing, Video show, and etc. They were getting this information to introduce [to] their friends, because youth feel interested in caring for their health and condom usage. (PER6, 06)

> They said that the mobile car was the way to get information about sexual, drug, HIV/AIDS and STDs disease, because it made most youth feel interested because they want information as well as fun programs. They think that when they get information they will practice it themselves. (PER7, 06)

> They sing karaoke, this is the best point for youth because they feel interested in it when they come to do advertisement at this area where there are many people. The mobile car is the best way to help youth and push them to prevent themselves from making a mistake and using drugs and becoming infected with AIDS/HIV diseases. (PER32, 06)

Further, some respondents identified the 'mobile' and 'outreach' nature of the activity as its main strength, giving youth access to the information without them needing to seek it out. By being out in the community, the van is able to bring information to young people where they spend leisure time, potentially accessing young people in the situations where they are making their decisions about sexual practice:

> They (the youth) can learn because the agencies of mobile van come to promote to a pair of lover sitting there for relaxing. After receiving this information, they and their lovers would discuss which ways they should choose to have sex. It is true that the best thing is the mobile van because we could get education about sexual reproductive health and understand the bad consequence of using drug. (PER4, 06)

> When meeting the van, it was comfortable that we sang for fun and received a gift for answering the questions. The van is very important to give information to the youth because sometimes the youth have no time to watch promotion through TV. But, sometimes they go out for pleasure and eventually see the people gathered at the van and singing so others come to join. That is the time that they also receive information. (PER15, 06)

One respondent also reported that the 'Mobile van is also a good way to get information on sexual health, drugs and AIDS because we don't need to pay for the services.' (PER1, 06) indicating that the access to free information as provided by outreach activities is also valued by this group of young men.

As with peer education in general, a perceived strength of this particular outreach activity was the likelihood that youth would follow the advice and teachings of their peers. A number of respondents also identified that the fact that information received 'from the van group' could be shared with their friends:

> I want peer educators to come to promote here like the group of the mobile van. A group of my friends have met the van group at this area. They are happy when meeting mobile van here. They have learned things that are good from the mobile van group. They have followed what the mobile van group instructed them. They said that it is the best thing because what they explain what is good. (PER11, 06)

> Some times I took this information (from peer educators from the van outreach) to tell other friends in order to make them get aware on how to prevent from HIV. The mobile van is an important source for young people to get information about sexuality, drug and HIV/AIDS because in the promotion they deliver leaflets for young people to read to get knowledge. (PER16, 06)
>
> (talking about van outreach activity) …they get to practice using condoms by changing the condoms themselves and they continue to spread these messages to other friends because it can help them. They consult them, and at least they can know about that information too. It can help teenagers to understand about the dangers of using drugs and HIV/AIDS disease infection and STDs. It can also help them to be conscious and to change themselves to be a good person in society. (PER18, 06)

A small minority of respondents related that either they, or their peers, had negative impressions of van based outreach activity:

> The bad thing is that they are educating people who are too young. It makes them want to test having sex because the nature of the youth is to really want to know what is strange and what they have never seen, so knowing it causes them to have sex at the guesthouses without caring about customs. (PER4, 06)
>
> They are feeling that they want to know, and want to talk or have a discussion with them (van group folks), but their van embarrasses young people because there are a lot of people watching. (PER24, 06)
>
> … there is only leaflet distribution, and explanations so they (his friends) seem to not want to listen because they think that it is a waste the time. (PER25, 06)

These few comments were in contrast to the great majority of comments made by the young men interviewed in the second round of the PER interviews, which, as evident from the preceding quotes, expressed positive opinions of an outreach van as a source of information.

It is assumed that the majority of the comments about “mobile vans” are referring to the Playing Safe Van Outreach activity, due either to explicit mention of the project, or to detailed descriptions leading to this conclusion, however, it is recognised that conclusions may only be usefully drawn about ‘outreach style’ activities due to the ambiguity inherent in some of the cases.

Overall, the young men interviewed perceive peer educators and outreach activities as sources of relevant, important and high quality information, placing pressure on implementers of these styles of project to ensure that these expectations are met, and that the information delivered by peer educators is consistently accurate. Further, the responses around peer educators provide support for a number of the fundamental

precepts of peer education as a programming tool. Young men reported that they are comfortable talking to their peers, are likely to follow their advice and example, and in addition, that they commonly share the information they receive from peer educators with their friends. Similarly, responses capturing perceptions of outreach activities tended to support the intervention logic informing this style of programming, with young men noting that the 'youth relevant' approach, such as the use of popular culture through karaoke and youth focused educational 'spots', as well as the convenience of accessing the van at no cost during leisure time were positive aspects of the activity.

Outcomes of Interactions with Peer Educators

While it is important for project implementers to know how aware the target group became of the project activities, and how the target group perceived these activities, it is even more important to get a better sense of *what they actually learned and what they did with that information.* Young men who reported that they or their peers had met with peer educators, or seen an outreach van were also asked to provide some information relating to the content and outcome of the interaction (see Appendix Three, Conversation 3, questions 2-4) The Change Stories collected similar information from respondents by asking interviewees to describe the most significant change in their life related to their interaction with Playing Safe.

Based on the results from this questioning, it seems that Playing Safe (and possibly other peer education programs) provided messages about condom use, HIV/AIDS (transmission and VCCT), STIs, contraception, drug use, and, to a lesser degree; provided information about available services, and gender and human rights issues.

Across both levels of data collection, the most common topic of learning or consultation was condom use, with a large majority of all respondents, including peer educators of Playing Safe identifying increased understanding of condom use as a key outcome of their interaction with the project. The following quotes have been selected from many more found in the data, to demonstrate the variety of messages around condom use:

> My friends and I have met the group of friend educate friend and have seen the mobile car advertise about reproductive health and drugs. After that, my friend knew how to protect himself from AIDS infection by wearing condom when he has sexual intercourse. Promoting these messages is something that can really make youth change their actions. After they got information or introduction from the mobile advertisement group, they changed from the one who never uses condoms to one who uses condoms with all girls. (PER3, 06)

> They (his friends) felt happy to see peer educators. They learned about how to take care of our health, prevent from contracting other diseases and using drugs, and especially how to effectively use condoms. (PER5, 06)

> I never met peer educators in my area to talk to me. But I have met peer educators who go along with a van because I saw it and I have asked peer educators about sexual problems. I asked about when I have sex with my sangsar (girlfriend) and I don't use a condom can she have a baby or not if my semen does not go in? The peer educator told me she might get pregnant because when we this strong sexual feeling the semen can come out easily and we are not aware of it. Some time I can also contract diseases from her if she carries diseases. And I saw him (the peer educator) seem happy to answer my question. Now I start to change--before we did not use condom, but after I heard and understand the things that peer educators explained I followed his advice. (PER9, 06)
>
> In an example from a friend; they met a group of 'Friends educate friends'. After that meeting, they changed their life –they learned to protect themselves from HIV/AIDS disease and STDs by using condom correctly. Through "Friends educate friend" they know how to use condom correctly. (PER18, 06)
>
> and then he said that he had been involved in Van Outreach Promotion many times. He told me that before gaining knowledge on health, he seemed not to think of his health too much. He often went out with his friends and they always had alcohol and women. He used condoms by putting two condoms on because he thought that if one broke, there was the other left, and he never pinched the reservoir end of the condom to expel the air before putting it on. Yet when he was aware of some parts of sexual and reproductive health, especially when he learned from a peer educator about how to put on a condom correctly and check it carefully, and he stopped going out often like before. (CS5)
>
> He told me that he felt highly worried about his health. After he saw van outreach of Playing Safe, ha gained much more knowledge and received the leaflets on AIDS as well. He told me he was very repentant abut his misdoing at that time (having unprotected sex with a commercial sex worker) and when his friend asked him to visit a commercial sex worker, he used a condom correctly because a peer educator told him how to use it. (CS13)

These responses suggest that while young men are aware of the importance of condom use, particularly in relation to its role in the prevention of the transmission of HIV/AIDS, they are also uncertain about the correct use of condoms. The frequency with which use of condoms was mentioned in relation to things learnt from Playing Safe also suggests that this is a prominent message of the project. Playing Safe is clearly perceived by young men as a source of information regarding condom use.

A similarly high proportion of cases from both sources of data identify young men accessing Playing Safe with questions related to HIV/AIDS risks. Often, these cases are responded to by peer educators with suggestions of accessing VCCT and avoidance of risky sexual practices. As evident in the following cases, it is clear that Playing Safe peers are able to provide clear information about both the transmission of HIV/AIDS and the nature of the virus.

> (talking about what he has learned from 'friends educate friends') If we have relations with one person, we cannot know if that person has HIV or not. To be clear, we need to test blood. For these reasons, we must use a condom every time when we have sex. We must use condom in the right way, following their (peer educators) instructions to avoid the condom tearing. Using a condom is the best way to lead us to stay away from AIDS and pregnancy by carelessness. (PER3, 06)

> We joined singing Karaoke too. Not only that, but also get a lot of knowledge from the peer educator. Sometimes I take this information to tell many other friends in order to make them be aware about how to prevent from getting HIV by accident. (PER16, 06)

> When meeting those peer educators, we receive information about condom use, HIV and drugs. For example: in the past used to have sex with many partners and think that it was happy and not care about HIV because of thinking [that] the condom can prevent it 100%. But now we know that though even using a condom HIV can still be transmitted and one can still get pregnant. Information disseminated by the van causes the youth to be discouraged to have sex as they are afraid of HIV and other diseases. (PER13, 06)

> (peer educator talking about a target group youth) At that time, he asked me if he could be infected with AIDS if he and two of his friends went to pick up a commercial sex worker to have sex at the hotel, and that night the first one had intercourse after putting on a condom, the second one put on two condoms, and he put on only one condom, but before he put it on he dropped it on the floor and it became dusty. In this case, I told him that he should consult with a consultant about having a blood test for AIDS, thus you would know whether you were positive or negative. Where could I get this consultation? He asked. I answered to him that "you should go to the Youth Centre because there is a consulting room there, or you should call through the counselling number (provided). (CS24)

STIs, drug use and contraception were the next most common topics of information gained by youth through their interaction with the project. Again, it appears that peer educators were able to provide clear information about STIs, drugs, and contraception to young people. The following cases demonstrate an example of peer educators providing information on each of these topics:

> I gained a lot of knowledge about STI's from the peer educators who provided me with the disgusting picture of STI symptoms such as wounds, a clear or creamy discharge from the penis, and they also named some STIs to me such as syphilis, Gonorrhea, herpes and so on, and they told me the consequences of them. For example, when a pregnant women has an STI it could cause the baby disability or even lead to death. (CS 23)

> For using contraception there are many way to use such as take the tablet, inject, put circle and so on. They (a married couple who does not want to have another baby) can choose anyone of these ways, but if he does not want to use these ways he and his wife can use condom together when he wants to have sex. Because condoms can help them to avoid AIDS diseases and other sexual diseases and can avoid pregnancy as well. (PER3, 06)

> (A peer educator talking about what a target group youth had learned from a peer educator) …he added that he had gained much knowledge from the Van Outreach, especially, he now knew about the consequences of drug abuse that always happen to many young people in our society. He told me that in the past he had not known about using drugs, but then a group of his friends asked him to test it saying it would make him feel relaxed, happy and study well. He didn't use it the first time, but finally he began to use it because they forced him to do so. At that time, he just felt headache, nausea and stronger than before; however, after he listened the peer educator coming to tell him the consequences which were related to health, he felt highly shocked from hearing that after abusing drugs for a long time, it could cause stroke or heart attack. He said that he had seen the van several times, and that he did not really want to die. Later, he decided to quit abusing drugs, it was very difficult for him to quit but eventually he was successful, and it took him three months. He now stops seeing his previous friends because he is afraid of them asking him to abuse drugs again. (CS 22)

As documented in the earlier section, *Access to Sexual and Reproductive Health Services* (pg XX- XX) a number of respondents reported peer educators referring young men to appropriate health services. In addition, a small minority of cases identified Playing Safe staff as providing information about issues relating to gender and human rights. One youth reported that

> 'One day, he accidentally saw the van of Playing Safe project that was promoting in front of Botum pagoda. He heard people asking questions related to rape. Having heard this, he felt not so good because it reminded him of his actions towards his girlfriend (who he had admitted to forcing to have sex with him, resulting in her being 'furious'). Also he heard about testing for HIV (having not used a condom)…whatever the results would be, he still regretted his actions… From then on he never committed such a thing again. He was afraid that one day it might happen to his only sister. He loved his sister very much.' (CS8)

> ' (Peer educator describing his interaction with a target group youth) After I listened to them telling about an incident of bauk, firstly I told them that they were at risk of contracting an STI if they had not used condoms correctly, secondly, I told them they could kill the woman whom they conducted bauk with, and thirdly, that they violated Human and Sexual Rights, even if she was a sex worker' (CS31)

Playing Safe and Peer Education: Summary

Several of the quotes from target group youth suggest that young men are looking for specific types of information relating to their sexual and reproductive health, and that they are quite happy to receive these messages from peer educators. Our data suggests that the key public health messages in which target group youth in this sample sought information on and that consequently the Playing Safe peer educators provided guidance and details included condom use; prevention, transmission and symptoms of HIV/AIDS and STIs; as well as about the consequences of drug use. This type of information seeking has been supported in the Cambodian context by long running education campaigns. In particular, messages relating to condom use and HIV/AIDS are readily available in Phnom Penh, it is difficult to travel far in the city without seeing IEC advocating the benefits of one or the dangers of the other.

However, in the case of social change messages around gender and human rights, messages are not nearly as widespread in Cambodian society, thus young men accessing peer education services are unlikely to have a level of awareness of these issues to enable them to seek further information. Those that receive Human Rights and gender information by 'accident' (i.e. as part of a response to their questions about a particular topic such as condom use) are likely to recall little of this in comparison with messages that they are already familiar with and interested to learn more about. The challenge for Playing Safe, and similar future projects is to continue to raise awareness of these broader social issues and their importance, as it is through this deeper understanding of gender and human rights issues, that necessary attitudinal and behavioral changes may be achieved.

Discussion

Cross-Cutting Themes

Communication

It is very clear from the data collected and the findings presented in this report that these young men talk about sex with their friends in great detail. This is important because it is this type of peer-to-peer communication that underpins the logic of employing a peer education approach in the implementation of adolescent sexual and reproductive health programming.

Further, the data reveals that young men have two distinct (though not mutually exclusive) styles of talking about sex. Firstly, a significant number of young men revealed that they and 'guys like them' talk about sex with their friends for 'fun' this type of talking seems largely to take the form of 'boasting' about sexual encounters, as one young man explained:

> The youth like me talk about sex issues with friends because they want to let their friends know that they are great and can use different sex styles. For example: they said they wooed a girl successfully to have sex without spending money in order to boast to each other. Moreover it makes them happy when gathering. I knew for they have told me. (PER 12, 06)

According to another respondent, this type of talk is extremely common amongst young men, and happens frequently:

> It is so simple (normal) that when gathering together, they go out, and besides talking about football betting, they talk about girls and sex. When friends gather together it is almost 98%, they talk about their girlfriends or which girl is better, feeling more comfortable and is narrow (tighter) when having sex. Some said their girls are available for sex, but among them if some said they have girlfriends but are not allowed to have sex, they will be depreciated seriously by others because they insult them by saying that they have girlfriends but do not know how to use them and do not know about comfort. Additionally, they chat about sexual styles, boast to each other and want to share experiences with each other about sexual issues, such as whether those girls are virgins or not. About sexual things, men can talk until death. Some also talk about their wives to their friends (PER 13, 06)

This sentiment was repeated by a number of other young men, suggesting that this type of 'fun' sex talk is a normal part of youth male bonding and leisure time. Several young men gave detailed descriptions of the types of 'fun' talk they, and guys like them engage in. Only one respondent suggested that sex might be something that other young men like him would be unwilling to talk about as it is private and "their secret."

It is clear that the purpose of this type of sex talk is to share fun with friends and to gain the approval of peers. When asked about the purpose of 'talking about sex for fun', focus group participants responded that "Sex talk for fun is fun" and they noted that it is "a way to learn about sex, because it is not always easy to talk about sex" (FGD 02.03.06). The idea of learning from friends was also mentioned by one PER respondent who describes talking about sex with friends as common and not shameful because "If they did not talk about this thing (sex), perhaps they would never know about it. So firstly, if they talk they will talk about sexuality." (PER3, 06)

In addition to talking to boast, joke and learn about sex with their friends it was also clear that young men talked about sex and sexual health issues in a more serious manner, to share information with each other. As noted in previous sections young men talk about accessing sexual and reproductive health services, acting as informal referral networks to their friends:

> The youth like me also talk about receiving information of sexual reproductive health. For example they say which clinics have good services and if many people go there. (PER 11, 06)

> The youth like me talk about receiving information of sexual reproductive health with their friends and also sexual health services. For instance one of friends asked where to test blood to find HIV. (PER12, 06)

> Youth also talk about getting sexual health services with their friends. And they talk about condom usage. For example, when youth have sex they should know how to use condom in the right way… they want to get information about HIV/AIDS and STD disease. And we should introduce our friends to meet doctors to discuss these things. (PER7, 06)

Several young men reported that other youth are a source of sexual health information, particularly about HIV/AIDS and condom use:

> When talking about sexual issues, they often discuss about HIV and condom using – what kind of condom to use and how many condoms at one time (1 or 2) they should use. (PER14, 06)

> Many young people talk about sex with their friends because they want to know the problem related to AIDS. Some of them are shy to talk about condom use to prevent AIDS because of a dangerous disease no medicine to do treat. But there is only ARV. I used to hear my friend talk about problems related to AIDS. (PER1, 06)

Overall, it appears that young men have open, frank, and often informative discussions about sex and sexual health with their peers. It seems that these talks, particularly the 'fun' talks, are part of maintaining male friendships and that they are a way in which standards of expected behaviour are shared between youth, with boasting, joking and

teasing the norm. This provides an insight into the way that groups of young men may encourage and support each other in adopting new or different sexual and reproductive health behaviours as this informal group self monitoring would allow for 'positive' peer pressure to be placed on group members not conforming to new group standards. In addition, the evidence of 'learning' talking implies that young men are willing and comfortable to learn from their peers, and that they share health information, not only stories of sexual exploits.

These two facts work together to strongly support the intervention logic of Playing Safe, which seeks to work with groups of young men to utilise positive peer pressure, and also serves to build a SRH knowledge base through the training of peer educators.

The impact of this group building can be seen through several of the Change Stories collected from peer educators of Playing Safe which identify making new friends and the support of project staff and other peer educators as the most significant change in their lives resulting from their involvement with the project:

> When he was studying at Playing Safe, he knew many good friends that he could get along with and work together. This is the most significant change in his life after he had studied and worked at Playing Safe. (CS49)
>
> Now I have much knowledge from the project and also how to work. That's why I titled it "To be awakened on time" because I am now a good friend. When we met other good friends, we worked together. They were different from my previous friends. It was fortunate that I knew Playing Safe (CS47)
>
> Playing Safe project provided me much knowledge and experience; particularly the staff in Playing Safe Project who made me become thoughtful of my actions through indirect ways through their words and gestures. Do you know what is better than that? It is their love and paying close attention to me that are the main factors I need, and it is my power in every day life to be a good son and a model youth. (CS39)

These examples provide evidence that the model of Playing Safe is effectively creating behaviour change supporting groups of young people (both men and women) who are well placed, according to the reported behaviour and perceptions of the young men interviewed, to share sexual and reproductive health information with their peers.

Human Rights / Women's Rights / Attitudes toward Prostitution

The results also illustrated that these young men have no understanding of Human Rights, Women's Rights or the concept of consent. The practice of *bauk* seemingly remains common, and while some young men reported that they or their friends no longer participated in *bauk*, the vast majority of cases indicated that this change was the result of informed self interest in the form of HIV risk, not due to changing attitudes towards the abuse of women. Indeed violation of rights was mentioned by only one respondent in the

second round of PER interviews, and again, this was in conjunction with an increased perception of self risk:

> They said that it makes them feel very happy, wonderful, enthusiastic. They think that it is a happy skill for some people such as gangsters. For me, I think having sexual intercourse in a group is not simple, but that it is extreme strangeness because having sexual intercourse in group can transmit disease if they don't use condoms. On the other hand, it also violates reproductive rights. (PER 18, 06)

Beyond this, rape, or 'forcing' women to have sex is apparently within the boundaries of 'normal' sexual behaviour with a small, but significant number of young men reporting that they, or their friends had been involved in pressuring, forcing, coercing or raping women, most commonly sex workers, but also girlfriends. In the majority of cases, this is not recognised as criminal. Examples of this kind of aggressive behaviour and negligent attitudes reported by respondents are highlighted in the Group Sex and Drug Use (*Increasing Aggressive Sexual Practices)* sections of this report.

Conclusions

This research indicates that young men are aware of HIV/AIDS, STIs and the role condoms play in the prevention of transmission of these and unplanned pregnancy. It also indicates that this knowledge is not enabling consistent safe and responsible sexual practice amongst young men, as there is a lack of understanding of Human Rights, gender and Cambodian laws as these apply to sex and reproductive health. While it appears that these young men *are* increasingly able to make 'safe' and 'responsible' decisions for themselves; to use condoms with 'risky' partners, access services and seek information; they appear unable, or unwilling to extend the concepts of safety and responsibility into their interactions with their female partners. Amongst the group of young men targeted by this research and Playing Safe, this is clearly not an issue of knowledge, but of attitudes.

Public health messages currently and will continue to fail to address the underlying causes of sexual violence and the exposure of young women to sexual health risk. It is clear that attitudes towards women and masculinity are propelling these issues and thus are the source of potential change. This research further indicates that CARE Internationals Playing Safe (pilot) project demonstrates considerable potential in its ability to create change within the target group. The implementation model of the project is well perceived by the target group and there is significant evidence of behavioural impact within the (small) sample of the research study.

There is additional evidence to support the utility of creating behaviour change supporting groups and encouraging dialogue amongst young men in terms of negotiating new group mores. The challenge that remains for Playing Safe is to push beyond simply reinforcing and refining existing public health messages and to begin to seriously challenge the current understandings of gender and identity that limit young men's

capacity to fully embrace the 'safe and responsible' ideal, that necessarily excludes involvement in sexual violence and denial of a partners rights.

Topic Specific Conclusions

HIV/AIDS

Knowledge of HIV/AIDS is extremely high amongst this group. All cases mention HIV/AIDS in some context. The vast majority of young men demonstrate knowledge of transmission routes, variations of risk levels associated with different behaviours, the impact of HIV/AIDS and at least one method of prevention (condoms). Further, over the course of the research there was a clear increase in knowledge of the nature of HIV/AIDS amongst this group, with an understanding that physical appearance is not an indicator of HIV status leading to increased interest in and access to VCCT services

Sexual Relationships and Activities

The findings indicate that **sexual debut is overtly socially negotiated and influenced.** These young men typically have their first sexual encounter at around 18 years of age; this was consistent across both rounds of data collection. This sexual encounter may involve either commercial sex or occur in the context of a sweetheart or marriage relationship, with a slightly increased tendency towards the latter two noted in the second round of data collection. Young men perceive the biological changes associated with adolescence *in concert* with the messages they receive from their social environment about what sexuality, masculinity and adulthood mean. In general, young men report that these messages are coming from friends and the popular media, including pornography. Typically, messages seem to circle around 'natural' male sexuality, changes in 'modern' society and sexual activity defining adulthood. Masculinity and adult status are closely tied to sexual activity, in particular there is peer pressure for young men to be involved in commercial sex. The stories from peer educators of the Playing Safe project suggest that these social constructions may be renegotiated on an individual level, with a small number of individuals reporting choosing to either delay sexual debut until marriage, or to practice abstinence despite being previously sexually active.

The results indicate that **sweetheart relationships are common and frequently preferred amongst this group of young men, and condom use with sweethearts among this target group appears to have increased in the past seventeen months.** Sweetheart relationships can be seen to serve multiple purposes, both fulfilling young men's needs for affection and emotional support and providing them with an opportunity to gain status amongst their peers. Condom use within sweetheart relationships is largely based on the personal risk assessment of the young men involved. This has a variety of outcomes including; non-use with girls perceived to be 'pure' and the seeking of virgin sweethearts for the express purpose of avoiding using condoms. Discussions of the decision not to use condoms frequently involve mention of decreased pleasure and diminished feelings of intimacy and 'naturalness', hence the seeking of 'low' or 'no' risk

partners. There was no mention of fear of transmitting disease to partners, or of 'keeping partners safe' outside of a minority of Playing Safe peer educator stories. There was evidence of change across time; young men reported an increase in condom use amongst sweethearts as a result of increased awareness of condoms ability to prevent pregnancy as well as changing perceptions of young women, whom are no longer seen to be as 'pure' or 'fresh' as previously. Furthermore, successful condom negotiation by young women appears to be increasing over time, suggesting that messages aimed at young men are enabling young women to enact their sexual and reproductive health choices. While the Change Stories from peer educators of Playing Safe indicate that peers are both making different choices and doing their decision making differently to the wider target group. Condom use within sweetheart relationships is more consistent amongst peer educators, and there is a strong tendency for sex and condom use decisions to be made as a couple, with consideration given to what is appropriate for both partners – including abstinence.

Engaging in commercial sex is 'normal' and common amongst these young men. Commercial sex is sometimes preferred to other types of sexual relationship due to the 'easy' negotiation of sex within the commercial context. Condom use within a commercial sex context is more consistent than within sweetheart relationships, based on the young men's perception that 'those' women (sex workers) will transmit HIV/AIDS, and the fact that many (most) sex workers insist that clients use condoms. Young men appear to be reducing the frequency of their engagements with commercial sex as a result of the perceived HIV risk associated with this activity. There is no evidence of young men choosing to stop seeking commercial sex services; rather, they appear to be choosing to 'better their odds' by limiting frequency. Change stories collected from both the target group and Playing Safe peer educators support the 'normalised' and common characteristics of accessing commercial sex services. Peer educators report either reducing frequency of access, or stopping using these services as a result of fears of contracting HIV, and as a result of increased understanding of the fallibility of condoms.

Findings identified young men engaging in sex with **Unpaid, casual partners**. Young men report being involved in a 'new' type of sexual relationship with young women 'met by chance' in parks, on streets or in restaurants and night clubs. These relationships are neither commercial (as the young men do not pay for sex) nor sangsar relationships as the term is normally understood. Superficially, this is 'typical' casual sex, but there exist power and status differentials between partners which may add an extra dimension. Condom use within these relationships is again based on the risk assessment of the young men involved. As 'not good' girls, it is assumed that these young women may have HIV, thus condom use appears to be relatively high and consistent.

Both rounds of data collection revealed that **a significant proportion (most) of young men felt peer pressure to be involved in commercial sex in a group. Sex in a group is widely considered by young men as a fun, cheap bonding experience.** It is a masculinity affirming behaviour through which both sexual experiences and peer approval may be gained. Descriptions of group sex across time were consistent, describing various levels of coercion, humiliation, intimidation and/or physical violence. Round two data provides two conflicting messages of change. Firstly; *bauk* is seen as an

increasingly normalised practice amongst young men. The language describing incidents; 'normal', 'simple' as well as the prevalence of *bauk* stories across each level of data collection indicates that this is considered to be a common and not an extraordinary activity. Secondly; there appears to be some avoidance of the practice of *bauk* amongst both peer educators of the project and the wider target group. This avoidance is largely the result of an increased understanding of the (HIV/AIDS) risks associated with *bauk* and demonstrates almost no understanding of *bauk* as a violation of Human Rights.

Findings support those of earlier studies (Bearup, Soprach, Wilkinson) suggesting that group sexual violence is a normalised part of youth male sexual experience in Phnom Penh. The findings also illustrate the limited utility of a public health based approach in addressing the constructs that contribute to sexual violence. While self interest based public health messages focusing on HIV/AIDS and STI risks appear to be impacting on young men, and in some cases reducing their involvement in *bauk*, overwhelmingly, this is not the case, as the 'safe' message of condom use competes with avoidance as a strategy for keeping oneself safe. In addition, different perceptions of risk among different categories of women could simply see *bauk* shift from a crime predominantly committed against sex workers to one targeting other vulnerable or 'available' but lower risk groups of women.

There is significant evidence that **young men do participate in and/or have knowledge of others participating in same sex sexual relationships.** It is also clear that young men do not consider that this need define their sexuality, nor preclude them from having sexual relationships with women.

Drug Use

Knowledge and use of drugs is common among this group of young men, almost all PER cases and a significant number of CS cases demonstrated either knowledge of and/or experience with drug use. Drug use is considered to be a 'cool' and fashionable group activity among young men and significant numbers of respondents mentioned experiencing peer pressure to use drugs. *Yama* (an amphetamine) continues to be the most popular drug, with even non-users able to identify locations and cost of purchase. Over time, however, there appears to have been a proliferation in the types of drugs available to and used by young men in Phnom Penh. In particular, there is an apparent increase in the intravenous use of heroin by this group. This presents challenges for the continued successful management of Cambodia's HIV epidemic as well as pointing to probable changes in drug related behaviours in the future.

Drug use within this group is primarily influenced by access to money, with most decreases in use being attributed to reduced income/access to money. There is evidence of increased understanding of both the impacts of drug use on individuals and wider society and the illegality of drugs over time. In particular, respondents in the second round of PER interviews identified changes in the legal environment surrounding drug use. However, this did not translate into an overall reduction in levels of drug use as

perceived by PER respondents, possibly as a result of feelings of impunity stemming from the ability of young men to 'buy out' of trouble with the police and judiciary.

The Playing Safe model has been shown to effectively contribute to behaviour change in drug use habits with a number of cases identifying young men, or their peers, stopping using drugs as a result of information and advice gained though the project. While this does not translate into a sample wide reduction in drug use, it does provide support for the model of the Playing Safe intervention.

Drug use has emerged as specifically linked with sexual activity and sexual violence. In addition to reports of increased sexual desire and frequent accessing of commercial sexual services after drug use, a significant proportion of second round respondents identified taking drugs *in order* to have sex for longer. This identifies a shift in drug habits where the 'drug/sex' linkage is acknowledged, planned and exploited. This development is concerning in terms of both public health impacts around ineffective or non- use of condoms as a result of drug use, and in terms of the *type* of sex youth engage in when under the influence of these 'passionate' drugs. Use of condoms in the context of drug influenced sex conforms to the general trend identified within this research of increased understanding of the importance of condoms and subsequent increases in use. However, there remains evidence of non-use of condoms as a result of drug use, and quality of use issues while under the influence of drugs are similarly problematic. Drug use also emerged as a factor in the prevalence of the rape and abuse of sex workers. A drug induced sense of power may be seen to contribute to the violent behaviour experienced by sex workers; in addition, there is evidence of young men forcing sex workers to participate in drug use under the threat of violence.

Condoms

Condom use appears to be increasing over the research period. In the context of sweetheart relationships this is a reflection of increased understanding of the role of condoms in preventing pregnancy, changes in young men's perceptions of the (HIV/AIDS) risk associated with 'sweetheart' sex and some evidence of improved capacity for condom negotiation by young women, despite this, condom use within this group remains inconsistent at best. Condom use with commercial and 'other' non-sweetheart partners appears more consistent, largely as a result of perceived 'high' levels of (HIV/AIDS) risk associated with these types of sex. Social marketing campaigns appear to be both successfully raising awareness of the dual benefits of condom use and normalising purchase and use amongst this group, with evidence of declining levels of 'shyness' surrounding access to condoms.

Young men reported that condoms were widely available at pharmacies, hospitals, health clinics, guesthouses, hotels, shops and on the streets at night. No young people reported that finding condoms to purchase was difficult, or that condoms were inaccessible due to price. Most respondents in the first round of interviews found purchasing condoms to be an embarrassing experience, but generally recognised the

importance of overcoming their embarrassment and the stigma around using condoms in order to protect themselves. Seventeen months later, there were fewer respondents identifying buying condoms as prohibitively embarrassing, with many citing advertising and awareness campaigns as the source of this shift. Nonetheless, both interview respondents and participants in the focus group discussion stated that they still felt some embarrassment with both female sellers and 'mean' clinic or pharmacy staff whom they felt to be judging them.

There is a perception that young people would be seen as 'bad' for carrying condoms with them. This was evident in both rounds of PER collection, and documented further in some of the Change stories. Media promotion of condoms, as well as peer promotion through such vehicles as the Playing Safe van outreach activity appears to be reducing this perception, with the second rounds of data indicating a higher level of 'normalised' access to condoms.

Access to Sexual and Reproductive Health Services

Young men have increasingly accessed health services. They most commonly reported accessing NGO clinics, health centres, private clinics and hospitals for reproductive health services. In particular, and increasing across time, RHAC clinics appear to be well known and frequently accessed by members of this target group. The first round of interviews in particular identified reluctance and discomfort associated with attending these health services, with a number of young men reporting that it was both embarrassing and too expensive for them to visit these sites for reproductive health services.

Changes in the services sought were evident over the period of the research. Initially, the majority of respondents reported seeking health services for the treatment of symptomatic STI infection. In the second phase of the research, **a significant shift towards seeking VCCT services was noted.** Across time, access to contraception, learning about condom use and abortion services were also amongst the most frequently sought.

Young men talk with each other about accessing health services, acting as informal referral networks for their friends. This is a positive factor in the promotion of good sexual and reproductive health amongst this group, however, it is evident that the majority of young men have quite limited specific knowledge of available services demonstrating the need for continued awareness raising in this area. Referrals through the Playing Safe van outreach activity have been seen to increase youth access to reproductive health services. Peer educators are able to both provide information about available services and strongly advocate to other young people about the benefits of accessing appropriate services.

There is an apparent shift away from the use of traditional *Krou Khmer* for the treatment of Sexual and Reproductive health issues. Cited as a less expensive and less embarrassing option than clinics and hospitals for dealing with sexual and reproductive health issues in the first round of PER interviews, there was almost no mention of accessing *Krou Khmer*

in the second round of data collection seventeen months later. It is uncertain whether this is reflective of a more general trend away from the use of traditional medicine.

Access to Sexual and Reproductive Health Information

Access to sexual and reproductive health information remains problematic, with a significant proportion of young men reporting that they would access SRH information at service points such as clinics, health centres and hospitals while simultaneously identifying their reluctance and discomfort in attending these services. This suggests that while young people know where they *should* go to receive information they are unlikely to actually access these sites. The focus group discussion clearly articulated this conflict with the comment "you need to be sick to go there" in reference to these locations. NGOs, media and peer educators/people disseminating were other frequently identified sources of reproductive health information. The findings suggest that young men are most commonly learning about sex outside of the home and through sources other than family. Across both time periods only very few young people referred to learning about sex or reproductive health issues through older people or relatives. However, family were seen to exert clear and significant influence on the sexual and reproductive health of young people through their support, or otherwise, of their children's involvement in reproductive health programs/learning.

Young men themselves are frequently acting as sources of information, regularly reporting that they 'retell' what they have learned about sex and sexual health to their friends. Most commonly, young men are seeking information about HIV/AIDS, STIs, contraception, using condoms, and less frequently, abortion services, in addition, the second round of data collection revealed an increasing number of young men seeking information about VCCT. That young men are seeking these services indicates an underlying level of awareness of these issues within the target group.

Knowledge of Playing Safe

As expected, recognition of the project has grown over time; and while there are still limited numbers of respondents identifying Playing Safe by name; and a concentration of project knowledge in some target areas; it is most significant that the majority of respondents report that they or their friends had seen or interacted with a peer educator or a van either in the area in which they were being interviewed or, in another location within Phnom Penh.

Given the structure of the PER sample and the way that it can be seen to be drawing on the experiences of a wide group of young men, it can be assumed that most young men in Phnom Penh have access to peer educators, and that a significant number of these young men have been exposed to either Playing Safe peer educators, or the Playing Safe van outreach activity

Perceptions of Peer Educators

Responses about peer educators in particular were very positive, with respondents articulating some of the foundational reasons for the employment of peer education models. **Commonly, young men interviewed expressed that peer educators were a good way for them to get information as they perceived that peer educators were well informed and provided information that was both relevant to them and accurate.** Young men seemingly feel that peer educators are able to provide them with information to help them care for their health and to make good decisions. Respondents also felt that peer educators were a suitable information source for youth because young people are both comfortable talking to other young people and likely to follow the advice and encouragement of other youth. Young men felt that information from peer educators was naturally shared amongst other friends. From these comments it seems that information delivered by peer educators is perceived to be particularly suitable for 'retelling' and this appears to be an understood part of the process of learning through peer educators. This supports the efficacy of the 'multiplier' effect on which peer education programs necessarily depend.

Perceptions of Outreach Models

The outreach was perceived as a model having the benefits of peer education, plus the addition of a number of special features making it especially suitable for youth. As with Peer Educators, respondents felt that the outreach service provided relevant, important and accurate information that was useful for making good decisions about their health. **The use of a youth relevant approach, employing popular culture through karaoke and specifically youth targeted educational spots was seen as a key factor in the value of the outreach model used by Playing Safe,** respondents felt that this made the activity interesting and attractive to young people. Youth friendly aspects of the outreach model were also valued, free access to information in a convenient location were reported as important and 'good' for young people.

Playing Safe Health Messages

Condom use, HIV/AIDS transmission and prevention, contraception, STIs, drug use and available services information were the most commonly reported messaged recalled from Playing Safe. These messages were reported from both peer educators of the project who have had extensive exposure to the program, and from the wider target group, whose level of exposure, while hard to gauge exactly, may be assumed to be considerably lower. Evidence from both the second round of PER interviews and the Change Stories suggest that these messages are being recalled and heeded by young people, with significant numbers of cases reporting behaviour changes reflecting the advice and information they received through peer educators of the project. **Messages relating to social change; gender concepts and Human Rights appear to be being less well recalled and consequently less followed by young men.** It is probable that this is a refection of the relative levels of awareness of each public health and social change messages, with the former being extremely prevalent in Phnom Penh in the form of long running IEC and BCC campaigns from multiple NGOs and the Ministry of Health, while the later is much less common, particularly in terms of youth focused, male centred messages, in which

Playing Safe is felt to be unique. Higher levels of awareness of 'common' issues such as condom use and HIV/AIDS lead young men to actively seek additional information on public health topics as they are understood to be important, highlighting the need for additional awareness raising in the areas of Human rights and gender concept education. In addition, it is probable that messages relating to gender and Human Rights concepts have been less frequently and less skilfully presented by peer educators of the project involved in outreach activities. Gender in particular is a complex concept, much harder to 'learn' than facts relating to HIV transmission and so on. Thus peer educators are less likely to be able to provide clear, comprehensive messages around gender than around basic SRH facts. This combined with the probability that youth are actively seeking the 'health' type messages has likely led peer educators to focus on the presentation of these messages with which they feel comfortable and which they perceive as being prioritised by youth.

Communication

Young men talk about sex with their friends. Young men involved in the research indicated that they and their friends engage in two distinct types of 'sex talk'. Sex talk can be divided into 'fun' talk revolving around boasting and sharing sexual exploits, and 'learning' talk in which young men share information about SRH and services. It seems that these talks, particularly the 'fun' talks, are part of maintaining male friendships and that they are a way in which standards of expected behaviour are shared between youth, with boasting, joking and teasing the norm. This provides an insight into the way that groups of young men may encourage and support each other in adopting new or different sexual and reproductive health behaviours as **this informal group self monitoring would allow for 'positive' peer pressure to be placed on group members not conforming to new group standards.** In addition, the evidence of 'learning' talking implies that young men are willing and comfortable to learn from their peers, and that they share health information, not only stories of sexual exploits.

Perceptions of women

Perceptions of women, while not explicitly sought, are clearly articulated across cases. Cambodian social discourse commonly separates women into categories of "good" and "bad" women largely on the basis of their sexual status. Added to this is the perception that "bad" women, those who stray from rigid traditional standards of 'appropriate' behaviour, are more likely to carry and transmit HIV and other STIs, serving to further stigmatise these women as "unclean" and "impure". The impact of this on young men's perceptions of 'types' of women is **most clearly demonstrated through the devaluing of sex workers, who are referred to and treated as fundamentally subhuman in the context of group rape (*bauk*)**. Even within the context of 'normal' sex with sex workers **there is limited respect for the women, their bodies or their rights to choice.** There appears to be a perception that as 'sex workers' these women are obliged to fulfil the requests and desires of their clients irrespective of the nature of these demands. That the separation of sex workers from 'normal' women serves to increase their vulnerability to sexual violence and rape was documented in a number of cases. Disregard for the rights,

welfare and health of ‘sweethearts’ and ‘other’ partners was similarly demonstrated through the absence of consideration of these factors in condom use decisions in the majority of cases, as well as in the reporting of coercion, rape and sexual violence perpetrated against women other than sex workers, but not “good and accurate girls”. It is clear that within this group of young men there is an overriding lack of understanding and acknowledgement of human rights within the context of sexual behaviour.

Recommendations

The following section contains two distinct sets of recommendations: The first set is comprised of immediate directions and calls to action for the NGO community, Government agencies and all other organisations and individuals working in fields relating to adolescent sexual and reproductive health. The second set of recommendations identifies areas for additional research and investigation so as to determine the best directions for future action.

Immediate Directions

- Conduct follow up research into the availability of and access to pornography by young men, with a view to developing strategies restricting access/decreasing demand.

Access to pornography: Responses around first sex and the factors driving sexual debut revealed that young men within this group are frequently accessing pornography, largely through DVDs, VCDs and the internet. The ready availability of pornography, specifically to minors, has been previously documented and the role of often 'hard' and violent pornography in forming the 'sexual script' of young people within the Cambodian context has been recognised. Further research into the availability and access of pornography by young men is needed to determine the scope and scale of probable impacts. It is recommended that this research be conducted with a view to informing interventions focussing on restricting access to and reducing demand for pornography. As far as possible, this work should be conducted in cooperation with relevant Ministries, ensuring government level support for advocacy and possible legislative developments.

- Encourage condom sellers to provide a more comfortable environment for young people to purchase condoms.

Access to condoms: According to the young men interviewed in this study, behaviour of sellers continues to be the major obstacle in obtaining condoms. Thus it is recommended that work be done with vendors emphasizing the importance of condom use amongst young people and encouraging sellers to provide a comfortable environment for young people to purchase condoms. Condom suppliers (such as PSI) could establish a 'preferred retailer' program whereby vendors undertake a short training/sensitisation session and then agree to abide by a code of conduct in return for either additional signage identifying their 'preferred' status or reduced cost or free stock.

- Continue to market condoms as part of pleasurable and loving sex.

Condom Use: Condom use does not reflect awareness of the value of condoms in protecting from HIV/AIDS and unplanned pregnancy. The most commonly reported reason for non-use, excluding the influence of illicit drugs, was a concern for reduced

pleasure, intimacy and naturalness in sex between sweethearts. There exists an opportunity for the marketing of condoms as part of pleasurable and loving sex. While partially addressed by PSI's *Klahan* (Loving Couples) campaign[11], the pleasure aspect appears to be unresolved.

- Integrate MSM as a key topic in 'mainstream' sexual and reproductive health programming

MSM: This research provides simply confirms what has been noted in previous reports on this topic that suggest that 'mainstream' male sexual experience does not exclude same sex experiences. Thus, 'mainstream' sexual and reproductive health programming should integrate MSM as a topic of life-skill trainings and other educational materials.

- Strengthening and expansion of current quality improvement and awareness raising campaigns focusing on young peoples access to sexual and reproductive health services.

Services: Access to services for young people remains an issue of comfort with specific details of available facilities. The experience of Playing Safe peer educators, and the accounts recorded by the PER interviews demonstrates that Peer referral is an effective mode of increasing youth access to services. Thus it is recommended that awareness raising campaigns focusing on young people, including peer referral initiatives be continued and scaled up in response to the desire expressed by young men to access services. In addition, work towards making more services youth friendly and acceptable to young people must continue.

- Increase the availability of sexual and reproductive health information to young people outside of 'health service' sites.

Information: Reproductive health information resources for young people need to be made available separately from a clinical 'sickness' focused environment. While young men are able to identify these locations as sources of information, it is likely that they are under-accessed due to individuals' reluctance to attend 'service' sites. Initiatives such as Playing Safe – which does not provide clinical services – presents reproductive health information in a 'learning' environment, removing this particular barrier. This research has shown that the Playing Safe van outreach model in particular is seen as an appropriate and non-threatening source of information to be accessed outside of a 'sickness' context.

[11] See PSI website: www.klahan.com

- Develop/strengthen quality assuredness measures within peer education programs; ensuring peer educators meet the expectations of youth seeking their services.

Peer Education: Peer educators are seen as sources of reliable and useful, relevant information by young people. Thus, it is essential that sufficient care is taken within peer education programs to ensure that peer educators are capable of providing information of high and consistent quality. Peer educators must equally be aware of the limitations of their role as providers of information and choices, rather than medical professionals.

- Include family members and other gatekeepers in adolescent sexual and reproductive health interventions; maintaining traditional social linkages and contributing to an enabling environment.

Family/Gatekeepers: In order to both support traditional familial/social hierarchies and encourage an enabling environment for young people to access sexual and reproductive health information and services, it is essential that ASRH interventions do not by-pass parents, teachers and members of extended family and community networks from whom young people traditionally seek advice.

- Work with appropriate ministries and state bodies in the production of public education campaigns specifically targeting (male) youth and focusing on Human Rights, Cambodian law and Gender.

Group Sex: It is essential that bauk (involving rape) come to be recognised as criminal by young men, as opposed to a 'high risk' activity for HIV/AIDS transmission as a result of the involvement of sex workers. Increasing awareness of bauk as a violation of Human Rights and Cambodian law provides less scope for a shift in victim profile than the current HIV/AIDS focused public health approach and is more likely to lead to a sustained decrease in this practice. Clearly the self interest motivation factor attached to public health messages makes these the most immediately appealing in combating illegal and unsafe behaviour, but there is limited evidence in this case that this approach is either ideal, or likely to be significantly effective in the long term. Thus it is recommended that specific youth, male focused public education strategies focusing on law, gender and Human Rights within the context of sexual behaviour be initiated and provided with adequate resources, ideally through cooperation with relevant ministries.

- Develop the messages and materials of Playing Safe (other male centered SRH interventions) to respond to the need for increased dissemination of social change messages and exploit the lessons learned from the pilot phase of the project.

Messages: The messages of Playing Safe/ male centered SRH interventions need to increase their focus on social change and its potential to influence sexual and

reproductive health choices. Respect for women, as partners, and individuals, their Rights and their choices must be emphasized, as it appears to be the lack of these that is preventing the adoption of safe and responsible sexual practice. While increasing reproductive health knowledge remains vital, particularly around STIs other than HIV/AIDS, it is recognized that 'common' public health messages are widely available, resulting in high levels of awareness of basic SRH information. Given the experiences and lessons learned through implementation to date, Playing Safe (CARE) is uniquely placed to accept the challenge of shifting attitudes and enabling meaningful changes in behaviour.

Directions for Further Research/Investigation:

- Conduct research into the use of intravenous drugs amongst young middle class Khmer men to assess the scale of this issue and respond proactively with the introduction of harm reduction strategies and scale up of services as needed.

Drugs: Additional research into the use of intravenous drugs, particularly heroin, amongst young middle class Khmer men needs to be conducted to satisfactorily assess the scale of this issue. The introduction of additional drug education and rehabilitation services specifically targeting this group of potential users should be implemented in conjunction with harm reduction strategies to avoid the potential loss of ground in the successful containment and mitigation of the Cambodian HIV/AIDS epidemic to date.

- Conduct research to explore the evolving links between drug use and sexual behaviour, with a view to integrating learning into future reproductive health programming.

Drugs:
The explicit link between drug use and sex warrants further investigation, in particular, it is critical to determine which drugs are being used by these young men as 'passionate' drugs so as to determine the likely impact of these in terms of condom use and impacts on sexual behaviour including sexual violence. These understandings must then be acknowledged by and integrated into future reproductive health programs.

- Research developments in youth sexual behaviour so as to ensure the continued relevance of adolescent sexual and reproductive health programming given the dynamism of youth culture.

Casual, unpaid partners: Additional research into this evolving facet of sexual behaviour needs to be conducted so as to gain a complete and comprehensive image of the sexual relationships young men (and women) are engaging in. Of particular interest would be research conducted into female perceptions of these non transactional encounters, examining the motivations and expectations of young women involved in this type of sex.

Only through continued efforts to stay current may adolescent sexual and reproductive health programs remain relevant to the social context in which decisions are being made.

- Initiate research into the construction of modern gendered identities in Cambodian youth culture, enabling young men to be provided with facilities to explore alternative definitions of masculinity.

Gender and perceptions of Women: Young men are defining their masculinity through sex. This is interacting with existing cultural understandings of women to create situations where respect for female partners is limited and their choices and rights are reduced and violated. Young men need to be provided with tools and spaces with which to develop alternative ways to express and affirm their masculinity. Concurrently, young men need to be provided with gender training, encouraging them to examine their perceptions and understandings of women and 'good' and 'bad' femininity within modern Khmer culture. As youth establish and construct a group identity within Cambodian society, there is an opportunity to re-negotiate 'modern' values to the benefit of all. Further research into the dynamics of constructing gendered identities within Cambodian youth culture is needed to tailor appropriate programming.

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Appendix One:

Conversational Prompts as developed through PER Training: Round One

Conversation One: Sexual Relationships

What are the types of sexual relationships that young men have and what is the role of condoms in these?

Example prompts:

At what age do young people like you loose their virginity and how?

What are the different types of sex that young people like you are involved in.

Are condoms always used in these examples of sex, or only in some. Why?

Do most young guys you know have sex one-on-one or in groups?

Can you tell me any stories or examples you have heard of about that?

Conversation Two: Drug Use

Have you heard of young people like you from this area using drugs?

What types of drugs do young people like you use?

When are drugs used and why?

Could you tell me any stories or examples you know about that?

Conversation Three: Access to information and services

Where can young people like you go to get information about sex and drugs or get access to services?

Have you ever met any peer educators or seen an outreach van in this area talking about sex or drugs? If yes where do they come from, who do they work for?

Appendix Two

Conversational Prompts as Developed through PER Training: Round Two

The following prompts are the result of extensive discussion within the PER supplementary training session. The descriptions of the goals of the conversation and the key directive prompts were given to the volunteer PERs at the commencement of the development exercise, in accessible terms in Khmer language as a way to direct the development of the secondary prompts.
Though the PER model does not employ a 'survey' technique, the PERs felt it useful for them to have a collection of secondary prompts available during the interviews so the results of the session were printed and issued to the PERs in Khmer.

Conversation One: Sexual Relationships and Condom Use

The function of this conversation is to gain an insight into the way young men experience, negotiate, learn and talk about sexual relationships. The following prompts are designed to highlight the main areas of interest within this broad topic.

1. We have found that many young men like you begin having sex around 17-18 years of age; do you think this is the same now, or has there been a change?
    a. When are guys like you beginning to have sex now?
    b. Why do they start having sex at that age?
    c. What is it that has caused this change?

2. We also learned that men your age often have different kinds of sexual relationships, What sorts of sexual relationships are young men like you involved in?
    What, if anything has changed about the types of sexual relationships your friends or other young men like you are involved in over the past year?
    a. Are they more/less likely to be involved in commercial sex now? Have the types of commercial sex they are involved in changed?
        i. Can you give me any examples of that?
        ii. Why has it changed?

    b. Do young men like you talk to their friends about sex?
        i. Why or why not?
        ii. What do they talk about when they talk about sex?
        iii. Have you had any new discussions about things you have heard/learned about sex and sexual relationships in the last 12 months?
            1. What were the discussions about? Can you give me an example?
            2. Where/ how did your friends learn about it?

c. How do young men like you feel about different types of sexual relationships?
    i. Which type of relationship do they prefer?
    ii. Why do they feel that way?
    iii. What do they say about these different relationships?
    iv. Has there been a change in this in the last year?
    v. Why? Why not?

d. In last year's research, we found that many young men had sex in groups with their friends; is this common among young men like you now?
    i. Who do they have sex with?
    ii. What do they say about having sex in a group?
    iii. Has this changed from one year ago?
    iv. Why has it changed?
    v. Do you think that it is more or less common amongst your friends now than it was one year ago?
    vi. Why has it changed?
    vii. Can you give me an example, or tell me a story about this?

3. Last time we found that young men regularly used condoms with sex workers, but rarely, or never with their sangsar; is this still the case?
    a. Have there been changes in this among your friends?
    b. Why or why not?
    c. How have they changed, can you give me an example?
    d. What caused this change?
    e. Where did this information come from?

4. How do young men like you feel about buying condoms?
    a. Why do they feel like this?
    b. Has this changed in the last twelve months?
    c. Why has it/ has it not, changed?

Conversation Two: Drug Use

The aim of this conversation is to learn about the drug use behaviours of young men; including how/if they share information about drugs among their peers.

1. Last year we found that many young men in this area were aware of their friends or other young men like them using drugs, have you heard about any changes in this?
    a. How has it changed?
        1. more/less frequent
        2. different drugs
        3. new reasons for using
    b. Can you tell me any stories or examples you know about that?
        1. How did you hear about this story?
    c. Why has it/ has it not changed?

1. What have they learned? How? From where?

2. We know that drug use influences the sexual behaviour of young men; last year young men said their friends have more aggressive sex and sometimes forget to use condoms when they have been using drugs; have you heard of any changes in this?
    a. Why? Why not?
    b. Can you give me an example of a change in this behaviour?
    c. What caused this change?

Conversation Three: Access to Information and Services

This is the main focus of the interviews this round. We want to understand where, how, and why young men get their information about sex/ sexual and reproductive health. The following questions are designed to focus the discussion about SRH services and information on communication between peers, because this is the underpinning of Peer Education as a model, and thus, Playing Safe as an intervention.

1. Where do young men like you get information about sexual health such as; AIDS/HIV, non-consensual sex, STIs, contraception and condom use and accessing services on a daily basis?
    a. What makes them go there?
    b. Do young men like you talk about accessing sexual health information with your friends?
    c. Do young men like you talk about accessing sexual health services with your friends?
    d. What sort of things do you talk about?
    e. Can you give me an example of this?
    f. Are there any other ways that you or your friends would like to get information about sex and HIV/STIs?

2. Have you or your friends ever met any peer educators or seen an outreach van in this area talking about sex or drugs?
    a. What have you or your friends heard (if anything) from peer educators?
    b. Do you know any examples of changes in thinking about sex or sexual behaviour as a result of peer educator information?
    c. Where do they come from?
    d. Who do they work for?

3. Could you tell me a story about someone who has met a peer educator in this area?
    a. How did they feel about meeting the peer educator?
    b. What did they learn from the peer educator?
    c. What have they done with this information?
    d. Did they think that the peer educator was a good way to get information on sex/ drugs/HIV?
        i. Why/why not?

ii. What was/ was not good?

e. Did they have any ideas for making peer educators better for young men like them?
    i. What?
    ii. Why not?

4. Could you tell me a story about someone who has seen an outreach van in this area?
    f. How did they feel about seeing the outreach van?
    g. What did they learn from the outreach van?
    h. What have they done with this information?
    i. Did they think that the outreach van was a good way to get information on sex/ drugs/HIV?
        i. Why/why not?
        ii. What was/ was not good?
    j. Did they have any ideas for making the outreach van better for young men like them?
        i. What?
        ii. Why not?

Appendix Three

Debriefing/Discussion Protocol:

The following was used to direct the PER debriefing and discussion session held after the initial analysis of data collected through the PER component.

Facilitators/Participants: Key facilitator: unknown Playing Safe team member with strong facilitation skills, 2 senior researchers having participated in PER, Key note taker/additional facilitator: second unknown Playing Safe team member; 6 Group discussion participants (of possible 8 PERs)

Questions- Part One: Notes for Facilitator:

The purpose of the group discussion is to get a wider view of young men's experiences and thinking about sexual and reproductive health.

The data collected gives us specific examples and descriptions and we are trying to add to this by talking to the researchers *as part of the target group* what we need to explain to the researchers is that we are not asking them to remember all their cases and try to answer the questions from that. (that is our job in the data analysis stage)

What we are asking them is "from your experiences, as a young guy in Phnom Penh, as a researcher, and as a member of the Playing Safe target group, how do you answer these questions?"

We are not asking about what the researcher think *should or should not* happen, or their thoughts about what is good or bad activity. We want them to tell us "*in their opinion, from their experiences, what does happen and why"*

There is no right or wrong answers, we are asking for thoughts, ideas and guesses from the PERs. It is a step in the data analysis process designed to direct the guesses and interpretations that the research team make from the great data that they have given us already.

None of the answers will be recorded with names, they are all confidential. Some of the answers will be used in the research report, to support the data and analysis, but there will be no name attached to the information.

1.) *First Sex*

From looking at the data about when young guys first start having sex, we learn that there is no change from last year to this year and that young men still begin to have sex around 16-18 years of age

- Do you think this is correct for most young men? Are these results representative of young men in Phnom Penh?

The reasons that were given for starting to have sex around that age were; curiosity, peer pressure, foreign influences, proving masculinity and watching pornography.

- What do you think is the most common reason for young men to start having sex at that age? Are there other reasons that you know are important?

2.) *Condom Use in Different Relationships*

From looking at the about using condoms in different types of sexual relationships, we find that some young men use condoms *now* with their girlfriend/sangsar, but other young men do not.

-What are the reasons *why* some young men *do* use condoms with their girlfriends/ sangsar?

-What are the reasons some young men *do not* ?

3.) *Bauk*

The data shows that many young men still have sex in groups with their friends. Some cases said that there was a decrease in this because: i.) young men are afraid of contracting HIV/AIDS through this activity, ii.)Sex in a group/bauk is 'boring' and not sexually satisfying, iii.) Sex in a group/bauk is bad because it is discrimination against women and violates their rights.

- Could you give a ranking of the reasons from the most important/common to the least important/common?

- Do you think group sex/bauk is overall more or less common among young men than in late 2004?

- Have you heard of any messages about group sex/bauk being promoted in the community? Have you noticed any difference in the way young guys talk about group sex/bauk? (what is the 'buzz' around bauk in the youth male community?)

4.)*Buying Condoms*

The data shows that some young men are still embarrassed about buying condoms, especially if the seller is a woman.

-Is it an accepted social norm to buy condoms?

-Is it necessary to have 'other' ways to access condoms (like the Playing Safe van) Or do young people who want to use them feel able to buy them?

5.)*Drug Use*

Some young men reported using Yamma, and other drugs, to make them able to have sex for longer.

-Is there discussion in the youth male community about this as a reason for using drugs?

Some cases gave increased police and government action on drugs(arresting drug users and dealers) as reason for a decrease in drug use among youth.

- Is a fear of police/arrest a common reason for not using drugs?

6.)*Talking about sex*

Many cases mention incidents of young men boasting and talking in 'fun' about sex. Some cases mention that their friends are where young men learn about sex and sexual reproductive health issues.

-Do you think that there is a link between these different types of communication about sex? Do you think that young men talk about sex, so that they can learn about SRH from their friends?

7.)*Sexual Health Information:*
If a young man had a question about his sexual or reproductive health, how would he get it answered?

8.)*Peer Educators and Van*
-How do young men like you feel about peer educators as a way to get information about SRH?
-Do you think that the van outreach activity and the peer educators are valued by young people as ways to access sexual health information? Why?

Questions- Part Two:

The purpose of this section is to learn some lessons about the process of conducting the research. We are hoping to learn from your experiences as a researcher, so that we can make the process better for other researchers in the future. We can't make changes to this round of research, but we can do it better, or differently in the future.
There are no wrong or right answers to any of these questions, and your answers will be confidential. Only your answers will be noted, there will be no record of who said what, so there will be no way for the team to know who gave which answer. It is important that you feel open and comfortable to give honest answers to the questions**.**

1.) You were asked to volunteer to participate in this research, why did you agree to participate in the project?
2.) What were the challenges you faced doing the research?
3.) What were the good things about doing the research?
    a. In what way, if any, do you feel you have benefited from participating in the research?
4.) You were provided with training at the beginning of the research, and again after the first cases were collected
    a. What did you like about the training? Why?
    b. What was the most useful part of the training? Why?
    c. Is there anything that would have helped you complete the research that was not included in the training? What extra information did you need?
5.) There were two 'senior researchers' assisting you with the research
    a. How did they help you?
    b. Do you think they offered enough support?
6.) What suggestions would you make to CARE when they do this type of research again?
    a. Why?
7.) Would you volunteer to participate in this type of research again? Why?, Why not?