



ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN

CAMBODIA

Status, Issues, Policies,
and Programs



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POLICY Project

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
BCC	Behavior change communication
BCI	Behavior change intervention
CBO	Community-based organization
CCC	Cooperation Committee for Cambodia
CEDPA	Centre for Development and Population Activities
DHS	Demographic and Health Survey
FP	Family planning
HIV	Human immuno-deficiency virus
IEC	Information, education, and communication
IO	International organization
IOM	International Organization for Migration
MCH	Maternal and child health
MOCR	Ministry of Cult and Religion
MOH	Ministry of Health
MOND	Ministry of National Defense
MOWVA	Ministry of Women's and Veterans' Affairs
NGO	Nongovernmental organization
NPHRI	National Public Health and Research Institute
PLWHA	People living with HIV/AIDS
PSI	Population Services International
RACHA	Reproductive and Child Care Health Alliance
RHAC	Reproductive Health Association
RTI	Research Triangle Institute
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
TFR	Total fertility rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNTAC	United Nations Transitional Authority
USAID	United States Agency for International Development

1 INTRODUCTION

This assessment of ARH (ARH) in Cambodia is part of a series of assessments conducted in 13 countries in Asia and the Near East.¹ The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with the social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Cambodia.

The issue of ARH in Cambodia, like many other issues in contemporary Cambodian society, owes much to Cambodia's experience of the past 30 years of conflict and the massive social and infrastructure destruction enacted during the regime of the Khmer Rouge between 1975 and 1979. As a result, Cambodia was left with a devastated infrastructure and a serious lack of human resources. While these issues are now being addressed following the reestablishment of order and political control during the 1990s, particularly since the 1993 elections under the United Nations Transitional Authority (UNTAC), there is no "quick fix" and the lack of infrastructure and human resources affect every sector.

Although there has been some economic development over the past 22 years, particularly in the post-UNTAC period, the Cambodian economy remains weak. Apart from the export of some primary products such as timber, rubber, and precious stones, and a textile industry (which is a major employer of young women), the main source of income for Cambodia is international aid funding. This comes into the country through government departments, international organizations (IOs), and local and international nongovernmental organizations (NGOs). With the aim of growth, ministries compete for program funding from IOs, and a number of informants interviewed during the process of writing this report commented that ministries have developed a "yes" culture of agreeing to participate in programs regardless of the capacity of staff to actually implement the programs concerned. Although staff in many ministries are engaged in ongoing processes of "capacity development," this is not an overnight process; it is also a process that imposes a substantial work load on staff, usually in addition to their normal work load. Such processes are funding-driven and, as ministries seek to acquire funding, it is not uncommon to find that staff members are simultaneously engaged in three or more "capacity development" programs. Also, in terms of policy development, the highly politicized environment in which ministries compete for funding and territory means that policy development is slow, policies tend to be constantly updated and changed, and there are frequently competing claims to the ownership of programs. Also, programs may be undertaken because of the resources they bring to a particular sector rather than any inherent interest of a ministry (or ministries) in that area, so ultimately there may be little relationship between policy and actual implementation.

Another issue of practical relevance to the ARH situation in Cambodia is the situation with regard to overall infrastructure, which tends to lead to a substantial gap in ARH between the capital (Phnom Penh) and provincial centers and between those centers and even more remote rural areas. Although a gradual program of reconstructing major transport routes is now underway, because they have received little or no attention since the 1960s, most roads to provincial centers are in an atrocious condition. Traveling

¹ The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.

between centers is an extremely slow process of lurching from pothole to pothole, and the shaking and banging about that road travel entails take a substantial toll on both vehicles and their occupants. As a result, actual program implementation throughout the country is slow and extremely tiring on program staff who need to travel to field sites to conduct training. Similarly, the travel is tiring for field staff who travel to Phnom Penh for training. It is also expensive because the time taken to travel to rural areas, in concert with problems concerning the security of travel during non-daylight hours means that staff undergoing training must be accommodated either at field sites or, in the case of those who travel to Phnom Penh, in Phnom Penh. Thus it is common that once developed, policies in all areas are initially implemented in urban areas such as Phnom Penh, the regional center of Battambang, and in known “hot spots” in the case of AIDS policies, for example. However, due to infrastructure and financial issues, their extension throughout all provincial areas takes place over a period of years.²

Health care staff tends to be concentrated in urban areas and health workers are poorly paid (something they have in common with other members of Cambodia’s civil service), with most receiving about 20 percent of a living wage.³ As a result, health workers may operate their own private clinics instead of working at their “official” jobs in order to survive financially. The result is that the implementation of policies proceeds slowly in more remote, rural districts, despite policy implementation in Phnom Penh as the administrative center.

As far as ARH policy is concerned, Cambodia has no such policy nor does it have any multisectoral policy on youth. Cambodia’s Ministry of Health (MOH) and other relevant ministries simply do not recognize the need for an ARH policy and instead focus on maternal and child health (MCH) care and issues such as birth spacing and on safe motherhood policies. Additionally, over the course of the 1990s, as the scale of Cambodia’s HIV/AIDS problem became apparent, the development and implementation of health policy also has focused on this priority area.⁴

As discussed below, the lack of a Cambodian ARH policy is likely due, in part, to the fact that scarce resources have been directed to the perilous state of MCH prior to addressing ARH issues. An additional factor that may be operative here was pointed out by a noted Cambodian expert in the area of MCH: there has been a cultural emphasis on curative rather than preventive health care in the past, and current moves toward a preventive approach embodied in policies and programs directed to areas like ARH involves changing a long-held mindset on the part of senior health officials and policymakers.⁵ A recent report on the Cambodian reproductive health context also suggests that the same factors (discussed below) that lead many Cambodian policymakers to deny the existence of sexual activity among young people, lead them to consider that reproductive health training activities are inappropriate for young people prior to marriage.⁶

² Thus, for example, by early 1992 after almost a decade of work on AIDS and after the formulation of an extremely good national AIDS policy, financial, and other considerations mean that “STD treatment kits” have only been provided for 328 regional health centers (those considered most critical in terms of STD control, of a total of 945 centers. Interview with Dr. Mean Chhi Vun, National Center for HIV/AIDS, STDs and Dermatology, Phnom Penh, February 2002.

³ Chhun Long et al., 1977.

⁴ A recent study on future demands for health care in Cambodia (Ministry of Health and National Public Health and Research Institute, 1998) makes no mention of the issues of adolescent health, suggesting that this is not viewed as a priority issue.

⁵ Chhuan Long et al., 1997.

⁶ Beaufils, 2000. The magnitude of Cambodia’s HIV/AIDS epidemic and a recognition of the crucial importance of the whole Cambodian population needing to know about AIDS and about HIV protection may slowly be changing this situation. Yet, in 2002, it remains true that the bulk of ARH activities in Cambodia take place in the context of other programs.

Yet, the denial on the part of policymakers that adolescence is a specific period or that adolescents have special reproductive health needs contradicts clear evidence to the contrary. Cambodia has a young, primarily rural (85%) population. More than one-half of the population of 13.1 million is younger than 20, and nearly 20 percent of the population is 15–24 years old.⁷ Approximately 2.4 million adolescents live in Cambodia, and the size of this age group will increase rapidly over the next 15 years, peaking at 3.8 million in 2015. By 2020, it is estimated that approximately 3.55 million youth will be living in Cambodia (Figure 1). Education levels are low, and there is a significant disparity in education between boys and girls. Twice as many girls (21.5%) have no education compared with boys (11.7%). One-third more boys have completed secondary or higher education than have girls (Figure 2). The number of births to adolescent girls will double in just 20 years, from 113,000 in 2000 to 226,000 in 2020 (Figure 3). Unmet contraceptive need is high for girls ages 15–19 (37.1%) and girls ages 20–24 (36.1%) (Figure 4).

Knowledge of reproductive health and issues such as birth spacing has been shown to be even lower for the adolescent age group than for the population as a whole. For example, qualitative research conducted among garment factory workers found that many young women did not know about menstruation before they began menstruating themselves.⁸ Similarly, few young people have accurate knowledge about fundamental issues such as the time of the menstrual cycle when a woman is likely to become pregnant; traditional beliefs hold that a woman is most fertile at the time of her menstrual period (and, thus, they refrain from sex during this period); and engaging in sexual activity mid-cycle is the common practice as this is considered a time when the uterus is “closed” and a woman is least likely to become pregnant.⁹ This situation, in concert with issues such as a high rate of migration of young people (primarily young women) to work in factories in Phnom Penh, a nascent youth revolution (and its associated notions of individuality and sexual freedom) fueled by both local pressures and the media from neighboring countries, and the overwhelming presence of high levels of HIV/AIDS in all sectors of the Cambodian community, make it imperative that ARH issues are comprehensively addressed.

⁷ National Institute of Statistics, 1999.

⁸ CARE, 1999b.

⁹ CARE, 1999b; Chap and Escoffier, 1996; Health Unlimited, n.d.; Ministry of Women’s and Veteran’s Affairs, 1999.

ARH indicators in Cambodia

Figure 1. Total Adolescent Population (Ages 15-24)

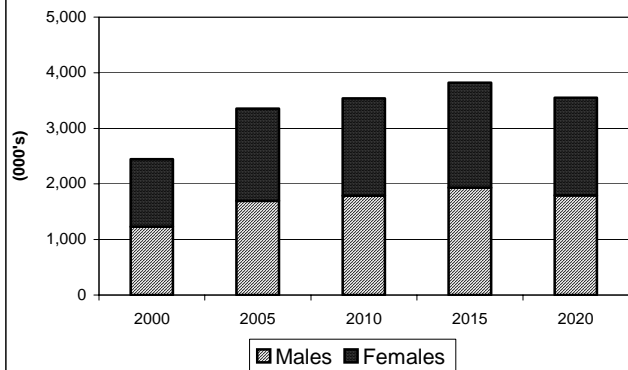


Figure 2. Years of Education Completed (Ages 15-24)

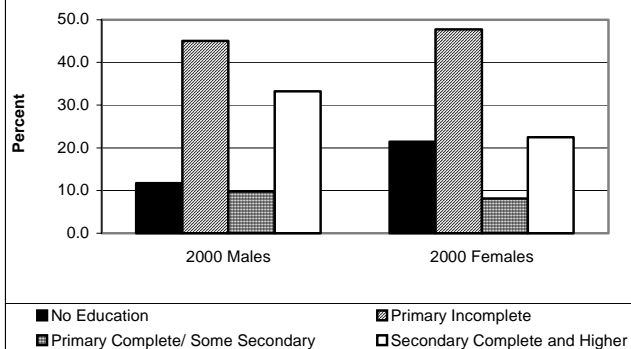


Figure 3. Annual Pregnancies and Outcomes (Ages 15-24)

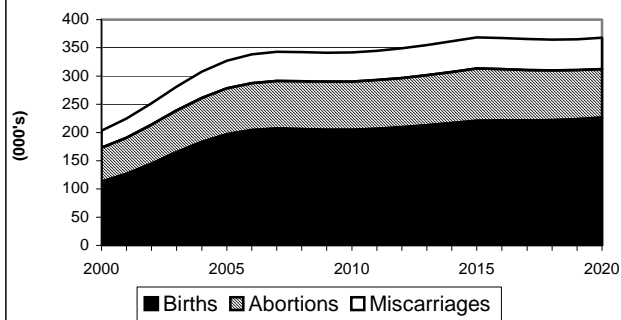
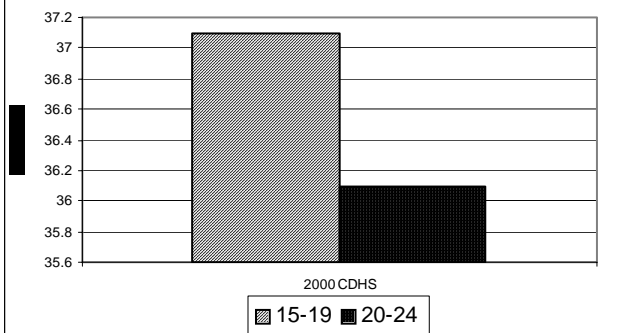


Figure 4. Total Unmet Need for FP (Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 4

2 SOCIAL CONTEXT OF ARH

A number of issues must be considered when speaking about the social context of reproductive health, which include gender socialization, education, employment, and marriage.

Gender socialization

Cambodia has clear-cut notions of male–female gender differentiation, gender-specific behaviors, and gender-specific work and domestic roles. Traditional Cambodian cultural beliefs portray women’s place as in the home and, regardless of statistics that demonstrate that a considerable portion of the household income derives from women’s work,¹⁰ the work women undertake outside the home is not as valued as that undertaken by men. Marriage and domestic labor are viewed as the primary goals for girls, and young girls are often removed from school to care for younger siblings and help with household and agricultural tasks. There is a strong double standard of behavior for men and women, and this is particularly pronounced during the period of adolescence. Adolescent girls are expected to uphold the virtue and honor of their family by taking care of their reputation and maintaining not only their actual virginity but also their imputed sexual reputation.¹¹ However, no such strictures are placed on males; their virginity at marriage is not an issue and it is expected that they will seek out multiple partners both prior to and after marriage because they have irrepressible sexual needs. The adage “men are gold, women are cloth,” which suggests that when soiled through their actions men can easily be cleaned but women can never be completely cleaned, illustrates the Cambodian belief about the fundamentally differing natures of male and females.

Poverty regularly leads to the sale of young girls, who are valued less than boy children, into the urban sex industry by parents or other relatives. There is a high level of rape of girls younger than 12, as well as a high level of rape of teenage girls as a means of forcing male demands for marriage.¹² LICHARDO, an NGO working with human rights, noted that 26.3 percent of the cases they investigated in 2000 involved rape and indecent assault, of which 61.7 percent were cases with child victims (younger than 18).¹³ In marriage, there is also a high level of marital violence, which is possibly related to wider patterns of violence in Cambodian society and high levels of male alcohol consumption, although to date this issue has not been comprehensively studied.¹⁴ Recent interview research sponsored by the Ministry of Women’s and Veteran’s Affairs (MOWVA) found that 16 percent of the women surveyed had experienced domestic violence; approximately one-half of these women had been injured as a result.¹⁵ The recent *Cambodia: Demographic and Health Survey 2000* found that 16.3 percent of 15–19 year old ever-married women had experienced beatings or other physical mistreatment since age 15.¹⁶

¹⁰ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

¹¹ Ledgerwood, 1990.

¹² LICHARDO, 2001.

¹³ Note, the number of cases this refers to is not specified.

¹⁴ Beaufils, 2000; LICHARDO, 2001; Ministry of Women’s Affairs, 1999; Watmough, 1999. Under the Ministry of Women’s and Veteran’s Affairs’ (2001) five-year Neary Rattanak Strategy, there has been a revision of the Cambodian law code in relation to domestic violence. However, the problem now facing Cambodia is the implementation of this code through a judiciary and a police force that is reluctant to act in such cases. In addition, indeed, women themselves often prefer to suffer private violence rather than public shame and may be reluctant to initiate action against an abusive spouse whose economic support they need.

¹⁵ MOWVA, 1999.

¹⁶ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

Once married, the workload of women increases to include responsibilities for child care, household labor, food production, agricultural labor, and contributing to family finances through activities such as petty trading. Within marriage, women experience a considerable lack of autonomy. They rarely have the final say on any marital decision making except about daily household purchases. Only 37 percent of women make decisions about their own health care; 52.5 percent make such decisions jointly with their husbands.¹⁷ In the case of health care for ill children, mothers have the final say in only 21 percent of cases and decisions are made jointly in 74.5 percent of the cases.¹⁸ Decisions about whether a woman should work to earn money are least likely to be made by the woman alone (9 percent).¹⁹ In marriage, much of men's lives continue as before; they work, drink and gamble with friends, and visit brothels and karaoke bars for the entertainment and sexual variety they claim to need.

Education

Levels of educational achievement in Cambodia are extremely poor. The *Cambodia: Demographic and Health Survey 2000* states, "Survey results show that the majority of Cambodians have little or no education, and females are considerably less educated than males."²⁰ Among 15–19 year-olds, 18.7 percent of females and 11.1 percent of males have no education. In the same age group 47.4 percent of males, and 49 percent of females have "some" primary education but 10.9 percent of males, compared with 9.1 percent of females, complete primary education.²¹ Boys and girls have similar enrollment rates until age 10. Then, as noted above, girls tend to be pulled out of school to work within the household. From this age onward they start falling behind boys until, by age 15, the male school enrolment is 50 percent greater than the female enrolment.²²

Officially, education in Cambodia is free and accessible to all. However, given the extremely low wages paid to teachers—around U.S. \$20 per month, which is about 20 percent of a living wage—teachers are forced to charge students unofficial daily fees of one or two hundred riel. It is also reported that passing exams often requires an additional special payment. For families living on the financial edge, as many rural families are, this is likely one factor influencing them to withdraw children from school as soon as possible. On the part of boys, evidence suggests that withdrawal from school is a decision made primarily on economic grounds. School requires spending money on uniforms, books, and unofficial payments, and boys' labor is needed to support their families.²³ The withdrawal of girls from school is partly to utilize their domestic labor and, as many analysts point out, due to a traditional belief that education is of little use to women.²⁴ Yet, other issues, such as physical access to schools (a typical rural household lives about 40 minutes away from a school) and fears about the safety (rape or abduction) of adolescent daughters who walk to school, may also be significant.²⁵

¹⁷ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

¹⁸ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

¹⁹ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

²⁰ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

²¹ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

²² Beaufils, 2000; Ministry of Education, Youth, and Sport, 1998a.

²³ Ministry of Planning, 1998.

²⁴ Beaufils, 2000: 26-27.

²⁵ Beaufils (2000: 27) also suggests that subtle factors, such the absence of basic infrastructure in the form of toilets may also be an issue influencing post-pubertal young women to leave school, as 72.2 percent of Cambodian schools have no toilet facilities (Ministry of Education, Youth, and Sport 1998b).

Employment

As the above discussion of the Cambodian educational system suggests, Cambodians commence work at an early age whether it be domestic work in the household on the part of young women or farm or other labor on the part of young men. Overall, 73.5 percent of women older than 15 are economically active, compared with 81.2 percent of men. However, a larger proportion of women than men work on the family farm or for relatives doing work for which they are not paid.²⁶ Girls entering the labor market are likely to be less educated and less skilled than boys. Many young women work in Cambodia's garment manufacturing industry (discussed below in the context of migration), in which they are subject to varying degrees of exploitation including low salaries, the frequent docking of salaries due to rule infringements, unsafe working conditions (e.g., faulty electrical connections, inadequate lighting), forced overtime, and sexual exploitation.

Cambodia adopted a labor code in 1997 but its enforcement is lax. Women have the right to paid maternity leave but in reality, pregnancy results in the employee being laid off. A similar situation pertains to employees who take sick leave or complain about issues such as sexual harassment. Among all occupations, there is a significant degree of gender discrimination with regard to wages.²⁷

Marriage

When discussing marriage in Cambodia and its effect on ARH, age at marriage, social pressures, and the choice of a marriage partner are important factors to consider.

Age at marriage: There is no legal age for marriage in Cambodia and the normative “desirable” age for marriage varies between urban and rural areas and among ethnic groups.²⁸ Currently the median age at first marriage among Cambodian women is 22.5 and among men it is slightly older, at 24.2.²⁹ Median ages for marriage are slightly higher for both women and men in urban areas compared with rural areas, with that for females being 23.6 and that for males 26.6.³⁰

Social pressure: There is substantial social pressure to marry. Khmer tradition expects women to marry between the ages of 16 and their early twenties, and some women marry as young as age 15.³¹ It is assumed that a woman who postpones marriage until substantially later than the norm will become ugly and bring shame to her family.³² This traditional view also holds that too much education limits a girl's prospects for finding a husband. Also, irregardless of transforming sexual norms among the younger generation, a great deal of pressure is still exerted on women's behavior (including sexual behavior) by their families, which view daughters and their behavior as responsible for upholding much of the family's reputation.³³

Choice of marriage partner: What actually constitutes marriage in Cambodia ranges from massive and hugely expensive public displays of merit making—activities such as sponsoring the chanting of large numbers of monks and the making of contributions to temples—and feasts for hundreds of guests on the part of the urban elite to the paying of a small bride price and some limited merit making on the part of

²⁶ Beaufils, 2000: 30.

²⁷ Ministry of Planning, 1998.

²⁸ Chhuan Long, et al., 1997.

²⁹ National Institute of Statistics, 1999.

³⁰ National Institute of Statistics, 1999.

³¹ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

³² Beaufils, 2000.

³³ Beaufils, 2000; Tarr, 1996a; Tarr and Aggleton, 1999.

the poor to merely commencing to live together on the part of the poorest. Common to all is public recognition that the couple has commenced living together, and only 20 percent of women report signing a marriage contract in front of their local district authorities.³⁴

With respect to the choice of marriage partners, it is commonly understood that parents have the right to choose a spouse for their daughter. It is common that rich and powerful men will seek to take multiple wives, and it is also understood that when parents choose a partner for their daughter that they have the right to choose a rich and powerful older man regardless of his marital status.³⁵

Recent research shows that 43 percent of ever-married women in Cambodia met their spouse for the first time at the time of marriage, and an additional 7 percent knew their husband for less than one month before their marriage.³⁶ The data suggest that this practice is declining over time; among ever-married women ages 15–19 only 34 percent met their husband for the first time at the time of marriage, compared with 42 to 43 percent of women ages 29–39 and 48 percent of women ages 40–49.³⁷

³⁴ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

³⁵ Tarr, 1996a. See Ledgerwood, 1990.

³⁶ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

³⁷ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

3 ARH ISSUES

Early, high-risk pregnancy, sex and violence, sexually transmitted diseases (STIs) and HIV/AIDS, and migratory adolescent workers are all subjects that should be identified in the discussion of issues affecting ARH.

Early, high-risk pregnancy

It is not unusual for childbearing in Cambodia to begin in the teenage years; recent research shows that 8.2 percent of women ages 15–19 have become mothers or are currently pregnant with their first child. The percentage of women who have begun childbearing increases with age, from less than 1 percent among women age 15 to 22 percent among women age 19.³⁸

Among vulnerable youth such as street children, of which there are many, sexual activity commences at an average age of 16, and recent research shows that 93 percent of 15–19 year-olds and 86 percent of 20–24 year-olds claim to have been pregnant. Indeed, 43 percent and 40 percent, respectively, of the sample of 110 girls were pregnant at the time of interview.³⁹

The overwhelming majority of births (89%) was delivered at home. Traditional birth attendants assisted with the majority of births (66%), trained midwives assisted 28 percent, and doctors or nurses assisted 4 percent. The remainder of births had no outside assistance. Cambodia has one of the highest levels of infant and child mortality in the world with the most recent statistics for neonatal mortality at 37 per 1,000 live births. The post-neonatal death rate is 58 per 1,000. Thus, the risk of dying for any Cambodian child who survives the first month of life increases during the next 11 months.⁴⁰ Cambodia also has a high level of maternal mortality, with a recent UNFPA study estimating the current maternal mortality rate at about 500 deaths per 100,000 live births. About 2,000 Cambodian women die each year of childbirth-related causes.⁴¹ The most important direct causes of maternal deaths are hemorrhage, obstructed labor, hypertension, and sepsis.⁴²

Sex and violence

Violence against women, particularly sexual violence, is a problem in Cambodia. Forced sexual activity is seen as a way of getting sexual access to an unwilling woman and as a way of forcing a marriage. It is common for young men to make statements such as “if we love her, and the parents do not agree, we rape her.”⁴³ The logic of this is that, having been raped and having lost her virginity, the women in question will be considered a *serey khoic* (a fallen woman) and will no longer have any value for other men and so will be forced to marry the rapist. Indeed, there is well-documented evidence to show that, particularly in rural areas, it is common for village-level resolutions of rape cases to be marriage.⁴⁴

³⁸ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

³⁹ See UNFPA, 1999. Also see Mith Samlanh-Friends, 2001. Mith Samlanh-Friends claim that in Phnom Penh alone there are approximately 1,200 adolescents “living rough” on the streets, with another 10,000–20,000 working on the streets daily. See also World Vision, 2000.

⁴⁰ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

⁴¹ UNFPA, 1996.

⁴² UNFPA, 1996.

⁴³ Save the Children (UK), 1997.

⁴⁴ See LICHARDO, 2001.

In the commercial sex arena, a common variety of violence directed against young women is taking them from establishments providing either direct or indirect sexual services (or picking up sex workers working on the streets) under the pretext of taking them to a guesthouse for sex. However, they find themselves taken to a room or a bushland setting where they are subsequently gang raped by as many as 20 waiting men who not only steal their money and jewelry but may also beat them up.⁴⁵ The majority of men involved in such activities do not wear condoms.⁴⁶

STIs and HIV/AIDS

HIV was first encountered in Cambodia in 1991 during serological screening of donated blood, and the first cases of AIDS appeared in late 1993 and early 1994. By way of response to the threat of AIDS, the MOH established a National AIDS Program in late 1991. This later became the National Center for HIV/AIDS, Dermatology, and STDs in 1998. To assist via a multisectoral approach, the government also established the National AIDS Committee in 1993, which was succeeded in 1999 by the National AIDS Authority, and is responsible for the coordination of the response to the epidemic across all sectors. Specific components of the response to the AIDS threat include HIV/AIDS awareness and STI education (including both information, education, and communication (IEC) and outreach activities for high-risk contexts), 100 percent condom use (initially for “hot spots” and then more widely), STI services, blood safety, prevention of mother-to-child transmission, AIDS care, surveillance and research, and strengthening capacity in the areas of planning and coordination.

The mode of transmission of Cambodia’s HIV/AIDS epidemic is sexual, primarily heterosexual, activity. Cambodia has few injecting drug users and little data is available on this issue beyond recent suggestions that injecting drug use is increasing in Cambodia.⁴⁷ The epidemic in 2002 is considered a “generalized” AIDS epidemic with HIV and AIDS cases representing all social groups.⁴⁸ Among 15–49 year-olds there are currently 169,000 persons estimated to be living with AIDS—97,000 men and 72,000 women. HIV in the general population was approximately 2.9 percent in 1996, which increased to 4.6 the following year. However, by 1999 it had declined to 3.2 percent, and the current estimated HIV prevalence among the general adult population is 2.8 percent.⁴⁹

Currently, women working in the sex industry have the highest rate of HIV seroprevalence among the sentinel surveillance groups (direct sex workers, indirect sex workers, policemen, antenatal care (ANC) patients, tuberculosis (TB) patients, and hospital in-patients). Direct sex workers (those working in brothels) have a seroprevalence rate of 31.1 percent HIV-positive whereas indirect sex workers (those working as beer, bar, and karaoke girls) have a seroprevalence rate of 16.1 percent HIV-positive.⁵⁰ UNAIDS notes that limited data are available on the extent of STIs in Cambodia but that seroprevalence rates of chlamydia (22.4%), gonorrhea (35%), and syphilis (14%) have been found in female sex workers in a study of four Cambodian cities.⁵¹ Preliminary data from the 2001 seriological surveillance suggests a fall in STI figures among men and a reduction in HIV prevalence rates among all sentinel groups.⁵²

⁴⁵ Interview with informants at Oxfam Hong Kong, February 2002. See also Fordham et al., 2002.

⁴⁶ Interview with informants at Oxfam Hong Kong, February 2002. See also Fordham et al., 2002.

⁴⁷ Mith Samlanh-Friends, 2002.

⁴⁸ UNAIDS, 2001.

⁴⁹ UNAIDS, 2002.

⁵⁰ UNAIDS, 2001.

⁵¹ UNAIDS, 2001.

⁵² Ministry of Health, 2000b. Interviews with Mr. Peter Goodwin, Regional Advisor ADB, National Center for HIV/AIDS, Dermatology and STI, Dr. Francois Crabbe, Project Technical Advisor, national Center for HIV/AIDS, STDs and Dermatology, and Dr. Mean Chii Vun, Director National Center for HIV/AIDS, STDs and Dermatology, February 2002.

Condom use during commercial sex has increased among all sentinel groups but 30 percent of men still do not use condoms consistently. Thus, young men are at risk of contracting HIV because of a high rate of participation in commercial sex whereas young women who engage in sex with “*sangksa*” (sweetheart) relationships are at risk of contracting AIDS from their lovers, with whom condoms are rarely used. The meaning associated with condoms (called *sroum anmai*, or hygiene bags in Khmer) conflicts with the meanings of love, romance, and trust on which sweetheart relationships are built.⁵³ One single countrywide statistic, which derives from UNAIDS, claims that male condom use with commercial sex workers ranges from 53 to 63 percent, but with “sweethearts” is as low as 5 to 23 percent.⁵⁴ Other work confirms this low level of condom usage in “sweetheart” relationships and suggests that, as in the case of Thailand a decade earlier, suggestions of condom use are tantamount to suggesting a young woman is promiscuous. Rather, condoms have become what one uses with a prostitute.

The evidence suggests that young men and women are operating with different sexual scripts and that this situation renders young women highly vulnerable to contracting HIV. Research suggests that while young women enter into sweetheart relationships and see them as a prelude to marriage, young men utilize the idiom of sweetheart relationships to gain sexual access to women who they rate as being less likely to be HIV-positive than are commercial sex workers.⁵⁵ This phenomenon is similar to what occurred in early 1990s in Thai society.⁵⁶

Migratory adolescent workers

A feature of contemporary Cambodian society is a high level of migration from rural areas to urban areas and border areas in search of employment. Such migration includes the circular migration of young (and older) men who travel to Phnom Penh following the rice harvest; they go in search of wage labor in the “off” season and undertake temporary one-way migration for relatively long-term work in factories. The young men in the former group are of concern because a combination of cash in their pockets and a fascination with the commercial sex attractions of the big city, along with a likely limited knowledge of HIV/AIDS, renders them vulnerable to contracting HIV. However, the category of migrant workers of most concern is that of young people who migrate from rural areas to Phnom Penh to work in the factories of the garment industry. Estimates suggest that approximately 140,000 young people, the majority of whom are young women, work in about 65 factories. The women working in this industry are in their late teens and early twenties, likely to be separated from their protective family networks for the first time, and not “streetwise.”

Although their wages are extremely low (averaging US\$40 per month or less), as factory workers living in the big city, these young workers’ can leave behind the rustic rural areas (even while they live in dormitories or shared rooms) and participate in the modernity of the big city with its permanent electricity supply, markets, and the many entertainments. Even though most remit a considerable portion of their wage earnings to families in rural areas, for the first time in their life they have money in their pocket and the ability to buy new clothing and cheap cosmetics. Their desire to “experience modernity” (part of which may be the freedom to associate with young men) in concert with urban men’s beliefs that such country girls are likely to be free of disease, and men’s offerings of money or gifts, and a limited knowledge of how to protect themselves from HIV/AIDS makes these young women highly vulnerable to

⁵³ Beaufils, 2000.

⁵⁴ UNAIDS, 2001.

⁵⁵ Author’s fieldwork in 1985–1987, 1992–1994, 1995.

⁵⁶ Fordham, 2001. See Lyttleton, 2000.

contracting HIV.⁵⁷ Recent work by the NGO CARE suggests that while the majority of these young women know about HIV/AIDS and that it is transmitted through sex as well as other transmission routes (possibly the result of public service messages about AIDS over the past few years), there is a strong belief that HIV/AIDS and STIs are found among commercial sex workers.⁵⁸ Moreover, CARE's work suggests that "there is a strong belief that there is no risk of infection from sex with someone that you trust."⁵⁹ Also, the normative scripting of sex between young unmarried Cambodians is highly physical rather than verbal and dictates that the males initiate sex acts and no immediate rebuff indicates the woman's acquiescence, creating a situation in which the negotiation of condom use is highly unlikely.⁶⁰

An additional vulnerability of migrant adolescent women is that factory wages are not only low, but they are also frequently "docked" for infringements of various rules. Such docking, which may reduce a workers' monthly wages by more than one-third, in concert with financial demands from rural families who come to depend upon remittances from migrant daughters, often causes young women to cycle between their chosen factory work (which cannot fulfill their perceived financial obligations to their families) and short-term sex work in direct brothels of karaoke bars.⁶¹ Their limited knowledge about their own basic physiology and HIV/AIDS protection that rendered them "at risk" in the factory environment renders them doubly at risk in the sex work industry. Moreover, recent work focusing on young sex workers ages 14–17 suggests that because of issues such as shame and not identifying themselves as sex workers, they do not participate in the many AIDS risk-reduction programs offered to sex workers.⁶²

Drugs: Cambodia is starting to experience the beginnings of a major drug epidemic as Thailand's amphetamine epidemic seeps across its borders.⁶³ As yet there is no widespread concern about the impact of drugs in Cambodian society. However, police drug seizures, anecdotal evidence about drug use among social groups such as up-market night club patrons, and hard evidence of drug use among street children (ranging from glue sniffing to amphetamine abuse), sex workers (who are often forced or tricked into amphetamine use by clients), and fishermen suggest a growing rate of drug use and easy accessibility of drugs.⁶⁴ This will invariably impact on rates of HIV/AIDS and STI transmission because, as sex workers point out, when affected by drugs neither they nor their clients are in a position to negotiate condom use.⁶⁵

Trafficking: A major problem in contemporary Cambodian society is the trafficking of young women from Vietnam to Cambodia, and from rural Cambodia to Cambodia's urban centers or, to a lesser extent, Thailand for the purposes of prostitution. The magnitude of trafficking is hotly contested, and reliable statistics on trafficking are scarce due to the small-scale and short-term nature of most research. International Organization for Migration figures that there are 14,000 female commercial sex workers, of whom 40 to 60 percent entered sex work involuntarily.⁶⁶ Men of all ages are also trafficked to Thailand for the purposes of cheap labor, while children and older women are trafficked to Bangkok to beg for

⁵⁷ Regardless of what these young women paint as fairly oppressive working conditions, CARE (1999b) notes that the desire to experience modernity is a fundamental reason for migrating to the city to find factory work. Mills' (1997, 1998) work on the experiences of young Issan women migrating to work in Bangkok shows this even more clearly.

⁵⁸ CARE, 1999b.

⁵⁹ CARE, 1999b.

⁶⁰ See CARE, 1999b; Tarr, 1996b; Tarr and Aggleton, n.d.; and Tarr and Aggleton, 1999.

⁶¹ See Fordham et al., 2002.

⁶² Fordham et al., 2002.

⁶³ Mith Samlanh-Friends, 2002.

⁶⁴ For a brief discussion of alcohol and other drug use among fishermen and its impact on their sexual practices with young sex workers, see Family Health International, n.d. and Greenwood, 2000.

⁶⁵ Fordham, et al., 2002; and Mith Samlanh-Friends, 2001.

⁶⁶ IOM, 2000.

money. In the case of young Cambodian women, the paradigmatic model is exemplified by the situation of young women who are sold into prostitution by their families, boyfriends, or other individuals (ranging from motorcycle taxi drivers to police).⁶⁷ However, as one specialist on trafficking points out, there is much complexity in this area and “a clear distinction between coercion and freedom of choice becomes blurred” in cases where parents or other relatives utilize the emotional pressure of imputed financial or social obligation to coerce young women into sex work.⁶⁸ However, regardless of the modality of trafficking of young rural women into the sex industry, the act of being trafficked into the sex industry has major ramifications for their own reproductive health and that of others. Like the rural migrant workers discussed above, they have low levels of education and limited levels of knowledge about HIV/AIDS and safe sex. Moreover, as trafficked women, they are often kept in closed brothels where they have no access to HIV education programs directed to sex workers.

Vietnamese women trafficked to Cambodia are doubly disadvantaged because they not only have a high degree of illiteracy in their own language, but they are also totally illiterate in Khmer. Thus, they can only access safe sex and basic physiology information campaigns directed especially to them in Vietnamese.⁶⁹

Cambodia now has strong legislation against trafficking and there are heavy penalties for those engaged in the trafficking of women. The MOWVA has also established a Counter Trafficking Bureau and, together with the International Organization for Migration, has recently conducted a major anti-trafficking campaign.⁷⁰ However, the substantial profits made from trafficking at all levels have led to endemic corruption among many of those charged with enforcing anti-trafficking legislation, and anti-trafficking legislation is currently not effectively enforced.

⁶⁷ See CARAM, 1999. See also Greenwood, 2000.

⁶⁸ Derks, 1999; Derks, 2000. See Fordham et al., 2002.

⁶⁹ CARAM, 1999.

⁷⁰ Fordham, 2001b.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

A number of issues should be considered in a discussion of legal and policy issues related to ARH, including legal barriers, existing ARH policies, and ARH policy initiatives.

Legal barriers

Although Cambodia has no ARH policies, ARH activities are addressed in other policy areas. There are no legal barriers to the implementation of ARH activities, but there are substantial infrastructure barriers, and there may be a vast gulf between policy as such and implementation, particularly in rural areas.

Existing ARH policies

ARH activities are conducted within the context of other policy areas, primarily within policies regarding MCH, population/birth spacing, gender equity and equality (MOWVA), and AIDS.

Population/birth spacing policy: Following the decimation of the Cambodian population under the Khmer Rouge between 1975 and 1979 (estimates vary between 1 million and 3 million deaths from starvation and execution during this period), the Cambodian Government followed a pronatalist policy from 1979 to 1991. This policy was reversed in the early 1990s (due to maternal health needs rather than population issues) with NGOs implementing pilot birth-spacing programs. In 1994, the Ministry of Health Annual Congress recommended the development of a birth-spacing policy.⁷¹ With the introduction of the birth-spacing policy in 1995 began the initiation of widespread dissemination of contraceptives and contraceptive information.⁷²

Recent research suggests that knowledge of family planning is high in Cambodia. For example, 92 percent of all women and 96 percent of married women know a modern contraceptive method. The daily pill and injectables are the most widely known modern methods, with 90 percent of currently married women having heard of these contraceptive methods.⁷³ Also, 71 percent of women know the (Chinese) monthly pill—a commonly used, high dose hormonal contraceptive. The research also found that 23 percent of all women and 37 percent of currently married women ages 15–49 reported using a contraceptive method at some time. Few women begin using contraception to delay birth following marriage; rather, almost one-half of the women who had ever used contraception (17 percent) started using it when they already had one to three children, suggesting that contraception is used for birth spacing and limiting the number of births.⁷⁴ Research in 1988 suggests that at that time, the overall source of supply for birth spacing was about evenly split between public and private sector sources.⁷⁵ However, a considerable scaling up of the work of Population Services International (PSI) and many other NGOs promoting safe-sex as part of Cambodian anti-AIDS initiatives suggests that the private sector is supplying the bulk of the demand for birth spacing at the present time. While there are several different sets of data used in the current Cambodian reproductive health literature with regard to unmet

⁷¹ Ministry of Health, 1995a.

⁷² Chhuan Long, et al., 1997; Ministry of Health, 1998.

⁷³ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

⁷⁴ National Institute of Statistics, Directorate General for Health, and ORC, 2001. Indeed, this was a clear finding from the 1995 Survey on Fertility and Contraception (Ministry of Health, 1995b).

⁷⁵ National Public Health and Research Institute, 1998.

contraceptive need, the availability of all data point to a large unmet contraceptive need.⁷⁶ Unmet need is high in Cambodia for a variety of reasons, including contraception was illegal until after the 1993 elections, access problems, and cultural beliefs about physiological reactions to oral contraceptives and injectables.

Recent work underlines emergency contraception as a virtually unmet contraceptive need in the ARH sector. Emergency contraception is not only nearly unknown, but it is also unavailable outside of a few NGO clinics. Yet, given the high incidence of rape and, as discussed elsewhere in this paper, the rise of recreational sex among both urban and rural Cambodian youth, the need for this form of contraception appears to be high. Projects working to meet this need, however, focus on urban and peri-urban areas because these areas tend to have the necessary infrastructure and the knowledge to staff the infrastructure.

Motherhood and childhood: A National Safe Motherhood Policy was developed in 1997 together with a five-year action plan (1997–2001), which was later superseded by the 2001–2005 action plan.⁷⁷ Cambodia’s safe motherhood policies, which are implemented through the MOH, aim at improving pregnancy outcomes and reducing maternal and infant morbidity and mortality. Thus, they aim to increase the proportion of women who have babies delivered by trained medical personnel to 60 percent (current five year plan), reduce morbidity and mortality from unsafe abortions by providing safe abortion services, increase antenatal care coverage to 70 percent of expected births, and increase family planning.

However, although safe motherhood services are delivered at community outreach, health center, and referral hospital levels, the bulk of the population does not access this system due to financial, infrastructure, and cultural issues. Moreover, effective implementation of these policies is slow because of financial and infrastructure issues discussed elsewhere in this document. As the executive summary of a 2001 USAID assessment of population, health, and nutrition issues in Cambodia stated, “The existing workforce, excessive in numbers, is grossly inadequate in skills; salaries are so low that there is little or no incentive to work; and parts of the country remained insecure until just two years ago.”⁷⁸

Abortion: Prior to 1997 abortion was legal only for saving the life of the woman, however, in August 1997, the Cambodian Parliament approved a new abortion law that is among the most liberal in Asia. Abortion is offered without the woman providing a reason and without restriction in the first trimester. In the second and third trimester, abortion is only allowed if diagnosis shows that the pregnancy is abnormal (growing abnormally or creating a risk to a woman’s life), if after birth the child will have a serious incurable disease, or if a woman has been raped.⁷⁹ Although the new abortion law states that providers who do not have authorization from the MOH should be punished, this has not yet been enforced.

Recent research on abortion shows that of those women who admitted to having had an abortion in the past five years, 41 percent of abortions took place in a private health facility, 27 percent in a public medical facility, 23 percent in the respondent’s home, and 7 percent taking place in other homes.⁸⁰ The most common abortion methods were dilation and curettage (41 percent) and vacuum aspiration (35 percent), with traditional methods being used in 9 percent of the cases (it is likely that the 14 percent who

⁷⁶ See Beaufils, 2000; Ministry of Health, 1998; Ministry of Health and National Public Health and Research Institute, 1998; and USAID, 2001.

⁷⁷ Ministry of Health, 1997; Ministry of Health, 2000a.

⁷⁸ USAID, 2001.

⁷⁹ Ministry of Health, 1998.

⁸⁰ Ryan and Gorbach, 1997.

answered “don’t know” to this question used traditional methods).⁸¹ Traditional methods range from abdominal massage, oral herbal medications, and insertion of plant stems into the vagina or cervix.⁸²

It is difficult to collect data on abortion, and the most recent survey in the area found that no woman aged 15–19 reported an abortion, and that few women without children reported having an abortion.⁸³ As this survey notes, this is clearly a massive under-reporting of such statistics throughout all age groups and, in particular, among young women. The pregnancy rate among vulnerable youth (noted above) as well as anecdotal evidence, suggests that at least some young women undergo abortions. Certainly abortion is a fairly normative practice for women in the older age groups, although the statistics are highly inconsistent. The 2002 Cambodia Demographic and Health Survey data indicate that 4 percent of women ages 25–29 had had an abortion, while 7 percent of women ages 30 to 34 have done so. Yet other data derived from married women attending urban reproductive health clinics indicate that nearly one-half the sample (48.6 percent) had had an abortion, with 22 percent of respondents reporting more than one abortion.⁸⁴

ARH policy initiatives

Current Cambodian policy initiatives in the ARH area plan to continue to target ARH within the context of the existing MCH, birth spacing, gender equity and equality policies, and HIV/AIDS policy initiatives. For the political, social, and infrastructural reasons discussed in other sections of this paper, this situation is unlikely to change for some time.

⁸¹ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

⁸² See White, 1995.

⁸³ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

⁸⁴ Ryan and Gorbach, 1997.

5 ARH PROGRAMS

ARH programming takes place through different channels. School-based reproductive health education and IO, nongovernmental, and community-based programming are discussed.

School-based reproductive health education

Under school health initiatives, the school curriculum has recently been revised to incorporate reproductive health and HIV/AIDS information in the science and social studies curricula, for example.⁸⁵ These materials meet a high standard. However, their effectiveness depends upon their implementation by school teachers who are generally not adequately qualified to present the information and who may choose to pay little attention to this portion of the curriculum due to a lack of reproductive health teaching experience or beliefs about the appropriateness of sexuality as a part of the school curriculum.

An additional area of concern is that although this reproductive health component of the curriculum is of high quality in the final year of primary school and throughout the secondary curriculum, only a small percentage of the population remains in school long enough to access such material. Of adolescents aged 15–19, only 9.1 percent of females have completed primary school, and only 10.9 percent of males have done so.⁸⁶

IO, nongovernmental sector, and community-based interventions

Unlike neighboring Laos, where the activities of NGOs are strictly controlled, or Thailand, where NGOs act with seeming relative freedom but are often restricted in subtle ways through political impunity, insult, or lack of cooperation on the part of state agencies, IOs and NGOs working in Cambodia are almost unrestrained in their activities. Cambodia's recent history has also structured the political position of IOs and NGOs (whether local or international), and they occupy a relatively influential position in the country as a substantial employer of a new middle-class (because of their role in general development activities and in rebuilding Cambodian civil society, which many view as an implicit role of most NGO activity).

As a result of these factors, as well as of the magnitude of the development tasks facing Cambodia, many IOs and NGOs have commenced work in Cambodia. The most recent NGO directories list 155 IOs and 395 local NGOs active in Cambodia.⁸⁷ Some of these organizations work directly on ARH while many others have interests that frequently crosscut ARH issues. The majority of these groups do high-quality work meeting real needs and, unlike larger organizations, they are generally quick to respond to grassroots needs. Moreover, although the scope of their programs is characteristically smaller than those carried out at the ministerial level by major IOs such as UNICEF or UNFPA, they are not beset by what some senior IO staff describe as a system that calls for constant negotiation through a minefield of competing ministries and their diverse and sometimes rather arbitrary policies in order to implement programs; rather, they are able to better “get down to work.”

There are a number of NGOs working in this area. These groups are using a range of strategies, including peer education programs, and a range of innovative IEC and behavior change communication (BCC)

⁸⁵ Ministry of Education, Youth, and Sport, 2000a; Ministry of Education, Youth, and Sport, 2000b.

⁸⁶ National Institute of Statistics, Directorate General for Health, and ORC, 2001.

⁸⁷ Cooperation Committee for Cambodia, 2001; Cooperation Committee for Cambodia, 2002.

strategies geared toward improving ARH among various target groups. Some of the larger NGOs and their work are detailed below.

NGO	Focus
CARE	Reproductive health issues among factory workers and other groups of young working people (e.g., motorcycle taxi drivers and fishermen)
FHI/Impact	High-risk populations
Futures Group	Supports the HIV/AIDS efforts of the Ministry of National Defense (MOND), MOWVA, and the Ministry of Cult and Religion (MOCR); improves the HIV/AIDS response of the faith-based sector; expands the involvement of people living with HIV/AIDS (PLWHA)
Health Unlimited	Primary health care training and capacity building for local health staff at provincial, district, and community levels (in the provinces of Ratanakiri and Preah Vihear); radio project that aims to inform and educate listeners in sexual and reproductive health issues
KHANA (EC/UNFPA-funded, “enabling” NGO)	Funds 35 NGOs and community-based organizations (CBOs)
Mith Samlanh-Friends	Street children and vulnerable youth
Oxfam Hong Kong	Young women in the sex industry
Oxfam (UK)	Community development, working through local partner organizations
Population Services International	Social marketing of condoms and oral contraceptives; development of IEC materials to address HIV/AIDS issues
Reproductive and Child Care Health Alliance (RACHA)	Policy and practical reproductive health issues including contraception, supporting the Cambodian Midwives’ Association, improving counseling skills for birth spacing, and conducting studies concerning maternal and child mortality at both national and provincial levels (only some provinces)
Reproductive Health Association (RHAC)	Largest private provider of family planning and reproductive health services in Cambodia; some of its clinics host behavior change intervention (BCI) activities targeted to youth and are “youth friendly” with separate entrances and waiting rooms for adolescents
Save the Children (UK)	Marginalized youth
World Vision	Marginalized youth, ranging from those in the sex industry to street children

As the bibliography to this paper suggests, these organizations and many others have produced a large corpus of research reports and program materials concerned with ARH. Also, major IOs such as UNICEF also have a substantial interest in ARH activities.⁸⁸ Similarly, the activities of major donors in the areas of MCH or HIV/AIDS crosscut the ARH area. Thus, JICA supports the National Maternal and Child Health Center and Hospital and USAID supports RACHA and RHAC, among many other projects.

NGOs provide reproductive health information to adolescents using innovative methods such as highly popular “radio phone-in” formats, question and answer columns in popular magazines and daily newspapers, and print-based reproductive health materials distributed in AIDS prevention programs that are also available for sale in local book stalls.⁸⁹ The NGO Population Services International and some

⁸⁸ UNICEF, 2000.

⁸⁹ Interview with Mr. Barry Whittle, Country Representative, Population Services International, February 2002. Other groups active in using such formats include the EC/UNFPA and The Cambodian Women’s Media Center (a Cambodian NGO). See SIPAR, 2001.

smaller NGOs also focus on “events” such as Cambodia’s New Year celebrations and the yearly Phnom Penh boat races, which draw crowds of hundreds of thousands from the countryside, to conduct general reproductive health and HIV/AIDS IEC campaigns.

6

OPERATIONAL BARRIERS TO ARH

There are a number of operational barriers to ARH. These include denial of the need for policies and programs targeting sexually active youth, infrastructure issues, minority group issues, and limitations on adolescents desiring access to existing reproductive health information.

Denial of the need for policies and programs targeting sexually active youth

As reflected in Cambodian literature, Cambodian urban culture has historically placed high value on female virginity. However, this is changing rapidly in the present day. The influences of television and other media from the neighboring countries of Thailand and Vietnam (and to a lesser extent from Hong Kong and other parts of Southeast Asia) and western culture via movies and cable television is contributing to the growth of an urban youth culture. This culture in turn reaches out from urban areas to provide a model of modernity for rural youth. This model of modern youth culture is one that includes notions of individual autonomy and romantic love and is accompanied by relatively high rates of sexual activity. This is a new feature of Cambodian society, and one that members of Cambodia's older generations find highly threatening. Cambodia's small middle class and political elite are acutely conscious of neighboring Thailand's problems with its contemporary youth "revolution." Therefore, through maintenance of what are viewed to be "traditional" Cambodian cultural practices, such as premarital chastity for women, they strive to differentiate Cambodia and Cambodian culture from Thai culture.⁹⁰ As a result, apart from a few key people—primarily those involved in the HIV/AIDS arena—there is a high level of "official denial" of sexual activity among unmarried youth.⁹¹ Since health policies have been developed to cater for other groups, it is likely that this is one reason for what seems a studied denial of the need for an ARH policy. By contrast, NGOs working among young people generally, street children, and those concerned with interventions in the sex industry claim a substantial level of sexual activity among young people.⁹² This observation is primarily with regard to urban youth, but it is also true, to some extent, of rural youth because of the circular migration of young people between urban and rural areas for both education and employment.

Infrastructure

The introduction to this paper addressed the issue of infrastructure and how this has affected policy development and implementation. This is certainly a factor that has directed the policy focus away from adolescent health to focus on the area of most pressing need—that of MCH.

⁹⁰ See Tarr and Aggleton, 1999.

⁹¹ Tarr (1996a) and Tarr and Aggleton (1999) use qualitative research to show increasing rates of sexual activity among young single people, in particular among young women. Work by Ly Solim et al. (1997) suggests a similarly increasingly high level of adolescent sexual activity. Tarr (1996b) pays some attention to this "culture of denial" among Cambodia's elder generation. In contrast, recent knowledge, attitude, behavior, and practice (KABP) research by the Reproductive Health Association of Cambodia (1999) in a study of sexual behavior among out of school adolescents ages 12–25 found that 26.8 percent of girls and 44.9 percent of boys were sexually experienced. But, they make the assumption (*ibid.*: 2) that "likely many of these adolescents are married." A similar assumption is made by the compilers of National Institute of Statistics, Directorate General for Health, and ORC (2001). For a similar occurrence in early to mid-1990s Thailand, see Fordham (2001).

⁹² See CARE (1999a), CARE (1999b), and CARE (2001), which take up the issue of sexual activity among Cambodia's substantial migrant population of young women factory workers. See also UNFPA (1999), which addresses sexual activity among street children, free-lance commercial sex workers, and vulnerable youth in provincial areas.

However, infrastructure issues have also had an impact on the issue of ARH policies and programs in one other way. There is a massive quantity of Cambodian reproductive health data (some of which pertains to adolescents), the bulk of which has been produced in the post-UNTAC (1993) period up until the present day. Yet, critically, the quality of this data ranges from extremely high quality data produced using trained researchers and first-class research methodologies to data produced by local personnel with little training in research methods to expatriate agency personnel (particularly in the case of those agencies who rely on interns for much of their research activities) whose work sometimes suffers from a lack of training in research methodology and from limited familiarity with the Cambodian cultural context.⁹³

Minority groups

Cambodia's population is 90 percent ethnic Khmer. The minority groups comprising the other 10 percent of the population are Chinese, Vietnamese, Chams,⁹⁴ and a variety of hill tribe minorities who live in the more remote highland areas. While the Chinese and Vietnamese are well known and their reproductive health needs may be addressed through mainstream programs, little is known of other minorities and of any special needs they may have. In neighboring Thailand, social science studies of minorities from the late 1950s onward provided a superb knowledge base on which to build HIV/AIDS programs, in addition to birth spacing and other reproductive health programs in the early 1990s. However, a context of almost constant conflict in Cambodia in the post-World War II period has meant that research has not been carried out among Cambodia's minorities, and thus little is known about the situation of these populations. Given the context of Cambodia's infrastructure and the many other areas of Cambodian society that need attention, this is likely to remain the case for some time.⁹⁵ It is also likely that given Cambodia's recent history of conflict, a contemporary focus on social consensus and cultural and ethnic homogeneity may be leading to a—perhaps unconscious—neglect of minority groups. Indeed, as a recent report on Cambodian reproductive health issues noted, “There has been no research on their needs, aspirations, or expectations.”⁹⁶

Limitations on adolescents accessing existing reproductive health information

In addition to other reproductive health information directed to young people, a substantial amount of text-based reproductive health information is available via the commercial publishing market in what appears to be an expanding genre of small (and cheap) paperback books dealing with ARH. Several were read during the preparation of this paper and, while they provide basic reproductive health information, it is likely that much of this cannot be fully utilized given the low levels of literacy among adolescents,

Additionally, these works are of some concern in relation to HIV/AIDS and STIs because the bulk of these are reprints of works from the pre-Khmer Rouge period, stemming from the 1960s and early 1970s. As a result they do not mention HIV/AIDS and their discussion of STIs and STI transmission and treatment is highly dated.

⁹³ Tarr and Aggleston, 1996; Tarr and Aggleston (n.d.) also make the point of “the absence of suitably trained and qualified social researchers” in Cambodia.

⁹⁴ Chams are a Muslim ethnic group that account for approximately 3 percent of Cambodia's population.

⁹⁵ In the HIV/AIDS area, for instance, where funding considerations restrict AIDS initiatives to working on “hot-spots,” when I raised the situation of minorities with senior officials in the HIV/AIDS section of the Ministry of Health I was advised that as there is only limited traffic in and out of these areas so they are not considered a priority. Yet, tourism, including tourism in minority areas, is booming in Cambodia, and it is highly likely that as these areas receive increasing tourist traffic as transport routes are improved that they too will be AIDS “hot-spots” in a few years.

⁹⁶ Beaufils, 2000.

7 RECOMMENDATIONS

The following are recommendations resulting from what is known about the ARH needs in Cambodia.

Development of an ARH policy: Ideally, given the age structure of the population and the many ARH issues that need to be addressed, Cambodia should develop a multisectoral ARH policy. In the real politics of ministries, which are split not only in terms of political allegiance but also in competition for funding, this is not likely to be achievable in the short-term. Rather, the aim should be to directly advocate for ARH policies to those ministries that are most likely to be cooperative, such as the MOH, Ministry of Education, Youth, and Sport, and the MOWVA, and to then work to achieve cooperation among these ministries in the actual development of ARH policies.

Need for good reproductive health research: There is a great deal of quantitative research about reproductive health issues in Cambodia (if not ARH issues). However, there has only been a limited amount of qualitative research conducted that can be used to interpret the “high-level” statistics. The suggestion that more work is needed here found almost universal agreement among the many senior policymakers interviewed during the course of researching this report. Additionally, while most funding periods are only one to three years, a medium-long-term perspective needs to be developed with regard to the training of Cambodian qualitative researchers. At the present time, there appears to be only one or two, at most, highly trained indigenous Cambodian social scientists.

Conduct research on the sexual behaviors of specific population groups: The most pressing ARH issue to date in Cambodian society is that of HIV/AIDS.⁹⁷ Although in some cases interventions still await “scaling-up” from pilot provinces to the national level, the response to the AIDS epidemic is, to date, successful, as measured by falling STI rates in men (particularly adolescent men) and in falling rates of HIV infection in sentinel groups. However, research to date has focused on the “easy” issues of KAP/KABP style surveys about AIDS knowledge and risk practices. Beyond the work of Tarr (1996a, 1996b) and Tarr and Aggleton (1999, n.d.), little first-class qualitative research about Cambodian male sexuality has been conducted. Indeed, while a fair amount of qualitative research has been conducted on female reproductive health and AIDS beliefs and practices, there has been no serious qualitative research conducted on the issue of masculinity apart from some rather limited focus group-based research conducted by local NGOs. Similarly, the issue of adolescent sexual activity outside of commercial sex has been subject to little qualitative research, and little is known about the nascent youth culture that drives such sexual activity apart from the fact that they are sexually active.

Research suggests the Cambodian population now has a high level of knowledge about HIV/AIDS, yet there is still a high level of unprotected sexual activity in the commercial sex arena and with sweethearts (*songsar*, or girlfriends). As de Lind Van Wijngaarden, a qualitative research specialist on Cambodian AIDS, recently noted, we need to know more about the motor that “drives” Cambodia’s HIV/AIDS epidemic.⁹⁸

Research on visual media to suit Cambodia’s low level of literacy: The large numbers of Cambodian NGOs working on the development of IEC and behavior change communication (BCC) materials on

⁹⁷ This is recognized by major donors such as USAID, which, in their next three-year funding period, plans to move its funding emphasis from the MCH area to HIV/AIDS. Interview with Mr. Ngudup Paljor, MCH advisor, USAID, February 2002.

⁹⁸ de Lind Van Wijngaarden, 2001.

HIV/AIDS and ARH issues have produced a wide range of high quality materials. However, these tend to rely on the printed text and, critically, in terms of ARH materials that aim to teach the fundamentals of human reproductive physiology, the representations they use are complex. It is suggested that some thought be given to the fact that a high percentage of the target audience has extremely low levels of print literacy; however, they may also be visually illiterate. Like map reading, the reading of complex physiological representations (such as diagrams of the internal organs of the human body and, in particular, detailed representations of the reproductive system) is a learned skill.⁹⁹ Thus, in the case of the Cambodian primary school curriculum, children start with simple diagrams of the internal organs of body in the early years before they encounter increasingly complex representations (and associated explanations) of the reproductive system at grade six and in subsequent years.¹⁰⁰ Because a wide gap exists between the traditional Cambodian folk model and the modern biomedical model of the internal human reproductive system and its functioning, it is likely that attempts to bridge the gap in one “jump” through IEC materials are not particularly successful.¹⁰¹ Research on this issue has critical implications not only for the development of IEC and BCC materials on reproductive health and HIV/AIDS, but also for the manner in which all aspects of reproductive health programs are presented to rural populations.

NGOs and program implementation: NGOs are generally doing good work in Cambodia and, given the lack of “official” attention to ARH issues, meet a critical need. However, a recent analyst, describing NGO-based IEC reproductive health campaigns conducted in Cambodia over recent years noted, “There has been a lack of coordination among all the major sources of information and messages, particularly in the design, production, and sharing of materials.”¹⁰² There have been many attempts to rectify this situation with the setting up of a variety of “interagency” working groups. These have been only partially successful, however, and have had a downside of adding yet another meeting for agency representatives to attend each month. Moreover, in the world of real politics there is some degree of competition for funding between agencies and information shared tends to be information about programs currently underway rather than those planned for future implementation, despite rhetoric of cooperation. Regardless, given the crucial role NGOs provide in the ARH area, new attempts should be made to secure a higher and sustainable level of coordination among NGOs working in this area to ensure a consistency of messages and to avoid duplication of programming.

A limitation on the work of many NGOs is that the programs they implement have little chance of continuity due to their own dependence on short-term donor funding. The danger of this situation, given that so many NGOs are active in reproductive health and other development issues, is that it does not take too many years before the continual implementation and winding down of such programs engenders a high level of cynicism at the village level and, eventually, a reluctance to participate regardless of the quality of the program offered. Some major IOs such as UNFPA and UNICEF and major funding organizations such as USAID have addressed this situation through the provision of long-term funding over several years to facilitating agencies. Agencies in turn provide recurrent funding to local NGOs and CBOs and thus provide a much more secure funding situation.¹⁰³ The need for medium to long-term funding should be considered when developing programs to be implemented through NGOs. In the AIDS arena, in particular, it is easy for programs to continue to operate in “emergency” mode; after 10 years of AIDS in Cambodia, it is now time for longer-term research and intervention programs that are not aimed at demonstrating results in one- or two-year “emergency” intervention modes, but at developing longer term solutions.

⁹⁹ Pigg, 2001a; Pigg, 2001b.

¹⁰⁰ Ministry of Education, Youth, and Sport, 2000a; Ministry of Education, Youth, and Sport, 2000b.

¹⁰¹ See Chap Phoung and Escoffier, 1996; Ministry of Health, 1998; and USAID, 2001.

¹⁰² Beaufils, 2000.

¹⁰³ Interviews with Sarah Knibbs (UNFPA), UNICEF officials, Choub Chamreun (KHANA), and Mr. Ngudup Paljor, MCH advisor, USAID, February 2002. See UNICEF, 2000; USAID, 2001.

Capacity development: The issue of coordination among funding agencies sponsoring capacity-building activities within ministries now needs attention. As noted above, ministries eager for external funding readily agree to participate in capacity-building programs proposed by development agencies. However, when ministries agree to participate in several capacity-building programs simultaneously, this exerts a great deal of pressure on mid-level government staff. The development of a means of coordination among diverse capacity-building programs will ensure that staff participating in such programs are not being pulled in several directions at the same time. It will also ensure that these staff are not gaining “half” skills in several areas instead of the desired skill level in any one area. There is a need to assess the individual’s capacity as it has been developed through programming provided to individual civil service members over the past decade. Future capacity building should then attempt to build on each individual’s knowledge and skills base in a planned and logical manner. Also, when capacity development programs are offered to ministries, there is a need to ensure that the younger staff have access to these programs that often tend to be monopolized by senior (and soon to retire) staff or by the relatives of senior ministry staff responsible for the implementation of such programs.¹⁰⁴

¹⁰⁴ AUSAID has recently taken steps to ensure that overseas study opportunities provided by the Australian government are not manipulated in this manner. Interview, Ms. Marg Johnson, Program Officer, AUSAID.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (ages 15–24) (000's)	2000	2005	2010	2015	2020
Males	1,231	1,697	1,790	1,933	1,794
Females	1,214	1,659	1,748	1,887	1,756
2. Level of Education (%)	2000 Males	2000 Females			
No Education	11.7	21.5			
Primary Incomplete	45.1	47.8			
Primary Complete/Some Secondary	9.8	8.1			
Secondary Complete and Higher	33.2	22.5			
3. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	203	327	342	369	368
Births	113	197	205	221	226
Abortions	59	81	86	92	86
Miscarriages	31	49	51	55	55
4. Unmet Need (%)	2000				
Total Unmet Need (ages 15–19)	37.1				
Total Unmet Need (ages 20–24)	36.1				

Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education was taken from the 2000 Cambodia Demographic and Health Survey (DHS) report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. Total fertility rate (TFR) and age-specific fertility rate (ASFR) for the base year were taken from the Cambodia DHS 2000 report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 49 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 2000 Cambodia DHS report.

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