

# DANGEROUS PLACES

Alcohol

A Discussion of the Process and Findings of PLA Research with Policemen in Svay Rieng, Cambodia

ocial life

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**condoms**

**"We have to use condoms and always carry condoms in our pockets."**

.....

**"Sex workers do know how to use the condoms and they are aware of the issues. ...they tell us to use condoms when we have sex with them."**

.....

**"If we are heavily drunk, we avoid using condoms even if we are given the condoms and told to use them."**

**sex wo**

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## **LIST OF ACRONYMS**

<b>AIDS</b>	<b>Acquired Immune Deficiency Syndrome</b>
<b>BAHAP</b>	<b>Border Areas HIV/AIDS Prevention</b>
<b>BSS</b>	<b>Behavioural Surveillance Survey</b>
<b>CHC</b>	<b>Cambodian Health Committee</b>
<b>FHI</b>	<b>Family Health International</b>
<b>HIV</b>	<b>Human Immuno-deficiency Virus</b>
<b>HSS</b>	<b>HIV Sentinel Surveillance</b>
<b>IEC</b>	<b>Information Education Communication</b>
<b>NGO</b>	<b>Non-governmental Organisation</b>
<b>PLA</b>	<b>Participatory Learning and Action</b>
<b>STD</b>	<b>Sexually Transmitted Disease</b>
<b>USAID</b>	<b>United States Agency for International Development</b>

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# FOREWORD

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The Border Areas HIV/AIDS Prevention Project (BAHAP) was established to promote changes in individual behaviours and the social environment of border areas in order to reduce the spread of HIV/AIDS in mainland Southeast Asia. Some border environments in the region have been identified as 'high risk' due to unsafe sexual encounters that form as a result of social vulnerability, patterns of sexual exchange for money, shelter or other means of survival; tourism, trading and transportation. These risks are especially pronounced among young people, many of whom have limited access to resources, limited power, and responsibilities to support their families.

*Participatory Learning and Action (PLA)* is a set of techniques that have been employed in border areas and among other vulnerable groups around the world in order to catalyse and strengthen a community's response to the HIV/AIDS epidemic. These techniques engage community members, including young people, to analyse their risks and behaviours, and identify social institutions and appropriate responses to create healthier and more supportive environments. The BAHAP Project strategically selected policemen to participate in this process to understand their own risks, and to appeal to their roles as gatekeepers and protectors of the safety of young people. It is clear from this report that policemen are necessary participants in a successful border project, due to their own risky behaviours, and the power and influence they exert in border areas.

The FOCUS on Young Adults Program is grateful for the opportunity to work with CARE Cambodia in applying the PLA techniques used in this report. We have been particularly impressed with how, through participating in the PLA process, the BAHAP staff have developed a deep understanding of the issues, strong relationships with the communities, and analytical and problem-solving skills to respond to the current and future needs of the project. We believe that the process of involving critical members of vulnerable communities allows us all to learn much about their needs and capacities in responding to this public health emergency.

**Dr. Katherine C. Bond**

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*Tulane University/FOCUS on Young Adults Program*

# ACKNOWLEDGEMENTS

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**CARE** Cambodia gratefully acknowledges the support and assistance of the many individuals who took part in the Participatory Learning and Action research process. For the police officers who shared their ideas and experiences with us, we offer our sincere thanks and appreciation for their time, patience and honesty. CARE hopes that the information that they generously provided can be used to develop targeted, useful, and participatory STD/HIV/AIDS prevention initiatives.

Special thanks are also extended to members of the research team, who displayed curiosity, courage and dedication when tackling these somewhat new methodologies. They are:

<b>Keo Sochada</b>	<i>Assistant Director</i>	<i>Cambodian Health Committee</i>
<b>Kong Visal</b>	<i>Field Project Officer</i>	<i>CARE International</i>
<b>Noun Visal</b>	<i>Health Educator</i>	<i>Cambodian Health Committee</i>
<b>Pum Sophiny</b>	<i>Senior Project Officer</i>	<i>CARE International</i>
<b>Som Thavy</b>	<i>Health Educator</i>	<i>Cambodian Health Committee</i>
<b>Sun Sath</b>	<i>Health Coordinator</i>	<i>Cambodian Health Committee</i>

The research team was supported by Chea Tina, who organised all transport and refreshments during the workshops and research sessions. Also indispensable was Alexandra Maclean, a PLA specialist, who provided technical assistance to the team over a two-month period. Alex analysed the results of the PLA research, and compiled the findings into a thoughtful and comprehensive study (contained in section two of this report). She was aided by a number of individuals: Mak Sourneak did a fantastic job translating the hoardes of materials; Kong Visal helped to clarify difficult concepts; Sann Veasna and Tan Srey copied the visual outputs; and Pum Sophiny compiled the glossary and checked translations. Other individuals read report drafts and offered useful comments and support. They include Caroline Francis, Julie Forder, Sarah Knibbs, Charlotte Colvin, Kate Bond, Catherine McKaig, Susan Rae Ross, Jonathan Patrick, and Jeanette Kesselman.

Learning and applying the PLA techniques in the Border Areas HIV/AIDS Prevention Project (BAHAP) was made possible by a grant from USAID, with joint programming funds from CARE International and the FOCUS on Young Adults programme. CARE International in Cambodia gratefully acknowledges the financial and technical contributions from these organisations and the individuals therein, especially Kate Bond, Susan Rae Ross, and Catherine McKaig. We would also like to highlight CARE Zambia's groundbreaking PLA draft manual, titled "Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents," which served as a guide for our activities.

# EXECUTIVE SUMMARY

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This report presents a précis of the process and findings of Participatory Learning and Action (PLA) research with police officers in Svay Rieng province, Cambodia. The information and experiences collected in the report were compiled by staff and partners of the Border Areas HIV/AIDS Prevention Project (BAHAP), implemented by CARE International in Cambodia and the Cambodian Health Committee. In March 1999, CARE Cambodia received short-term funding from USAID, FOCUS on Young Adults and CARE International to trial a Participatory Learning and Action manual developed by CARE Zambia. Over a period of four months, the BAHAP project received technical support to adapt the PLA tools to its particular context, to provide training and support for research staff, and to analyse and compile the research findings.

Section I of *Dangerous Places* chronicles the process of learning and applying PLA tools. It details the process of selecting PLA participants, and identifying and training the research team. It lists the materials necessary for PLA activities and the manner in which PLA activities were recorded. It captures some of the experiences of the BAHAP research team, particularly their difficulties and their successes in using the PLA tools. Finally, this section highlights lessons learned during the application process.

Section II of the report presents the findings from a 3-day PLA session with 14 male police officers. The objectives of the research were as follows: (1) to understand the health seeking behaviours of police officers in Svay Rieng; (2) to identify the levels of knowledge and the attitudes of these men in the area of STDs/HIV/AIDS; (3) to understand the sexual relationships and behaviours of the police; and (4) to assist these men to learn, share and analyse their knowledge, attitudes and behaviours for better sexual health. Over the three-day period, the police participants talked with surprising frankness about these topics and other issues of concern. Results were then analysed and the findings presented to police officials and governmental representatives in Svay Rieng in an effort to develop more relevant STD/HIV/AIDS prevention initiatives for this vulnerable sub-population.

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# INTRODUCTION

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In March 1999, CARE International in Cambodia received short-term funding from USAID, FOCUS on Young Adults and CARE International to trial a Participatory Learning and Action manual developed by CARE Zambia.<sup>1</sup> Funds were divided between two CARE Cambodia projects: (1) the Sexual and Reproductive Health Project; and (2) the Border Areas HIV/AIDS Prevention Project (BAHAP). Over a period of four months, each project received technical support to adapt the PLA tools to their particular contexts, to provide training and support for research staff, and to analyse and compile the research findings. This report details the PLA research process as implemented by the Border Areas HIV/AIDS Prevention research team among police officers in Svay Rieng province, Cambodia.

## ***Dangerous Places* is divided into two broad sections:**

**Section I** chronicles the process of applying the PLA tools to the Cambodian context, selecting the target population, and training the research team(s). This section also highlights lessons learned during the application process.

**Section II** of the report details the findings from a 3-day PLA session with 14 male police officers. With surprising frankness, the police discussed their health seeking behaviours; their knowledge of STDs and HIV/AIDS; their sexual behaviours; and their relationships with friends and partners. Recommendations which follow from the findings were shared with the police participants in August 1999, and will be used to develop participatory STD/HIV/AIDS prevention interventions in the province.

## THE BORDER AREAS HIV/AIDS PREVENTION PROJECT

The Border Areas HIV/AIDS Prevention Project (BAHAP) is a regional project that brings together the countries of Cambodia, Thailand, Laos, and Vietnam. Implemented by CARE International - through USAID funding provided by Family Health International - the project seeks to provide STD/HIV/AIDS messages and services to persons on both sides of border crossings. The assumption is that such messages and services will have a greater impact if they are reinforced at "twin" border sites. The aim of the project is to promote behavioural and contextual change in an effort to make these areas safer environments or catchment areas. Concentrated prevention efforts in these areas of affinity, through which an increasing number of people pass and/or reside, will thus contribute to reducing the spread of STDs/HIV/AIDS throughout Southeast Asia.

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<sup>1</sup> For information on the CARE Zambia manual, please see: Meera Kaul Shah et al. (1999), *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents*. CARE International in Zambia, FOCUS on Young Adults.

BAHAP was first piloted in October 1997 and received funding for an additional two years in November 1998<sup>2</sup>. The objectives for Phase Two of the project are as follows:

1. Conduct site assessments in identified border areas.
2. Demonstrate attitudinal and behavioural changes among selected target populations for the prevention of STDs/HIV/AIDS.
3. Reduce the contextual risk factors in border areas.
4. Increase the capacity of local partner(s) to plan, implement, monitor and evaluate HIV/AIDS programs.
5. Develop a model for cross-border HIV/AIDS interventions.

In Cambodia, BAHAP operates in two provinces: Koh Kong<sup>3</sup> and Svay Rieng. Svay Rieng province borders Vietnam in the southeastern part of the country. The provincial capital, Svay Rieng town, boasts a population of 21,205. Roughly 10,667 people live in the border town of Bauvet.

National Highway #1 passes through Svay Rieng and Bauvet, and connects Cambodia's capital, Phnom Penh, to Ho Chi Minh City in Vietnam. Not surprisingly, these communities see their share of both short and long-term visitors. Cambodians from different parts of the country also migrate to the area in search of employment opportunities, for reasons of marriage, and/or to be near family members.

The people of Svay Rieng province earn a living primarily through *rice farming, logging, palm tree cultivation, animal stock raising (e.g. cows, pigs, chickens), and the cross-border trading of goods*. A smaller proportion of the population is involved in service occupations, such as *transportation workers, beer promotion women, sex workers, and police officers*.

HIV prevalence rates for the period of 1998 show that 25% of sex workers in Svay Rieng were *HIV positive*. Data further indicates that *risk behaviours are widespread among sex workers, their clients and youth/young people (UNAIDS Provincial Profile 1999)*. CARE Cambodia has subsequently partnered with a local non-governmental organisation—the *Cambodian Health Committee*—to provide *STD/HIV/AIDS prevention education to vulnerable groups in the area*. They include *sex workers, beer promotion women, motortaxi drivers, married women, and most recently, police officers*. Tandem interventions take place in the Vietnamese site of Tay Ninh, in an effort to contain the virus and prevent its spread.

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<sup>2</sup> In Phase 1 of the project, CARE Cambodia focused on the single site of Svay Rieng. The goals of the overall project, too, were revised and particularised following the end of the first phase.

<sup>3</sup> Koh Kong site activities had not yet commenced when BAHAP field tested the PLA manual, and as such, all PLA research took place in Svay Rieng province.

## HIV/AIDS IN CAMBODIA

HIV was first detected in Cambodia through the serologic screening of blood donors in 1991. In 1993, the first cases of AIDS were diagnosed. The completion of a HIV sentinel surveillance (HSS) survey in 1995 indicated that HIV cases were distributed among different population groups. Among those found to be at risk for contracting HIV were commercial sex workers, police/military, and pregnant women attending antenatal clinics in high risk areas.

Subsequent HIV sentinel surveillance surveys (1996, 1997, 1998) suggest that the epidemic is poised to overtake Thailand and Myanmar as the worst in Asia. The 1998 national results show that 6.2% of police personnel, 2.4% of married women, and 41% of sex workers aged 15-19 years are infected with the virus. Even more alarming is the fact that HIV is spreading to groups previously at low risk. Young adults (aged 15 - 29 years) were found to have the highest infection rates; women aged between 15 - 45 years have been identified as the largest at-risk group. Approximately 180,000 Cambodians are currently infected with HIV and/or AIDS, the majority of whom will die in their most economically productive years. Recent HSS results also indicate that the epidemic has moved beyond the cities and towns, into the villages of the countryside. Highest prevalence rates are currently found in the southeast and central provinces and along the Cambodian-Thai border. The spread of the virus is fueled by factors such as mobility/migration, poverty, availability of commercial sex, and the reluctance to use condoms with persons deemed "low risk" (e.g. young/beautiful/"clean" men or women, indirect sex workers, spouses et cetera). As a consequence, the epidemic is becoming increasingly generalised.

Heterosexual transmission accounts for the largest proportion of HIV exposure. Current evidence further suggests that the presence of a sexually transmitted disease (STD) substantially increases the likelihood for contracting HIV. In Cambodia, high STD prevalence has contributed to the spread of the HIV virus. Data on other transmission modes - such as *homosexual intercourse and injecting drug use* - remains negligible.

4 In addition to the loss of labour, the indirect costs of HIV/AIDS to the Cambodian economy have been estimated at approximately USD \$2 billion by the year 2006 (National Strategic Plan Draft for STD, HIV, AIDS Prevention and Care in Cambodia, 1998, 2000). National AIDS Program, Ministry of Health.

5 Migration may be external (between countries) or internal (within a country).

6 See *Southeast Asian Subregion Response to AIDS: A Strategy for HIV/AIDS Prevention and Care in the Mekong Subregion*.

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# SECTION 1: APPLYING PLA TOOLS

## RATIONALE FOR USING PLA

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In many current STD/HIV/AIDS prevention initiatives, target populations are encouraged to engage in "safer sex" activities in an effort to reduce HIV prevalence rates. Such messages include abstinence from sexual intercourse; using condoms when having sex (particularly commercial sex); practising monogamy or "one-to-one" love; and focusing on non-penetrative sexual activities. The manner in which messages are disseminated to the target populations may assume numerous forms. In some cases, outreach and/or peer educators may be commissioned to provide prevention education to individuals deemed "at risk." In other cases, information education communication (IEC) materials, such as posters or leaflets, and condoms are distributed to vulnerable target communities. In still others, drama or theatrical events may be used to relay information in a culturally appropriate manner.

Whatever the form, it is clear that simply providing information or "telling people what to do" without input from the persons involved is insufficient and a trifle insulting. Individuals, whether they be youth, motortaxi drivers or commercial sex workers, must be given the opportunity to discuss and analyse their sexual behaviours, and the impact these behaviours have on their lives. Allowing target populations to develop their own responses to issues like HIV/AIDS will make subsequent interventions more informed, effective and, ultimately, more sustainable. The question is "how can this be done?"

Participatory Learning and Action, or PLA<sup>7</sup>, is a body of approaches that "enable local people to analyse, share and enhance their knowledge of life and its conditions, and to plan, prioritise, act, monitor and evaluate based on this knowledge" (see Meera Kaul Shah 1999). Certain key principles underpin the methodologies. They include<sup>8</sup>:

- *Programmers learn directly from the local community, rather than vice versa;*
- *Listening replaces lecturing; probing is used to understand issues; the opinions of marginalised groups within the community are sought out;*
- *Diversity of information, opinions and expressions is encouraged;*
- *Facilitators are constantly challenged to examine their own behaviours and biases;*
- *Sharing of information and experiences within and between communities is emphasised.*

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<sup>7</sup> PLA is known by several other labels, among the most common being Participatory Rural Appraisal (PRA).

<sup>8</sup> See Meera Kaul Shah et al. (1999), *Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents*. CARE International in Zambia, FOCUS on Young Adults, for a more thorough discussion of PLA foundations.

PLA techniques arose in the late 1980's in response to the need for ways to involve local communities in rural development projects being implemented in their areas. However, the application of PLA tools to topics such as sexual health<sup>9</sup> is relatively new. CARE Zambia's recent utilisation of PLA methods to understand the sexual health of Lusaka's young people was chosen as a guide for PLA activities in other contexts. The Border Areas HIV/AIDS Prevention Project, in particular, offered a unique opportunity to test the efficacy of such PLA methods in a variety of different geographical and cultural settings<sup>10</sup>.

## PREPARATION FOR PLA

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### TIMING

In March 1999, CARE Cambodia received funds<sup>11</sup> for field testing the CARE Zambia PLA manual. The funding ran for a period of four months, and was to be used for the adaptation of PLA tools; a PLA workshop for BAHAP regional partners; more extensive technical support for the BAHAP Cambodia research team; the analysis of research findings; and the compilation of a synthesis report<sup>12</sup>.

The services of a PLA consultant were secured as the project commenced. Alexandra Maclean provided technical support to both the BAHAP and Sexual and Reproductive Health project teams. She was also responsible for analysing the research materials and preparing the final synthesis reports. The consultant's analysis of the PLA research with police officers is contained in section II of this report.

### IDENTIFICATION OF PLA PARTICIPANTS

In order to qualify for this particular funding window, PLA research was to focus on young people, or in some way directly benefit young people in the area under consideration. "Young people", it should be noted, refers to boys/men and girls/women aged 15 - 29 years.

Police officers in Svay Rieng town (Svay Rieng province) were consequently chosen as a suitable target group. Approximately 770 police officers currently reside in Svay Rieng town.<sup>13</sup>

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9 Sexual Health is defined as the knowledge, attitudes, skills and abilities required to make safer sexual decisions in all areas of sexual being.  
10 BAHAP programs in eight border sites, representing four cross-border settings (e.g. Cambodia-Thailand; Thailand-Laos; Laos-Vietnam; and Cambodia-Vietnam).

Police work is a popular career choice for young men, as other economic opportunities in the area are largely limited. Very few women enter the uniformed services, perhaps because of the dangerous and patriarchal nature of the work. While little substantive information is available on the sexual attitudes and behaviours of this group, national HIV sentinel surveillance surveys and behavioural surveillance surveys identify the police as vulnerable for contracting STDs or HIV. Last year's (1998) HIV sentinel figures, for example, cited HIV prevalence among the police at 6.2% country wide.

Police officers - by virtue of their status and their power vis-à-vis other occupational groups - are also important "gatekeepers" in the community. They are the ones entrusted with keeping the peace, withholding the laws, and protecting members of their areas. Many HIV/AIDS prevention initiatives - for example, the national 100% condom use policy in brothels recently initiated by the Royal Government of Cambodia - rely on police support for their success. Accordingly, the police are an important, albeit under-utilised, resource in the fight against AIDS.

CARE Cambodia and the CHC contacted Svay Rieng police officials in March 1999 to ascertain commitment for their involvement in the PLA research process. The chief of the police department expressed enthusiasm for the project and explained that he would personally choose representatives from each of the police bureaux (e.g. fire, prisons, administration, finance, et cetera). Criteria for the participants, particularly with respect to age and marital status, was explained to key officials before the research progressed. However, higher ranking officers (who were inevitably older than their younger ranking counterparts) felt that they should be given the opportunity to participate in the initial research. The hierarchical nature of police institutions - and Cambodian society in general - implied that future support of the police department may be compromised should members of the PLA team insist on other participants. And while the participants who eventually participated did not fit in the "young adult" age bracket<sup>14</sup>, they are respected role models for their younger colleagues. The participants' knowledge levels, attitudes and behaviours, then, may shed some light on the knowledge, attitudes and behaviours of younger colleagues.<sup>15</sup>

## IDENTIFICATION OF, TRAINING AND SUPPORT FOR PLA RESEARCH TEAM(S)

Preparation for the PLA research process involved training and support of research teams at two different levels:

- 1. Training of BAHAP regional partners;**
- 2. Identification of, training and support of BAHAP Cambodia research team.**

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<sup>14</sup> The policemen who participated in the research were between 28 and 39 years in age.

<sup>15</sup> BAHAP is currently developing participatory HIV/AIDS interventions with these lower ranking police officers.

In March 1999, members of the regional BAHAP network were exposed to PLA techniques during a four-day workshop in Phnom Penh. The workshop brought together three representatives from each BAHAP country. They included the BAHAP project coordinators - the majority of whom were expatriate; senior project officers; and field project officers from the various CARE offices.<sup>16</sup> Over the course of the workshop, participants practised using the PLA tools, and explored ways in which these tools could be applied to each BAHAP site. The mood during the sessions was generally spirited, enthusiastic, and often full of hilarity. However, the limited time frame of the workshop did not allow for comprehensive learning and some participants were frustrated at their perceived inability to share and apply the information. As one participant from Vietnam explained:

***"The PLA methods are enjoyable for both the facilitator and participant. I think they would be great to use in Vietnam . . . but I don't feel I know enough yet to be able to train our counterparts."***

Following the workshop in March, PLA training continued with the BAHAP Cambodia research team. The core team consisted of four employees from the Cambodian Health Committee and two CARE Cambodia staff. Of these six individuals, three were male and three female.<sup>17</sup> Four additional CHC staff members and one Ministry of Health official also attended the training workshops, although they were not involved in the PLA sessions with police officers.

Subsequent PLA training workshops occurred over a two-week period in April, 1999. Again, the aim of the workshops was to introduce and practise using PLA tools; to explore the participants' fears and concerns when talking about sexual health topics; to discuss and clarify the PLA research objectives; and to improve the participants' facilitation, note taking and observing skills. This extra training time proved crucial for many members of the research team, who had some difficulty supplanting their role of "teacher" to that of "learner". Following numerous discussions and practise sessions, participants felt more comfortable in their new roles. According to one researcher, the practise sessions afforded numerous opportunities for learning together as a group:

***"When we are divided into small groups, we work actively and happily. Some people hold the marker pen to write, some sit and voice ideas to the group, some sit and correct [voice alternate opinions], and some sit and joke. Some speak low and some speak loudly. Some times we debate together and everyone speaks at the same time. Other times, we are quiet and think to ourselves. Together we learn many things."***

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16 Because of funding restrictions, partners or counterparts were unable to attend the PLA workshop. One of the aims of the workshop was to familiarise participants with PLA methods, so that they could pass on this information to their colleagues and partners.

17 Three members of the research team were aged 29 years or younger.

## APPLICATION OF PLA RESEARCH TOOLS

The PLA research with police officers in Svay Rieng had four main objectives. They were

1. To better understand the health-seeking behaviours of the police in Svay Rieng town;
2. To identify the levels of knowledge and attitudes of the police in the area of STDs/HIV/AIDS;
3. To understand the sexual relationships and behaviours of these men;
4. To assist the police in Svay Rieng to learn, share and analyse their knowledge, attitudes and behaviours in the area of sexual health.

A draft framework for adapting PLA tools for work with the police was first developed during the regional PLA training workshop. This framework was further revised following discussions with the research team and members of the Sexual and Reproductive Health project. The final document included a listing of important topics for discussion during the research sessions, and a description of PLA tool "tips" for the researchers, who voiced concern that they would "forget" how to carry out the activities without a set of guidelines in hand. This document is included in attachment #1 of the report.<sup>18</sup>

## PLA LOGISTICS

PLA research with the police took place over a three-day period on the grounds of the police headquarters. All police participants were provided with a \$3/day per diem, to cover the equivalent of lost earnings, and were given refreshments throughout each day, to offset fatigue during the long hours. No organisational difficulties (in terms of organising the venue/participants) were experienced by the researchers, despite the fact that the Cambodian New Year's holiday had been celebrated just a week previously.

During the research, the team divided into two groups of three persons. Each group of researchers was paired with a group of police participants. All research team members assumed specific roles, such as facilitator, observer or note taker. These roles did not change, for example, a facilitator remained in this role throughout the duration of the research. Such continuity over the three days allowed the researchers and participants alike to become comfortable and fostered a sense of continuity and familiarity which is illustrated in the research findings.

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<sup>18</sup> For more information on the application of PLA tools, please see Julie Forder (1999), *PLA Tools in Action: Lessons Learnt During a Sexual Health Needs Assessment with Cambodia's Young Garment Workers*, CARE International in Cambodia

In order for the researchers to conduct the PLA research sessions, the following materials were required:

- permanent markers
- large sheets of paper
- A4 sheets of paper
- coloured paper - e.g. blue, yellow, pink, green
- scissors
- masking tape
- notebooks
- tape recorders
- cassettes
- batteries
- camera
- bean seeds
- condoms
- leaflets with information on STDs and HIV/AIDS
- pens of different colours
- pencils
- highlighter pens
- rulers
- mats for sitting on (if outside)

## DOCUMENTATION OF PLA SESSIONS

### FIELD NOTES AND DAILY REPORTS

All PLA research sessions were recorded by note takers, who detailed discussions by hand and by tape recorder. Each group of police was assigned one note taker. Not surprisingly, it proved difficult for the note takers to write down all conversations. Participants often spoke quickly and/or more than one person spoke at the same time. Note takers sometimes "filtered" conversations, even when instructed to record everything that was said. Tape recorders, in these cases, were used to fill in the gaps.

At the end of each day, researchers met to reflect on the day's process and to share their experiences. Visual outputs were copied and field notes revised, if necessary. Researchers also used this time to provide feedback to one another and to plan for the next day's fieldwork. Not surprisingly, the days were long, often the researchers were still working at 10:00 p.m. in the evening.

### FINAL REPORT

Following the conclusion of fieldwork, field notes and daily reports were translated and PLA research findings analysed.<sup>19</sup> The results were then compiled into a final report. As illustrated in Section II of the report, responses were diverse - reflecting both complementary opinions and contradictory convictions. Recommendations arising from the research have been presented to the police and will now be used to develop participatory HIV/AIDS prevention initiatives.

# LESSONS LEARNED

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## BENEFITS & CHALLENGES

The process of learning PLA techniques and applying them to research with the police was enjoyable for both BAHAP staff and partners. "It's so fun!" exclaimed a CHC staff member. "I would like to use PLA with all of our target groups." Her comments were echoed by all team members, each of whom displayed enthusiasm for using PLA methodologies in other aspects of the project.

The positive tone of the evaluation, however, was tempered by some challenges voiced by the staff and/or advisors during the PLA research process. These challenges can be grouped as follows:

1) *Four months is a short time.* All staff members worked feverishly during the four-month life span of the project. Learning the PLA techniques, contacting and accessing the target population, compiling visual outputs, field notes and daily activity reports took the majority of the time allocated. In the end, time restraints limited the extent to which staff were able to analyse the data. Being involved in the latter stages of the research would have provided members of the research team with opportunities to triangulate or sort information and to discover themes and discrepancies in the responses. It would have also illustrated, perhaps, reasons as to why probing is necessary to ensure high-quality results.

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<sup>19</sup> Because of the short-term nature of the funding, findings were analysed by the PLA consultant. She regularly sought assistance from the members of the research team to clarify issues and/or assist with the interpretation of the results.

2) *Being "learners" rather than "teachers"*. Without exception, members of the research team had difficulty supplanting their role of "teacher" to that of "learner". Numerous discussions in the PLA training workshops, and even during the PLA research sessions with police, involved the "what do we do if the participants say something wrong" scenario. Some of the discussions were surprisingly spirited, as evidenced in the following dialogue:

- ***"Group discussions should have one opinion [group discussions should end in agreement]."***
- ***"No! I think that group discussions [should be used] to get the opinions from the group."***
- ***"I disagree . . . [as a facilitator] I want one opinion, especially if they say or draw something incorrect."***
- ***"You are wrong!!!!!"***

Using the term "research" to describe the PLA process calmed the team members somewhat, since research is usually done to "discover" some hidden information. Nevertheless, more support must be provided to the members of the team in order to assist them in facilitating, and ultimately accepting, expressions of diverse opinion.

3) *Probing is difficult*. Very few members of the PLA team had extensive research experience, nor had many attended university, where opportunities for critical thinking are more abundant. As such, probing, and the rationale behind it, was a difficult concept to grasp. The PLA specialist attempted to spur inquiry by asking the group questions about the reasons "why people think, do or say certain things." Such questions facilitated discussions between the researchers and stimulated further questioning processes. However, a small minority of group members became frustrated with the lines of inquiry and felt that the PLA specialist was speaking in a manner better suited for "persons in higher positions". Said one:

***"Whenever I ask a question, [the PLA specialist] never answers back. On the contrary, she always answers with another question. This causes me to think that I am ignorant and I do not dare ask more."***

4) *Sheer amount of materials*. During the PLA research with police, the amount of materials generated was enormous. They included transcripts of discussions, verbal outputs, field notes and daily research reports. All materials were in the Khmer language and then translated into English so that results could be analysed and a report completed. Translating costs were large and the time involved to complete the translation process was long. To streamline costs in the future, members of the research team suggested using particular PLA tools, such as listing and ranking, which require less probing on the part of the facilitator; conducting PLA sessions over shorter time periods; and/or reducing the number of participants.

## FUTURE PLANS

In August 1999, results from the PLA research with police were presented to groups of police officers, government officials, and health providers in Svay Rieng province. Following discussions about the significance of the findings, it was decided collectively that future STD/HIV/AIDS prevention initiatives with the police must involve them in all aspects of project implementation and monitoring. BAHAP is now meeting with police officials to develop a STD/HIV/AIDS prevention curriculum and to identify police peer educators to carry out subsequent activities.

On a more general level, the process of learning and applying PLA tools have led members of the research team to advocate for their greater use in other areas of the BAHAP project (e.g. outreach activities, monitoring, utilisation with additional target populations). Accordingly, two Cambodian nationals with PLA expertise were commissioned to provide technical support for BAHAP staff and partners during PLA research with motortaxi drivers and commercial sex workers in Koh Kong, Cambodia. Participatory outreach curricula for military personnel, sex workers, married women, and transportation workers have also been developed and tested. Finally, all team members have been encouraged to compile detailed outreach reports, using a monitoring checklist developed by the team. Through these and other participatory interventions, BAHAP hopes to better assist individuals to make safer sex decisions which will ultimately lead to an improvement in their sexual health.



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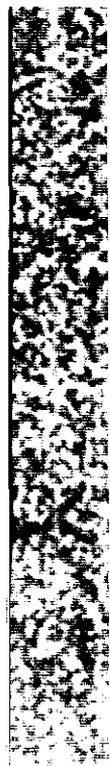
# **ATTACHMENT 1:** ADAPTATION OF PLA TOOLS

## BAHAP/CHC PLA RESEARCH ACTIVITIES WITH POLICEMEN

SVAY RIENG

27 ~ 29 APRIL 1999

**BORDER AREAS HIV/AIDS  
PREVENTION PROJECT  
CARE INTERNATIONAL  
IN CAMBODIA**



## RESEARCH OBJECTIVES

1. To understand the health-seeking behaviors of policemen in Svay Rieng
2. To identify the levels of knowledge and the attitudes of policemen in Svay Rieng in the area of STD/HIV/AIDS
3. To understand the sexual relationships and behaviors of policemen in Svay Rieng
4. To assist policemen in Svay Rieng to learn, share and analyze their knowledge, attitudes and behavior about sexual health

## TOPICS TO DISCUSS

Below are some topics which it may be interesting to discuss in order to meet the research objectives. These topics are based on the questions brainstormed during the Training Workshop, 5 - 9 April. They have been adapted from specific and closed questions to broader topics for exploration. If you can think of more please share these with the group.

### **LIVES IN THE COMMUNITY**

*Where participants live*

*Who participants live with*

*Where participants work*

*What participants do at work*

*Important institutions*

*Important services*

*Important people*

*Where participants go*

*What participants do in their free-time*

*Who participants spend time with*

*General concerns*

## KNOWLEDGE

*Knowledge about reproductive system*

*Knowledge about HIV/AIDS:*

- symptoms
- frequency
- severity
- causes/transmission
- treatment

*Knowledge* about STDs

- symptoms
- frequency
- severity
- causes/transmission
- treatment

*Knowledge* about contraception

*Knowledge* about condoms and condom use

- reasons for use
- how to use

Sources of *information* and *knowledge*

ATTITUDES

*Attitudes* towards marriage:

- ideal age to marry (for men & for women)
- preferred qualities in marriage partners
- attitudes to sex outside marriage

*Ideal* family size

*Attitudes* to contraception:

- what do participants think about contraception
- preferred types of contraception
- who makes decisions about contraceptive use
- conditions under which contraception is used
- conditions under which contraception is not used

In case of pregnancy, who takes *responsibility*

*Attitudes* towards condoms and condom use

*Attitudes* towards men & women with STDs

*Attitudes* towards men and women with HIV/AIDS

*Perception* of risk of infections from sex

*Preferred* qualities in sexual partners

## BEHAVIOURS

Who do people feel comfortable to talk to about their problems?

Health-seeking behavior: where people go; for what illnesses; Why - what factors influence these decisions. Are there different health-seeking behaviors for STDs compared to other illnesses

What is the ideal family size?

When do couples initiate sex in a relationship?

Who initiates sex in a relationship? When?

Who decides whether or not to use contraception?

Who decides on the form of contraception used?

What is discussed about AIDS within families?

Who looks after people with AIDS?

Why have sex?

Why have no sex?

Number of sexual partners and number of reasons

Preferred qualities in sexual partners

Use of condoms:

- With whom?
- Why?
- Why not?
- How often?
- Where are condoms available from? How much?
- Payment for sex



## TIPS ON USING THE PLA TOOLS

Here are some notes on using the PLA tools. The purpose of each tool is given and some suggestions on how to do it.

### ***For each tool:***

Tell participants what it is you would like to discuss

Start a discussion

Ask the participants to do the activity

Leave the group while participants are drawing or writing

When you return, you must discuss everything that the participants have drawn or written. Some prompt questions are suggested here for each tool. **These are just a few ideas to get you started, not a questionnaire.** You must ask about everything, and follow-up answers.

---

SOCIAL MAPPING: *this tool is to help us understand more about the community and the lives and work of the participants in the community*

Ask participants to draw a map of Svay Rieng showing the places that they live and work, the places that they go and other important places

Ask about everything participants have drawn

### **PROMPTS:**

Where participants live?

Who they live with?

Where do they work?

Where do they go where they are at work?

What other places are important? Who goes there? Why? Who with? When?

Where do they go in their free-time? Who do they go with?

Who do they meet there?

What do they do there?

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VENN DIAGRAM: *this tool is to help us understand the key institutions, services and people in the lives and work of the participants*

Ask participants to put a large circle representing themselves on the paper. Then ask them to cut circles to represent key institutions, services and people. The size of the circle and the distance from the main circle shows the importance of the institution, service or people.

Ask about everything participants have drawn.

**PROMPTS:**

Why are institution/service/people important?

How often do participants contact with the institution/service/people?

Do they contact directly themselves?

How easy or difficult is it to contact with the institution/service/people? Why?

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FREE-TIME ACTIVITIES: *this tool is to help us understand more about participants' lives in the community*

Ask participants to make a list of all their free-time activities. Ask participants to rank in order of preference.

Ask about everything participants have written.

**PROMPTS:**

Who do they do these activities with?

Where do they do these activities?

When do they do these activities?

What other people do the same activities?

-----

GENERAL CONCERNS: *this tool is to help us learn more about general concerns*

Ask participants to list General Concerns; Rank in order of importance. Suggest possible solutions.

Ask about everything participants have written.

**PROMPTS:**

How common are these problems?

**GENERAL HEALTH CONCERNS: *this tool is to help us learn more about general health concerns***

Ask participants to list general health problems; Rank in order of severity; Rank in order of frequency; Describe what people do when they have each problem

Ask about everything participants have drawn

**PROMPTS:**

- Ask about: Symptoms
- Routes of transmission
- Ways to protect
- Seasonality
- Consequences of illness
- Perceived risk

**MEN'S SEXUAL HEALTH CONCERNS: *this tool is to help us learn more about men's health concerns***

Ask participants to list men's health problems; Rank in order of severity; Rank in order of frequency; Describe what people do when they have each problems

Ask about everything participants have drawn

**PROMPTS:**

- Ask about: Symptoms
- Routes of transmission
- Ways to protect
- Seasonality
- Consequences of illness
- Who contracts these illnesses most commonly

**WOMEN'S HEALTH CONCERNS: *this tool is to help us learn more about women's health concerns***

Ask participants to list women's health problems; Rank in order of severity; Rank in order of frequency; Describe what people do when they have each problems



**PROMPTS:**

Ask about:       Symptoms  
                       Routes of transmission  
                       Ways to protect  
                       Seasonality  
                       Consequences of illness  
                       Who contracts these illnesses most commonly

---

**BODY MAPPING:** *this tool is to help us learn about knowledge and attitudes concerning sexual health*

Draw map of male body

Ask about everything participants have drawn

**PROMPTS:**

Ask about:       what the different organs are -  
                       what the different organs are for  
                       Where do babies grow  
                       How babies get out of the mother  
                       How do contraceptives work  
                       What organs do sexual health problems affect

Draw map of female body and repeat above

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**PICTURE STORIES:** *this tool is to help us understand about relationships and sexual behavior*

**1. What typically happens when a man and a woman start a relationship**

Ask about everything participants have drawn

**PROMPTS:**

Who starts the relationship? How would they take the initiative? Where would they meet? How do they spend their time together? What are the woman's concerns? What are the man's concerns? After how much time of knowing each other do they touch/have sex? How do they make contraceptive choices? Will the man tell anyone? Will the woman tell anyone? With how many people will she/he have a relationship? Is money paid for sex?

**2. What typically happens from courtship to marriage?**

**PROMPTS:**

What is the best age to find a marriage partner (for men and for women)? Why? Who is the best person to select as a marriage partner (for men and for women)? Why? Who selects the marriage partner? How long will a man and woman know each other before marriage? What are the man's concerns? What are the woman's concerns? Who makes contraceptive choices? How many children will they have? When will they first have sex?

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ROLE-PLAY: this tool is to help us learn how participants discuss condom use and sexual health problems within relationships

Divide participants into 2 groups. Ask for a volunteer from each group to be the mouthpiece. Tell participants the story and ask them to choose to pretend to be the husband or wife. Tell other participants that they can help the mouthpiece with things to say. When the participants have finished, ask them how they felt.

**Story 1**

*A man has a discharge from his penis. He thinks it is from sex with a sex worker. He has to tell his wife.*

**Story 2**

*A woman has a vaginal discharge. She is worried that it is a serious illness and does not know where it came from. She has to tell her husband. He thinks it is from having sex with another man.*

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CAUSALITY ANALYSIS: this tool is to help us understand the participants' attitudes and behaviour concerning sex and concerning condoms

Draw a large circle in the middle of the paper and write "Why have sex?" in it.

Ask participants to write:

*Reasons for sex (arrows going into the circle)*

*Consequences of sex (arrows coming out of the circle)*

Ask participants to score reasons and consequences for importance

Ask about everything participants have written

**PROMPTS:**

Explain each reason. Why is it important? How common is it?

Explain each consequence. Why is it important? How common is it?

Repeat for:

Why not have sex?

Why use condoms?

Why not use condoms?

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**THOUGHT BUBBLES FOR PREFERRED QUALITIES IN SEXUAL BEHAVIOUR.**  
*this tool is to help us understand the participants' sexual behaviour in greater detail*

Explain that no names are needed, and answers will not be discussed with the group

Ask participants to draw a thought bubble and write the qualities they prefer in a sexual partner

Collect papers

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**PAPER SLIP METHOD:** *This tool is to help us understand the participants' sexual behaviour in greater detail*

Explain that we would like to ask personal questions in order to help us understand more about sexual health and sexual health problems

Explain that it is confidential. The answers will be written on pieces of paper. No names are needed. The pieces of paper will be folded in the same way and collected all together. The note-taker will record the answers, and then tear up the pieces of paper

Explain that if any one does not want to participate they should leave the room for a short while. Everybody in the room must write on the paper

Questions:

Have you ever had sex?

How old were you when you first had sex?

Who did you first have sex with?

Did you want this sex?

How old were you the second time you had sex?

How many partners have you had sex with in the last three months?

How many times have you had sex with a condom in the last three months?

Who have you had sex with without a condom in the last three months?

Have you paid for sex in the last three months?

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## SECTION 2: PLA RESEARCH WITH POLICE

The discussions with the policemen took place over three days. We talked in a secluded part of the grounds of the police headquarters, next to a lotus pond, where the only interruption was the nearby chatter of pet monkeys. The participants enjoyed the discussions: several participants told researchers that they valued the opportunity to talk to each other.

The structure of this report follows, approximately, the chronology of the research. The participants relaxed noticeably as the research went on, and their discussions changed from a review of what they should think and do, to more honest conversations about what they do think and do. These conversations gradually revealed complex layers of concern, knowledge, values, and areas of misunderstanding or misinformation. At the end of the research, the participants had the opportunity to ask questions of the researchers, and most welcomed this opportunity to ask questions about HIV/AIDS.

The participants in the research were divided into two groups of seven men, according to rank and age. Some of the diagrams, maps and pictures produced during the research are included in this report. These were prepared separately by each group of participants, and so are labelled - and referred to in the text - as 'Group 1' or 'Group 2'. In general, however, there were not found to be significant differences of knowledge, attitudes and reported behaviour between the two groups.

The first section of this report discusses the family and community context of the participant's lives. The second and third sections discuss knowledge and attitudes about sexual health problems and health-seeking behaviour. The final section describes the participants' conceptualisations of sexual desire and contexts for sex, and the attitudinal and social framework within which safer sex decisions are made.

# 1. LIFE IN THE COMMUNITY

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The fourteen policemen who took part in the research were aged between 28 and 39 years. All the men except one were married. The participants define many responsibilities for themselves within their families, and are also proud of the contribution they feel their work makes to the wider community. However, they also attach considerable importance to what they consider to be their own needs as men, which are fulfilled outside the family context.

The following two sections describe the participants' perceptions of their lives and the duties and responsibilities they consider to be part of their role as married men. The third section begins by discussing the importance the participants attach to meeting their personal 'needs', and goes on to consider perceptions of social pressure to conform to a expectations of male behaviour.

The final section discusses the participants' concerns about the effects on their health of social pressure to drink and their expressed difficulty in controlling their alcohol consumption. It is concluded that there are significant differences between what the participants say that they should do and what they do. This is partially explained by the participants as resulting from the difficulty of meeting - or resisting - conflicting social expectations.

## 1.1 WORK AND INCOME

The participants are all police officers based in Svay Rieng town. Their ranks vary from one to four 'stripes'.<sup>20</sup> They have a detailed knowledge of local government structures and the relationship of their section of the police force to other departments. They provide the following descriptions of the contribution their work makes to social development:

*"We work in co-operation with the [Rural Development] department, supporting government policy to improve the rural development work."*

*"We are the ones who make sure the security situation at the local level in the province is good so that the development work does not get stuck due to security problems."*

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20 The highest-ranked police officers who took part in the research had four stripes on their uniform and were 'Chiefs of Section'.

However, the participants report that they are not well paid, with salaries insufficient to meet the daily needs of their families:

***"...my salary is very small. My wife's business at home is not going well.  
So my family living conditions are very bad."***

***"...government officials are badly paid, and so the family needs are not met."***

***"Some days we eat good food and some days we eat less delicious food."***

Their salaried jobs are often a part of a wider family livelihood strategy which may include family businesses, working wives, market gardening, and income-replacement activities such as collecting firewood:

***"Today, we are a poor family, but we very much want to have more. I am just trying to work harder in order to increase income and food for the family step by step. That's why at home we plant some vegetables and some other crops to support our family's livelihood."***

## 1.2 FAMILY LIFE

The participants articulate specific duties and desirable behaviour for themselves as married men who are concerned for family welfare. They perceive themselves to be responsible for contributing to the family livelihood, educating the children, organising family outings and protecting the family honour. In Figures 1 and 1a, the participants describe the activities - other than police-work - which they perceive to be most important for their lives. Activities in the house, supporting family livelihood strategies, education or leisure activities with their families were ranked as more important than peer-group-based leisure activities. The participants explain how some of these activities bring prosperity, honour and social approval to the family members:

***"...when we help do housework our families live prosperous and happy lives."***

***"...if we speak many languages we are honoured, and when we are valued and honoured, our family is honoured too."***

***"A house that is well-maintained attracts people to look at it, and brings our family a good reputation with other people."***

An additional role of educator and advisor on family welfare is identified by some participants:

***"...we all realise that people who seldom go out do not learn a lot about general knowledge, education and other things. So we, as men, have to provide those people - our wives and children - all the knowledge about keeping clean, and living in a clean home and village. For example, the kitchen, the bathroom, the living room, and other rooms have to be clean and tidy. In the bathroom, if the water jars are filled with mosquito larvae, the jars have to be drained and cleaned. Some water containers and very small ponds around the village have to be refilled with soil or something so that there are no larvae reproducing in the village."***

While the participants are keen to portray themselves as fulfilling the role they identify for themselves, there is a distinction between what the police say they should do and what, in discussion, they say they actually do. For example, the participants listed taking the family on excursions to beautiful places as the fifth most important free-time activity<sup>21</sup> (see Figure 1), but commented that this might not even happen once a year: they were anxious that listing 'go out alone' was 'less polite' than 'take the family to visit some places'. The statement in Figure 1a illustrates the participants' concern to explain that they perceive family-based activities to be more socially desirable than peer-group based activities, and to stress that they spend most of their free-time with the family.

It seems that the participants' perception of their financial hardship is a factor in their ranking of free-time activities. It is not clear whether the same duties and social values would apply if the participants were better-off financially:

***"I know that the activity number 23 [see Figure 1], 'Go to brothels', is important. But for us and for our people in the province, if we do not help our families, there would be difficulties. That is why we decided to select 'Help do house work in family' as number one. ...I wish Saturdays and Sundays [would] come sooner so that I can help do housework in the family... . Going for joy is for people who have lots of money. For us, we don't have money and time for that."***

## 1.3 SOCIAL LIFE

### 1.3.1 LIFE NEEDS

Although the participants stress the importance of their role in the family and of ensuring the family is provided for, they do not consider that all their needs can be met within the family. Activities ranked relatively low in Figure 1, such as eating out, drinking alcohol, massage, karaoke and commercial sex are described by the participants later in the discussions as necessary to meet their 'life needs'.

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<sup>21</sup> 'Free-time' refers to time when the participants are free from their police-work.

Figure 2 shows a diagram drawn by one group of participants of their relationship to different services and institutions in the community. Important services are those which the police access frequently, such as restaurants, and those which they need more often

***"We cannot live without the market... ..we buy many things like tools, food, medicines and many more things. Also, if we have produce from our cultivation or farming we take them to market."***

In Figure 2, the places where the participants go to drink, sing, get a massage and have sex<sup>22</sup> are again shown as less important than other institutions and services. This is at least partially due to the fact that participants state they access these places infrequently. Although one reason given by the participants for not going to these places more often is a lack of money, it seems that the participants are anxious to communicate that they perceive family welfare as more important than fulfilling their own needs.

Nevertheless, the participants enjoyed talking about accessing these services, and were anxious to ensure that favourite brothels, massage parlours, soup shops and bars were not omitted from maps they drew of Svay Rieng (Figure 3):

***"Draw the connection from our working place to the drinking places! It's not important to think of leaving the working place and going home..., but leaving the working place and then going to eat soup at Osmach [see below] is more important."***

One area of Svay Rieng, Osmach, is particularly popular with the participants as it provides 'all the services: beer, snacks, women, dancing, and guesthouses'. It is described as a friendly place, and 'important for our lives'. Customers of businesses in Osmach are reported to include men from many different walks of life: higher-ranking officials, ordinary people, simple government staff, moto-taxi drivers, soldiers, policemen and cyclo-drivers. NGO cars have been noticed there. The area is popular in the evening, when customers are free after work

### 1.3.2 GOING OUT WITH FRIENDS

The participants go to places such as Osmach in groups of male friends or work colleagues after work or at the weekend. They often go after receiving their salaries. The social aspect of these expeditions appears to be very significant for the participants:

***"I have many friends in the unit. All my friends and I usually eat and drink together. When I had no friends, I did not drink and go out for pleasure at all. After I met those friends, they often asked me to join them to drink and go out for pleasure [and] I started to be accustomed to that."***

<sup>22</sup> Brothels are not mentioned on this diagram, but guesthouses and hotels are both places identified by the participants as locations for sex with commercial sex workers and sweethearts. Sex with wives is not included here.

There are considerable expectations for men to participate in group outings with their friends:

***"This is life. Even if we are the proper people, when we have friends we have to drink and go out for fun...so that we are well adapted to live in the society."***

It is not explained why these activities are considered to contribute to the socialisation of men, especially when the participants also state that going out with friends can have negative social consequences (see Figure 1a).

While the participants appear to value their friendship groups, many of them also report that expectations that they will go out socialising with friends can often become unwelcome pressure. Their main concern is the heavy drinking involved in going out in groups of men. Drunkenness is considered a trigger for behaviour the participants believe to be dangerous, such as driving when drunk and having sex with sex workers<sup>23</sup> without a condom. The effect of alcohol on condom use is discussed in Section 4.4.3. Regular heavy drinking is believed to be a serious health problem. Alcohol and illness are discussed in the following section.

The strategies recommended by the participants for avoiding drinking sessions are mostly indirect ways of avoiding pressure from their friends, suggesting that the participants do not consider simply refusing an invitation would be either appropriate or effective:

***"...if we are in the bad situations where we are forced to drink, we have to run away from the group or we have to choose to drink very little...or we just sit with them and pour the wine for them."<sup>24</sup>***

***Also, we have to tell our friends that next time we meet we will drink together."***

***"...if we are insistently asked to join them, we have to go with them but we [can] just sit and pour the wine for them. When they are drunk, we can take the chance to leave secretly and go home."***

One participant feels that convincing his friends that he has a health problem would eventually enable him to opt out of drinking sessions:

***"We realise that we certainly have an illness. So we have to plead our friends at least two or three times, whenever we are asked to join them in going out for pleasure, not to wheedle us to go out and drink wine with them. Then they would not come to persuade and force us any more."***

However, not all participants have much confidence in these strategies:

***"What if we are forced to drink some wine each time they say 'cheers'?"***

23 Throughout this report, the terms 'commercial sex worker' or 'sex worker' are used to refer to women who sell sex for a pre-arranged sum of money. This is not a literal translation of terms used by the participants. While language is acknowledged to be an important indicator of attitudes, a thorough investigation of the connotations and meanings of terms used by the participants is beyond the scope of this report.

24 The term for alcohol most commonly used by participants is *am*. This is a specific and formal word for alcohol, but it is also used to refer to other types of alcohol.

## 1.4 CONCERNS ABOUT ALCOHOL USE

### 1.4.1 ALCOHOL AND ILL-HEALTH

The participants are seriously concerned about damaging their health by drinking large amounts of alcohol. Consuming small amounts of alcohol may be considered to have a beneficial effect on health:

*"Drinking very little wine at the beginning of a meal does not cause any problem... it can make us healthy and give us a good appetite."*

One participant offers the following description of the sort of behaviour that he considers can lead to problems:

*"...if three people drink 20 litres of wine, starting in the morning [and drinking] until the next morning - that makes us have a problem with our health. While we are still recovering from being drunk, friends ask us to join them again. We have to go and join them as we are afraid that they will be disappointed. This sort of behaviour is not good and gives us health problems."*

Other participants describe building tolerance to alcohol, and how this tolerance is affected by their state of health:

*"When I first started drinking, I was getting drunk after finishing one or two glasses. Later on, I drink as if it is drinking water. But when we are not well, after finishing one or two glasses, we collapse unconscious. In contrast, when we are very well, we can drink to the end."*

*"Sometimes we are strong enough and we do not easily get drunk. But [when] our health is not so strong, we become dazzled and completely drunk after finishing only two or three glasses of wine."*

It is understood that regular alcohol consumption may weaken or destroy health.

*"...drinking wine everyday makes us sick."*

*"...drinking wine causes illnesses - if we are too drunk, our health might be spoiled."*

*"We know that drinking harms our health, but we [and other people] still drink."*

Specifically, alcohol consumption is believed to be a cause of cancer, liver illness (particularly 'stunted liver'), skin diseases, stomach-ache and bad colds. These illnesses are all of considerable concern to the participants, either because they are perceived to be serious illnesses or

because the participants report that they suffer from them regularly.<sup>25</sup> It may exacerbate existing conditions. For example, one participant states that when a person with cancer drinks alcohol, lumps will appear on the body, which break open to become incurable wounds. Other reactions attributed to alcohol consumption are vomiting green liquids produced by the liver and a nettle-rash resulting from alcohol intolerance.

Continued alcohol use is understood to hinder or prevent these diseases from being cured:

***“when we have [cancer or liver disease] we have to refrain from drinking wine and smoking cigarettes, because these can make us more easily affected by the disease and then we get worse and worse even if we take medicines.”***

***“If the patients still drink wine they will not be relieved from the disease.”***

In contrast to the many negative effects of alcohol consumption described by participants, rice wine is recommended by one participant as a cure for haemorrhoids, while another includes beer in his suggested treatment for kidney problems:

***“...we have to take some tablets every three months. Also the other treatment is drinking some beer and eating pineapple, because a lot of beer and pineapple juice can also clean the kidney and relieve the disease.”***

#### 1.4.2 ALCOHOL DEPENDENCE

Many of the participants have seen people who suffer from shaking limbs and nausea which are alleviated by only drinking:

***“Sometimes the patients [sick people] have shaking hands and legs, and want to vomit. But when the patient drinks a glass of wine, it is better.”***

***“In the morning, the patient feels like vomiting, with sounds like ‘vark, vark’. After taking a glass of wine, the patient is much better and becomes normal. After that, when the wine is finished, the patient’s hands starts to shake again and [he] takes another glass.”***

***“But these people who have that kind of disease [shaking limbs and nausea that is relieved by alcohol] cannot live a long life. I have seen two or three people living at my birthplace that have this disease. The patients cut the palm stalk for a glass of wine.”***

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<sup>25</sup> The participants’ general health concerns are shown in Appendix 1. See Section 2.3 for an explanation of how the participants determine the relative severity of different illnesses.

***"In the past time, a man who was a commune militia had the same symptoms as [above]. But he died a long time ago at the age of 48. Then he was very thin. He ate once a day and he could starve for two or three days. He had very ugly skin similar to that of the people who have leprosy, like the skin of a crocodile. He was told to refrain from drinking but he could refrain drinking for three or four days only and then would start drinking again."***

One participant describes suffering similar withdrawal symptoms from alcohol

***"If we do not drink some [alcohol] our hands vigorously shake. I used to have that kind of illness when I was doing a course [abroad]."***

Some participants find it difficult to stop drinking, even when they believe that this would improve their health or allow them to recover from illness. For example, one participant describes how he found it difficult to follow medical advice to stop drinking, although he believed that the advice was good:

***"I am very worried about skin diseases... The doctor told me to refrain from drinking alcohol but I cannot follow that advice for the time period that the doctor advised. I can stop drinking for three days at the most. After that, I drink again and the disease recurs."***

However, only one participant uses the word 'addiction' in relation to alcohol

***"If we are addicted to drinking wine, we can be infected with stomach-ache too. I still drink and I know that I am wrong."***

Some participants consider that willpower is the key to ceasing or reducing alcohol consumption

***"...if we have strongly made up our minds to stop drinking wine, then [we can] refrain successfully."***

However, as discussed in Section 1.3.2, peer pressure is identified as a major obstacle to putting such as decision into practice.

## 2. SEXUAL HEALTH PROBLEMS

The participants are aware of a number of illnesses that are transmissible through sex. They have considerable knowledge about HIV/AIDS and express fear of contracting the disease. They also name several other problems which they consider may affect the sexual health of themselves or their partners.

The following three sections discuss the knowledge and beliefs of the participants about HIV/AIDS, sexually transmissible diseases (STDs) and other sexual health problems, focussing on: signs and symptoms; understanding of the transmission of infections from sex; and perceptions of the severity and prevalence of different infections. The fourth section reports on the sources of the participants' information. Section five discusses the stigma of infection with HIV/AIDS and STDs.

### 2.1 KNOWLEDGE OF SEXUAL HEALTH PROBLEMS

The participants' terminology and understanding of different illnesses do not always correspond to Western bio-medical understanding. The English terms used here are translations of the Cambodian language used by the participants, and are not based on any assessment of symptoms. In addition, there may be a tendency for certain terms - particularly syphilis - to be used as a generic term for STDs. A glossary of the names of illnesses used by the participants is in Appendix 3.

Most of the sexual health problems discussed by the participants were identified by at least some of the participants as sexually transmissible. Additional transmission routes were identified for some of these diseases, such as infection from contaminated blood and urine. The only diseases which all the participants agreed to be transmissible through sex are HIV/AIDS and syphilis. Other causes of sexual health problems identified by the participants include: contaminated water or food; becoming sexually active at a young age; malnutrition; overwork; congenital abnormality; pregnancy and childbirth.

Tables 1 and 2 summarise the participants' knowledge of the symptoms and progression, causes and transmission routes of sexual health problems. The information in these tables is an amalgamation of the participants' knowledge: the only knowledge which was common to all the participants is the information on HIV/AIDS and syphilis. The participants were able to provide considerably more detail about men's health problems than about women's problems and were more confident in their discussions of men's health. All symptoms described for

STDs should be assumed to apply to men only, unless otherwise stated. The following discussion of sexual health problems focuses on HIV/AIDS and other STDs, particularly syphilis (see above). This reflects the knowledge and interest of the participants

### 2.1.1 HIV/AIDS

All the participants had a considerable amount of knowledge about HIV/AIDS, and talked confidently about transmission and prevention. A distinction between HIV/AIDS and other STDs is drawn by the participants on the basis of the existence of cures and the perceived prevalence of infection:

*"...STDs are different from AIDS... ...because AIDS can cause the patients to die soon and STDs can be treated but people are often infected with them."*

The participants almost always refer to 'AIDS', although some participants were aware of two separate stages of the disease.

*"It is said that AIDS is in HIV...HIV will become AIDS."*

The participants state that people with 'AIDS' may have no visible symptoms - they may appear 'pretty and healthy'. Blood tests are known to be a foolproof way of diagnosing 'AIDS'. However, the police also state that 'AIDS' is suspected if a person's state of health is very changeable. The participants did not know how long an asymptomatic phase might last. A few participants mentioned that they had heard that a person with 'AIDS' might live for ten years. In general, there is a lack of understanding about the difference between HIV and AIDS, which may cause confusion and misunderstandings about asymptomatic infection. Questions from the participants after the research revealed they felt uncertain of some of their knowledge about HIV and AIDS and welcomed the opportunity to clarify their factual understanding.

The AIDS virus is known to be contained in blood, and contamination with infected blood is identified as the cause of infection in all the transmission routes identified in Table 1 except sexual intercourse and breast-feeding. Transmission of disease through sexual intercourse is discussed in Section 2.2. No assessments were made of the relative risk of different activities.

## 2.2 TRANSMISSION OF INFECTIONS FROM SEX

All participants know that condoms prevent the transmission of HIV/AIDS and STDs. However, they are generally not clear how infections are transmitted during sex. Some participants

believe that HIV/AIDS is contained in the sexual organs, while others are aware that bodily fluids carry the virus, believing that infection occurs when:

***"...the sexual organs touch one's unclean reproductive liquids."***

or when:

***"...the sperms and the ovum of the man and woman meet."***<sup>26</sup>

Some participants stated that a woman can avoid infections from sex by cleaning her body.

Most discussions about sexual intercourse focused on peno-vaginal intercourse. Some participants mentioned that commercial sex workers will sometimes offer to suck a man's penis.<sup>27</sup> Oral sex involving a man is considered by some participants to carry some risk of infection if the person performing oral sex swallows the man's sperm. Alternatively, the penis may be infected by:

***"...being scratched or bruised by decayed teeth or by another illness in the mouth."***

Some of the participants have seen videos of women having oral sex with women, which they state is very likely to transmit infection.<sup>28</sup> It is not explained why this is a particularly risky activity, but this perception may reflect the participants' apparent disapproval of a woman having sex with a woman.

One participant dismissed the idea that HIV/AIDS could be transmitted through oral sex on the grounds that oral sex is not sex. The lack of knowledge about how infections are transmitted during sex will prevent the participants from making informed decisions about the risk of infection involved in different sexual activities. If people believe that infections are transmitted 'when the sperms and ovum meet' they may logically conclude that other sexual activity, including penetrative sex between men, does not carry a risk of infection. The same false sense of security may be inspired by knowledge - or information - that infections are transmitted through sex, if sex is conceptualised as only peno-vaginal intercourse.

Some participants determine vulnerability to infection according to a person's current state of health:

***"Fewer of the rich people have been infected with AIDS. But in contrast, mostly poor people are infected with AIDS because the rich people have enough food to eat."***

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26 Participants state that a woman's ova are contained in her uterus and this is where fertilisation take place.

27 No participants mentioned requesting oral sex from a commercial sex worker or anyone else.

28 Two coffee bars in Svay Rieng show sex videos on television to attract customers. These videos are shown with the sound turned off, while another television shows an ordinary film. These bars are visited by men, women and children. The sex videos are believed to be primarily Thai, French and American in origin.

***"If we had an STD, we would be...at a higher risk of being infected with AIDS when we have sex again. This is because when we are strong and healthy enough we can have sex but, when we are not well and tired in terms of strength, we have to refrain from having sex for a period of time."***

The above statement was made in relation to a direct question about the existence of a link between STDs and HIV/AIDS transmission, and so no inferences about knowledge of STDs as a risk factor can be drawn. An individual's state of health is also considered to be a factor in the onset of symptoms of other STDs by some participants: they explain that symptoms of STDs might be expected to appear about 20 hours after having sex, but

***"Some people might feel that they are going to be affected with that [an STD] when the symptoms...appear four to five hours after having sex, because [they]...are not well before having sex."***

The belief that vulnerability to HIV/AIDS and other STDs is related to an individual's state of health suggests that the articulation of information and knowledge about these illnesses with local concepts of health and illness should be considered in any activities designed to increase knowledge or to enable behaviour change.

## 2.3 SEVERITY AND PREVALENCE

The sexual health problems were ranked by the participants in order of the perceived severity and frequency of each disease: see Tables 3 and 4.<sup>29</sup> The severity of an illness was determined by: the potential outcome of the disease - whether it is fatal or has other irreversible consequences; by the cost of treatment and by the length of time necessary for treatment to be successful:

***"...we thought of and valued the diseases according to severity in terms of time for treatment and medical expenses, because there are diseases that take a very long time to heal, diseases that kill the victims very soon, and the diseases that cost very much money to treat. For example, liver illness, dengue, and malaria can be cured in a very long period of time and also cost a lot of money for medical expenses. ...the diseases like cholera can kill in a very short period of time - sometimes it kills the victim in just one day. Hence, we are really afraid of being killed by cholera."***

***"The severity of the diseases depends on whether they cost a little or a lot of money for the medical expenses and how quickly they cause people to die."***

Cost and length of treatment are inter-related, as the economic consequences of a lengthy illness or recovery period are an important consideration to the participants: for example, the loss of earning capacity (including loss of employment), and loss of ability to perform productive work.

29 Although one group did not list syphilis on their table of men's sexual health problems, the discussion which followed the preparation of this table indicated that they were familiar with the disease: most of the participants were in agreement about the symptoms of syphilis. 30 For comparison, the participants' general health concerns are ranked for severity and frequency, and are in Appendix 1. HIV/AIDS and some other sexual health problems are included in this list.

HIV/AIDS is rated as the most severe sexual health problem for men by all the participants, and the most severe of the diseases listed as general health concerns. The participants state that they are very frightened of catching HIV/AIDS, because it is fatal:

***"AIDS has no treatments... It can not be solved. If we are infected with the disease we wait to die."***

***"AIDS is the most severe disease because there are no treatments to heal it.  
When the person is infected with it the person will actually die."***

However, HIV/AIDS does not seem to meet two of the participants' three criteria for determining severity - it does not cost a lot of money to treat,<sup>31</sup> and it does not kill the patient rapidly - especially if the participants believe a person might live for ten years after infection. In discussion, the participants mention other diseases which are of more immediate concern to them than HIV/AIDS, such as cholera and tetanus:

***"Sometimes we pedal the bicycle and we catch our leg in the spokes and are infected with tetanus. And sometimes we might be knocked down by a car and break a leg. Oh, that one is more terrifying than AIDS. That makes us suffer pain and also disables us, [preventing us from]...working."***

While exact impressions of the relative severity of different diseases may be of little general significance, this inconsistency suggests that the participants' ranking of HIV/AIDS as the most severe of the diseases they are concerned about was influenced by the fact that the researchers were known to come from an 'AIDS NGO'. There seems to be a perception of appropriate answers in certain situations, which is likely to affect assessments of participants' knowledge and attitudes.

STDs other than HIV/AIDS are not considered to be serious: no participant mentioned any connection between the transmission of HIV/AIDS and prior or simultaneous infection with an STD (except in the general terms mentioned in Section 2.2). While some STDs are believed to be potentially fatal, inexpensive treatments can be bought which the participants believe to be effective:

***"They are not afraid of being infected with syphilis...because there are treatments to cure it.  
It does cost money but only a little...it can be treated with traditional medicines."***

The participants state that HIV/AIDS and STDs are prevalent among sex workers. No participant reported knowing, or meeting, a person with HIV or AIDS.<sup>32</sup> The perceived prevalence of STDs is not clear, but all the participants contributed to discussions of symptoms and treatment. Many told stories about friends or acquaintances who have had an STD.

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<sup>31</sup> It may be that people spend a lot of money trying to treat HIV/AIDS, but this is not stated by the participants. Some participants state that there are treatments available to 'rich people' that can prolong the life of a person with AIDS. It is not clear whether the participants would expect to access these treatments themselves if they had AIDS - they do not identify themselves as rich people.  
<sup>32</sup> A few participants related anecdotes about AIDS patients, but these people were not personally known to them.

### 2.3.1 MEN'S DISEASES AND WOMEN'S DISEASES

Not all the STDs that were identified as sexual health problems for men were also listed as sexual health problems for women. As can be seen in Table 4, one group identified no STDs as women's diseases. Besides HIV/AIDS and syphilis, the STDs identified by Group 2 are considered less serious for women than other sexual health problems. In addition, with the exception of 'urinating difficulty' (which not all participants agree is transmissible sexually), those participants who did identify STDs as women's diseases considered them less common than the other sexual health problems listed.

The diseases listed in Tables 3 and 4 reflect the participants' perception that sexually transmitted diseases are more common among men than among women:

*"Hidden syphilis, gonorrhoea and 'urinating difficulty' are all men's sexual diseases - all single men often have these."*

*"Usually men are infected with rice-water gonorrhoea...[women] are sometimes infected with it."*

In contrast to other women, commercial sex workers are believed to have a very high infection rate. It not clear why STDs are perceived to be less prevalent among women than among men, unless, as suggested by one of the above quotes, the participants believe that a large proportion of men who have STDs are unmarried and therefore do not infect their wives.

## 2.4 SOURCES OF INFORMATION

The participants report that they have seen broadcasts about HIV/AIDS on the television and heard radio broadcasts. Most of these broadcasts are produced by the Ministry of Health. Additional sources of information are newspapers and magazines. Television broadcasts and print media often show pictures of AIDS patients. The participants also report that they have seen posters about HIV/AIDS in dancing bars, guesthouses, hotels and restaurants. They report that the message in these various health promotion materials is to use 'Number One' condoms, rather than to stop having sex:

*"We are not prohibited from having sex. We are still allowed to [have sex] but we are asked to use condoms."*

However, the messages are understood to instruct the participants to use condoms when having sex only with certain people, and that some sexual relationships do not carry a risk of infection

*"[Health promotion messages] always tell all the other people and us to use condoms when we go out and have sex with partners that we do not trust, and that if we want to be free from that we have to have one-to-one love."*

The participants' assessments of which sexual relationships carry a risk of infection are discussed further in Section 4.3.2.

The participants consider that if they were infected with HIV/AIDS, they would be useful and effective educators, recommending that they should:

***"... spread around all the information on the issues and be an example so that they do not have to follow us. If they follow us by not using condoms as we did, then more and more people will be infected with the diseases and then the population will be reduced everyday. It would result in many problems if we are infected with the diseases and we do not express our feelings and regrets - the disease would affect increasing numbers of people."***

However, this public-spirited approach is in sharp contrast to the participants' expectations of the likely behaviour of people with HIV/AIDS and the feared social stigma described in the following section.

The only sources of information on STDs cited by the participants is knowledge passed on by friends, neighbours or colleagues. For example, one participant describes how his friend learnt about syphilis:

***"One of my friends has got and learnt what syphilis is like and how it hurts. He went and asked another friend, who told him that syphilis makes you have swollen groin, hot urine, and a discharge when urinating. After hearing that the man said, 'Oh my god, if what you say is true, I've got syphilis'. ...he went to see the doctor and later he went to see a traditional doctor."***

## 2.5 ATTITUDES AND STIGMA

Infection with HIV/AIDS is perceived to carry serious social stigma. The participants state that hospital staff would not want to tell a patient that he/she was infected with HIV/AIDS because 'they would be afraid to affect our honour'. The participants expect that there would also be serious social consequences for the family of a person with HIV/AIDS. For example, it is believed that a daughter of a person with HIV/AIDS would have difficulty in finding a husband:

***"[if] it is spread around that we are AIDS positive, then they do not ask our daughters to marry their sons as they afraid of losing their honour."***

The participants also have very negative expectations of behaviour from people with HIV/AIDS, suggesting that such people might deliberately infect other people with the disease.

The participants report that there is a lot of teasing about HIV/AIDS infection among themselves and their colleagues - it is a suggested diagnosis for every illness they have

***"Even if there is some little pain in our arm, or it is slightly wounded, we are ... said to have AIDS."***

The participants explain that this is because HIV/AIDS:

***"is a cruelly acute disease and there is no treatment for curing it. ...medical scientists the world over also cannot cure the disease. This is why those people want to tease [to embarrass] us because we are infected with a disease that they really hate."***

However, accusations of infection with HIV/AIDS are not limited to banter as a way of addressing fears about a frightening disease. The participants report that rumours are often spread that people died of AIDS, regardless of the cause of death diagnosed by doctors or stated by their relatives. They say that people are 'disgusted' just to see the funeral of an AIDS patient. The participants believe that this is due not only to a fear of HIV/AIDS, but also to the assumption that the disease was contracted as a result of socially unacceptable behaviour and a sense that the deceased has received their just reward for such behaviour

***"they are afraid to be infected with the disease and some people say that the dead are the ones who are bad people and not loyal to their wives so they should have died from that disease."***

At no other time do the participants suggest that being 'disloyal' to their wives is socially unacceptable behaviour in general, although, as is described in Section 4.2.3.c, they do not expect married women to be happy about their husbands having extra-marital sex. Sex workers are considered by the participants to be the most likely source of infection with HIV/AIDS for men and commercial sex is one aspect of the 'life needs' discussed in Section 1.3.1. It may be inferred that the participants perceive that sex with sex workers is acceptable for men as long as they and their families are not forced to openly acknowledge its existence - or up to a certain point on an undefined scale of sexual activity.

This analysis does not explain the behaviour of villagers related in the following anecdote

***"...recently there were two women in Svay Rieng who died and [there were]... rumours that they died from AIDS. Hearing that, the people in the village did not go to make contributions for the funeral ceremony. But the village chief raised the contributions from villagers for funeral ceremony."***

It is not reported what the women were believed to have done to deserve HIV/AIDS. Although the participants all identify additional transmission routes for HIV/AIDS besides sex, it seems

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that the strong association of the disease with sex workers is a significant factor in the stigma attached to HIV/AIDS.

There is some stigma attached to contracting an STD, apparently mostly for the same reason - an association of STDs with commercial sex. The participants say that they sometimes fear being teased about having such diseases by friends or colleagues, and that men are sometimes too 'shy' to seek medical help. One participant identifies single men as people who find it particularly difficult to seek treatment for STDs:

***"Some of the single men are very shy and embarrassed when they have [an STD].***

***They do not want to go to see the doctor because they are single."***

It is not explained why a man would be particularly embarrassed by his marital status when seeking treatment.

# 3. HEALTH-SEEKING BEHAVIOUR

The participants have a number of options for treatment available to them. Decisions about seeking treatment are made by evaluating each option against a number of criteria. The following section describes the different options for treatment available to the participants. The second section discusses the different factors which influence the participants' health-seeking behaviour.

## 3.1 TREATMENT OPTIONS

The participants access both Western medicine and traditional medicine for treatment for their health problems.<sup>33</sup> Options for Western medical treatment are private and public hospitals and self-medication with medicines purchased from pharmacies. Traditional medicine includes treatments prescribed or performed by traditional doctors, and other popular treatments of coining and cupping.<sup>34</sup> Western and traditional medicine are perceived to heal in different ways:

*"...if we treat [illnesses] with [Western] medicines we have to take some medicines in order to...kill the illness..., in contrast, the traditional doctors try to force the disease that is affecting the patient to come out."*

Traditional doctors may prescribe medicines made from herbs, bark or roots, perform other procedures such as lighting fires under the patient or they may use magical powers

*"...if a person has had the dizziness, the traditional doctors magically blow onto the body of the patients."*

Therapies from Western and traditional medicine may be combined, as may those from within a single tradition. Treatment combinations may be necessary to achieve an effective cure or may cure the patient sooner than a single treatment. For example, irregular heartbeats may be cured by coining or by coining in conjunction with other medicines.

<sup>33</sup> The bio-medical tradition that is mainstream in Western countries is here referred to as Western medicine. Practitioners of this tradition are referred to as Western medical doctors, in order to distinguish clearly between the Western and Cambodian traditions. The medical tradition that is indigenous to Cambodia is here referred to as traditional medicine, and practitioners are referred to as traditional doctors. These terms are for ease of reference only; further implications - such as about the medical training received by doctors or the mainstreaming or otherwise of Western traditions in Cambodia - are not intended.

<sup>34</sup> Coining (គំរាង្គ្គ្គ) and cupping (ប្រើ្គ្គ្គ) are popular treatments in Cambodia for a wide range of health problems and symptoms. Coining involves rubbing the skin of the patient with a smooth metal object - such as a coin or spoon - usually hard enough to leave red stripes on the skin. Cupping involves creating a vacuum inside a glass by burning a lighted candle inside it. The glass is then placed on the skin of the patient where the vacuum causes it to stick, so that removing it leaves circular welts on the skin.

*"If we have irregular heartbeats we have to have coining in order to restore us to normal health...  
...Sometimes the coining does not cure the disease unless the patients take some [Western]  
medicines. There are many different choices such as coining, massage, and taking  
[Western] medicines that they can choose according to their preference."*

*"Sometimes, we go to have [coining] done at the parlour where they provide that service...  
After that, we take some more tablets so that we can be relieved from the disease  
[irregular heartbeats] more quickly."*

## 3.2 CHOOSING TREATMENT

### 3.2.1 SEEKING ADVICE

Most of the participants do not express an overall preference for a particular treatment but evaluate their options according to a number of criteria: perceived efficacy of the treatment; cost; convenience; confidentiality of the service and quality of the service. Decision-making by complex evaluations of these criteria, may result in the participants accessing several different health-service providers before they are satisfied with a cure.

Preliminary assessments of the treatment options for a particular condition are usually made by discussing the problem with friends. Participants report that they will usually seek out 'close and trusted' friends - often work colleagues - to discuss their health problems, especially when the problem is a potential source of embarrassment, such as an STD.

The purpose of this behaviour is both to assist in diagnosing the problem - as in the statement about a friend with syphilis quoted in Section 2.4 - and to draw on other people's knowledge and experience of which treatments are likely to prove effective. For example, the participants explain:

*"Some people might go to the private hospitals or [public] hospitals for buying  
treatments when their friends say that they [have]... liver illness. ... some others might  
go to traditional doctors for the traditional medicinal herbs because their friends  
told them that the traditional medicinal herbs are effective."*

Participants report that they discuss treatment options with their wives because of the cost involved. The cheapest option is likely to be explored first, although this may not be considered the most effective:

*"When we talk to our wives it is easier to deal with the money related to the treatment  
costs for medical expenses accordingly. We decide together where to access the treatment first..."*

***we think of the ideas together. If our wife thinks that we should purchase some medicines, we have to follow and take them for reducing the temperature. But if it is not relieved when we have used many medicines, we have to discuss again with our wife. If she thinks that we had better go to the hospital, we have to go to the hospital."***

As discussed below, cost is a very important issue in the participants' health-seeking behaviour. However, this assertion that wives will be pivotal in the decision-making of the participants is in direct contradiction to the expected health-seeking behaviour of their wives

***"...when the husband is informed about her illness, he might take care of his wife because the man is stronger than the woman is. The man also has got clever ideas about dealing with the problems like taking the wife to the hospital and so on."***

Consultation of wives is not recommended in the case of STDs: the participants say that they would be afraid of their wife's reaction:

***"When I have sexual health problems I usually go to see the doctor and talk about my problem secretly. I never tell my wife because I am afraid that I would be hit. So I have to go and get my illness cured - sometimes it takes one or two weeks and sometimes one month. When the illness is relieved, I go home as normal, but when I have an STD I cannot go near her because I am worried that there would be trouble if she knows."***

In contrast, they relate that, as husbands, they would be very sympathetic if their wives told them that they had an STD:

***"...men are so patient when a problem strikes. We might be suspicious that we have been infected with an STD and have transmitted it to our wife. We have a lot of pity" for our wife having been infected with the disease in this way. We have to try to access treatments for curing our wives."***

This is the only time that participants suggest that they could unknowingly pass on an STD to their wives.

### 3.2.2 COST AND PROXIMITY

Cost of treatment is a major determinant of health-seeking behaviour. As discussed in Section 2.3, it is one of the factors by which the participants measure the relative severity of diseases. Traditional medicines are usually the cheapest option. For example, the participants state that the majority of men go to traditional doctors when they have an STD because

***"...the treatments provided by the [public] hospital do cost some money.  
And if they access the services of private hospitals they would be charged more money."***

A pot of medicinal herbs from a traditional doctor, which many participants believe to be a very effective remedy for several STDs, including syphilis and rice-water gonorrhoea, costs around R3000.<sup>36</sup>

The official fees at public hospitals are lower than the fees charged by private hospitals, but the participants describe how, in practice, public hospitals are not necessarily a cheaper option:

***"... good medicines may not be available at the [public hospitals]. When we go to see the doctors at a public hospital, after consultation they say that there are no medicines to cure our diseases and they give us a prescription to buy the medicines at the pharmacy. If we calculate the cost for transportation to go to the hospitals and the cost of the medicine, the amount we pay is very similar to that charged by the private hospitals."***

The opportunity costs of going to a public hospital are also higher, due to increased travelling time and a slower service (see Section 3.2.5), and are included in calculations of treatment costs:

***"[If] we just get the prescription from the doctor [at a public hospital], then it is better to go to a private hospital, and we will gain some time for doing other work."***

The proximity of health services and the relative number of health practitioners is a significant factor in the participants' decision-making processes. No further explanation is given for this, but it may be inferred that this is due to calculations of travel and opportunity costs:

***"If the [Western medical] doctors are far away from our houses, sometimes we also believe in the traditional doctors."***

***"It depends on the number of medical people available at the place where we live. If there are many [Western medical] doctors living in the area..., we go to those doctors but, if there are few [Western medical] doctors we may go to the traditional doctors."***

### 3.2.3 EFFICACY OF TREATMENT

Belief in the likely efficacy of treatment is partially based on a general faith in a particular medical tradition - a few participants say that they 'do not believe very much in traditional medicine'. Another states:

***"...[Western medical doctors] have many good medical techniques and experiences that can make us believe that they can certainly cure our illness."***

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<sup>36</sup> R3800 is approximately equivalent to US\$1, at the present time.

First or second-hand experience of an apparently successful cure may positively affect a person's general confidence in a particular medical tradition:

*"I certainly believe in the traditional medicines. A traditional doctor who lives at ---- is skilful in curing diseases like stomach-ache traditionally. To cure that, the doctor burns a piece of a long iron till it becomes red and hot. He puts the hot iron on the patients' heel with some cloth between the patient's heel and the iron. This is very painful for the patient. However, after several days of treatment, the patient does not suffer stomach pains anymore. So, traditional medicine is pretty effective."*

*"Some traditional doctors are very good and can cure many diseases. For instance, my brother had been bitten [by poisonous snakes]. He was taken to the traditional doctor for treatment. Fortunately, the traditional doctor's herbs cured his illness. [The traditional doctor] was highly appreciated and he was judged very skilful and good at curing diseases. I asked him what herbs he used to the disease. He showed me...tiger bones and musk deer bones."*

However, it is more common for participants to describe choosing treatment according to their belief in the most effective treatment for a particular illness or category of illnesses rather than according to a preference for one medical tradition over another. These opinions differ and while it may be that a treatment choice reflects an underlying preference for one medical tradition, this is not stated by the majority of the participants.

The efficacy of treatment is measured by how quickly the patient gains relief from the condition, and whether a permanent cure has been achieved. In the context of STDs, opinions are divided as to whether Western medicine or traditional medicine can provide long term relief

*"...we boil traditional...[medicinal] herbs, but the disease cannot be cured forever. The disease can recur again when we eat something wrong."*

*"They often access the traditional medicinal herbs. After they were relieved from the diseases, the diseases will not recur again. But the [Western] medicines can only cure the diseases for a period of time - the disease will recur again when we eat something wrong."*

*"The traditional treatments cure...[syphilis] forever, but it takes a long time to cure it."*

Western doctors are generally recommended for diseases that the participants perceive to be serious, such as malaria and cholera.<sup>17</sup> It seems that some other considerations, especially that of cost, diminish in proportion to the perceived severity of the disease

*"When speaking about the malaria...[and cholera]...the patients have to go to the hospital immediately in order to have their blood tested for the germs of the disease so that the doctors can judge appropriate treatments... We have to think about the medical expense but we must treat [these diseases]... The [Western] doctors will surely know what treatment is needed for the disease. We do not need to think about [how]...they are going to deal with the illness - we have to wait for treatment and take the medicines as prescribed."*



Some services which the participants consider desirable, such as injections of serum, are not provided by traditional doctors.

Illnesses for which traditional medicine is often recommended include STDs such as syphilis, hidden syphilis and gonorrhoea, other sexual health problems such as impotence, haemorrhoids, poisoning from snake bites, heat inside the body,<sup>38</sup> liver disease and stomach problems.

Expectations of the potential efficacy of a treatment are carefully weighed against considerations of cost. One participant tells a story of how revenge was taken on a traditional doctor whose treatment was less effective than he promised:

***"... the traditional doctors guarantee that they can cure the illness by just burning three to four spots on parts of the body. Burning the spots costs R40,000 and [they] promise that they would give us their living body [if the illness is not cured]. Because of the promise, some people... came...and took revenge for the cost when their illness was not cured, by pouring acid onto the doctor. The doctor bled and died. The perpetrator was arrested and sentenced to jail."***

Western medicine is not without its dangers. One participant describes how a man with syphilis acquired hidden syphilis by taking more than the prescribed dose of medicine for syphilis. This caused the germs to hide themselves in his body, as well as a reaction to the medicine which resulted in infected sores on his hands. Incorrect compliance with treatment regimes will contribute to problems of drug resistance.

### 3.2.4 CONFIDENTIALITY

Confidentiality is an important aspect of treatment process for the participants, particularly with regards to STDs. One motivation for seeking traditional medicine for sexual health problems is that confidentiality is believed to be good, and the treatment is also effective:

***"...some people do not believe that their problems are kept secret, so they go to the traditional doctors. [Also], the traditional medicinal herbs are effective in curing this type of disease. So they do not go to the hospital."***

The participants report that the staff of the public hospital do not respect patient confidentiality:

***"Some medical staff are too open in talking about the STDs of patients [in public]. So the patients are very embarrassed... and they also become discouraged to take care of themselves."***

The participants are adamant that results of HIV testing in a public hospital would not remain confidential. They do not seem to feel that their permission would be asked before an HIV test was carried out:

***"...the information can not be confidentially private because before lying down in bed, they already took the person's blood and tested for the disease."***

### 3.2.5 QUALITY OF SERVICE

The quality of the service is also a factor in determining the participants' health-seeking behaviour. Important aspects of service provision are the attitude of the staff, the speed with which a patient is attended to, and the availability of equipment and medicines and other resources. The participants appreciate friendly service provision. Private hospitals are rated highly on these criteria; their motivation is understood to be business-oriented.

***"...private hospitals are very much concerned about the patients' health, and the staff are very friendly to the patients. This is the way they do business, and they hope that the patients would spread news around about their services to the other people, so that more and more people access their services."***

As suggested in Section 3.2.2, private hospitals are considered to have better equipment and to stock more medicines than public hospitals. There are fewer patients in private hospitals resulting in quicker service and the capacity to respond to emergencies.

In contrast, the participants have low expectation of the quality of the service provided by public hospitals. The participants have even heard rumours that people who are HIV positive are killed by injections from the medical staff there.

One participant sums up the reported difference in service at public and private hospitals:

***"I usually go to Mr. ----'s [private] hospital ... because it is fully equipped with medical equipment, such as an ultrasound machine. Because of this effective service, people often go there for treatment. ...sometimes at the hospital there is no electrical power..., and sometimes the hospital has no medicines to provide to the patients."***

***"...private hospitals...can deal with emergencies...while the [public] hospital cannot, because there are many patients accessing the public hospital services. Because of this, all the patients are asked to make a queue for seeing the doctors, and we are called to the consultation by number."***

***"But the private hospitals charge very much money for treatment. That is why a very small number of people access the medical services provided by the private hospitals - only the people who can afford to pay such expensive fees."***

## 4. SEX AND RELATIONSHIPS

The participants make decisions about their sexual behaviour and negotiate sexual activity with their partners within a complex conceptual and social framework. The following section explores concepts of sex and sexuality. Section 4.2 discusses the various contexts for sex identified by the participants, from the availability of commercial sex to negotiation for sex between sweethearts. The third and fourth sections discuss attitudes and beliefs that affect the ability of the participants to make decisions about safer sex, and the fifth section discusses negotiation for safer sex between the participants and their partners. The final section presents information gathered from the participants about their actual sexual behaviour.

### 4.1 SEXUALITY AND SEXUAL DESIRE

#### 4.1.1 PASSION AND JOY

The major reason for sexual intercourse identified by the participants is 'passion'<sup>39</sup> (see Figure 4). One participant explains passion as follows:

*"...passion needs force people to be interested in having sex. If we do not feel any passion for sex, we do not do anything. For example, if a person is really hungry, but he/she is given not enough food to eat, he/she would be looking for more food to fill their needs. So the person must be given enough food to eat."*

This statement describes passion as a physical need. This understanding is related to a strong link drawn by the participants between passion and health:

*"Obviously, people who do not eat enough food...are not powerful enough and less passionate. However, the urban people [wealthier/better-fed] are able to... have sex five times per morning."*

The participants also believe that too much sex can damage a person's health, and perceive that having sex has a direct effect on their general energy levels:

*"For example, normally before we have sex we can make approximately 50 trips carrying water on the yoke. But after we have sex, we can make only about 20 trips carrying water on the yoke."*

One participant offers the following estimate of 'normal' sexual activity:

*"It is up to the different men. Some men who are young and strong enough, they can have sex 30 times per month."*

The participants perceive that men are not always in control of their sexual passion. As Figure 4 shows, many of the reasons for sex involve men becoming involuntarily aroused by women - often by simply observing a woman, and when the woman's actions do not appear to have any overt sexual intent. The participants explain simply that

***"Anyway, men are usually cajoled to [have sex] and think of having sex when they have seen pretty women."***

The fulfilment of sexual passion is considered a sufficient imperative to over-ride other considerations:

***"They fulfil their passion desires and feelings. When they are enjoying themselves, they forget to think of anything else...[women] get pregnant at this time."***

The rape of women is considered the result of passionate impulses. The participants state that they themselves do not commit rape. It is considered the last of a three-stage strategy for relieving the passion of men when an interested sexual partner is not available

***"...we have to spend time in order to caress and coax the person with pleasant and flattering words so that they might be deceived to agree with us to have sex."***

***"Sometimes, money is given in order to make the partner agree with us, and also sometimes rape is the last choice."***

While the participants state that some men masturbate in order to fulfil 'urgent passion needs', they report that doctors prohibit this as it may affect the man's mental ability

A distinction is drawn between passion and desires for happiness, joy and to experiment with different sexual partners as motivators for sex. Establishments which provide commercial sex are described as 'men's pleasure places'. The relative weight given to these different needs and desires can be seen in Figure 4.

***"We just want to get enjoyment. When we have sex, we have enjoyment with the sex, we feel less depressed, whether we have sex with sex workers, our wives... we try many different people."***

***"Some people do not think about having children at all, they just like to serve their desires and feelings and sexual enjoyment. Both men and women agree to have sex because they want to have sexual enjoyment and orgasms."***

However, the distinction between passion - a physical imperative - and desire does not appear to be a sharp one. For example,

***“Some people can have sex times every week... as they have sex with different people. But if they have sex with the same people, they would be bored with sex and their health would become worse and worse.”***

In other words, the physical danger of having too much sex is negated by fulfilling a *desire* for multiple partners.

Most of the discussions with the participants focused on male sexual desire: discussion about female sexual desire in general was limited. The participants categorise women according to their sexual relationships with men. They identify strong cultural norms that dictate the sexual behaviour of certain groups of women. For example, married women are expected to have sex only with their husbands while, as is discussed in Section 4.2.2, women who have sex with their sweethearts are assumed to be concerned about pregnancy and their reputations. It is not clear, in either of these cases, whether the women's behaviour and priorities are believed to be determined by cultural norms that over-ride imperatives of sexual passion and desires for sexual happiness, or whether such women are not imagined to experience passion and desire. In contrast, the participants do express strong opinions about the sexual passion of commercial sex workers. This is discussed in the following section.

#### 4.1.2 COMMERCIAL SEX WORKERS: BUSINESS OR PASSION?

Commercial sex workers are considered to have a greater amount of passion than other women, and to be at least partly motivated in their work by passion:

***“[Commercial sex workers] can accept sex with seven to ten people [per day].”***

***“Commercial sex workers need both money and sexual passion.”***

This capacity for sex is contrasted to an anecdote about a married woman who had to divorce her husband because she could not stand his demands for sex seven times a day.

The participants state that 'worthy women' would not be able to 'accept' this level of sexual activity. However, it is unclear why the participants perceive that the sex workers are able to sustain this level of sexual activity because of their 'passion needs', as they also state that:

***“[Commercial sex workers'] health is actually getting worse and worse but they have to [have sex a lot] because it their business, which they do for money.”***

It seems from this statement that having many sexual partners is not considered to have the same restorative effect on women - or at least on commercial sex workers - as it does on men.

The participants are familiar with the terms and conditions of commercial sex work. They report that the client will pay the fee to the brothel owner who will deduct 50 per cent for their own interests. Part of this deduction will be used to pay for the sex worker's food and to advance money to her for medicines if she is seriously ill. The sex worker must pay for clothes, make-up and perfumes herself.

This awareness of the business-side of commercial sex enables participants to hold sex workers responsible if they do not use their work as a stepping stone to a new business. A divide is drawn on ethnic lines concerning sex workers' capacity to do this.

*"As far as I know those [Cambodian sex workers] do not have any money because they do not save as much money as the Vietnamese women do. The Vietnamese sex workers usually do that business until they have saved about four to five damlung of gold - then they set up a different business on their own."*

*"However, the Cambodian women who start commercial sex work will probably do the same job till they die... The majority of them spend their money on gambling - playing cards for money, for example. They do not think of taking rests to improve their health at all. Sometimes they make trouble and problems within the household, by stealing each others' possessions and fighting each other. Some of them are accused of committing crimes such as fighting and are jailed."*

Cambodian sex workers are held responsible for the perceived deterioration of their health in the above statement, in contrast to the comment that their health deterioration is due to the nature of their business quoted earlier. The idea that sex workers find fulfilment of their passion needs in their work, and the implication that they remain in their work because they are unmotivated to look for alternatives is contradicted by the participants in a discussion in which they describe how some women who sell sex have rewarding sexual relationships outside work:

*"...commercial sex workers do not feel much sexual pleasure [with their clients]. They feel very depressed and are not passionate in having sex at all. But they have to bear their suffering because they do that job for money. Whether the men are old or young, cyclo-drivers, or moto-taxi drivers... they just focus on making money from their business. That's why seeing her sweetheart and having sex with him can make her feel very happy and enjoy sex without using condoms. Particularly, those are the massage women living at the massage parlours. When I see the boys at the place, they told me that they come and pick up their sweethearts. Most people of these groups often do not use condoms when having sex with their partners because they live together like husband and wife. Sometimes, the woman earns the living to support the man as he is unemployed."*

### 4.1.3 HOMOSEXUALITY

One participant reports that he knows of women who are having sexual relationships with other women. He relates that they consider themselves husband and wife, with the 'husband' taking on a male social role: 'they are very strong and work very hard'. The participants have seen videos of women having sex in the video cafeteria:

***"We have watched the women having sex with women in the sex videos. They have sex orally, and also with the sexual organs. They lick, suck and caress all the sexual organs. Whether or not they are [really] enjoying themselves, they pretend to be enjoying what they are doing, flailing their arms and legs around. Women who have sex with women are very dubious. The things they do in order to solve their passion needs are dangerous, [causing] infection with many different germs and bacteria."***<sup>42</sup>

This statement assumes that the women in these videos are having sex with other women because of 'passion'. However, the observation that this sex is very dangerous suggests a level of disapproval.

Some participants state that men can have sex with men, and that this will be oral sex. They have read in the newspaper about foreign men raping Cambodian children, forcing them to have oral sex.<sup>43</sup> The participants comment that this kind of sex may carry a risk of infection:

***"This kind of having sex affects... health. ...the sexual organs are not always clean, and the person can also swallow the sperm.. Sometimes, the adults suck the sperm of children. Infections can be passed through the mouth."***

## 4.2 CONTEXTS FOR SEX

### 4.2.1 MARRIAGE

The participants say very little about relationships between husbands and wives. It is stated that married women do not have sex with men other than their husbands.<sup>44</sup> The participants do not expect wives to be happy about their husbands' extra-marital sexual activity; section 4.2.3.c describes how men try and avoid provoking trouble or blame from their wives by concealing their sexual activity. The participants do not themselves express disapproval of extra-marital sex for men.

### 4.2.2 SWEETHEARTS

It is explained that men always initiate relationships with women and always initiate sexual activity. Men may give money to their sweethearts: this is not described as direct payment for sex and the obligation to have sex this may create for the woman is not discussed by the participants.

<sup>42</sup> These videos are reported to be mostly Thai, French American in origin, and so do not feature Cambodian women.

<sup>43</sup> It is not specified whether these children are male or female, but the discussion takes place in the context of a discussion about men having sex with men.

<sup>44</sup> In response to a direct question from a researcher, the participants stated that it was extremely rare for women to have extra-marital affairs.

Money does not always change hands, but other 'gifts' - such as alcohol - may be made. For example, the participants describe how they interact with sweethearts who work in restaurants

***"[At] the restaurants where we go and eat, we give those women wine to drink and when they are drunk, we just bring them [to a guesthouse to have sex]."***

The participants outline scripts for courtship and seduction in which they describe the different concerns and desires of men and women. Figures 5 and 6 illustrate the chain of events that lead from initial introductions to a couple having sex. Figure 5 tells the story of a young man approaching a young woman and arranging a date. Over a period of several weeks they fall in love. They go to a restaurant, where the man gives the woman US\$20, as he feels much pity for his sweetheart'. They both get very drunk, before going to a guest house to have sex

***"[the woman] has noticed that the man is very nice to her. She willingly lets the man do everything he likes."***

The participants imagine that the woman will be very concerned after having sex that the man will leave her, but in this story the relationship continues for some time - the story ends with the couple attending ceremonies at the pagoda and going on other excursions. The story in Figure 6 describes a relationship that ends as soon as the couple have had sex. The participants describe how the man devotes a considerable time to convincing the woman of his love for her, promising, for example:

***"I will be sincere to you until the Mekong river runs dry."***

Before having sex the participants relate how the man agrees to everything the woman asks for, and state that the woman believes everything the man says.

***"Normally, before having sexual intercourse, the man tells the woman that he loves her and will be sincere to her forever."***

The participants explain that the man is concerned about catching AIDS from the woman and that he is probably planning to end the relationship as soon as he has had sex with the woman. The woman is expected to be concerned about her reputation, pregnancy and being abandoned by the man.

***"The woman fears many things. [She is] afraid that her sweetheart will leave her, afraid of being pregnant, and afraid that she is doing something against the tradition and beliefs, values of the culture."***

The man in this story initiates sexual intercourse, which the woman interprets as a sign that the man 'likes her very much'. The man then ends the relationship.

4.2.3 COMMERCIAL SEX

4.2.3.a Services and Clients

Maps of Svay Rieng drawn by the participants (see Figure 3) show a number of places identified by the participants as locations where commercial sex is available. Locations for commercial sex identified by the participants, on the maps and in discussion, are karaoke bars, massage parlours, coining shops and brothels, as well as hotels and guesthouses where commercial sex workers can be found or where men may take commercial sex workers. Brothels are identified by the name of the brothel owner and the length of time they have been in business. There are an estimated five brothels in Svay Rieng, and up to ten massage parlours.

The participants draw distinctions between elite and less elite places, based on cost. More expensive places are bigger, with dancing and karaoke rooms. These are reported to be patronised by people 'with a lot of dollars', such as NGO staff. Cars belonging to an international organisation have been noted there. The participants comment that such elite 'pleasure places' are usually beyond the reach of their salaries:

***"[Customers] are usually staff of different NGOs, especially the ----- staff, some participants from different police administrative posts, participants of any organisations that are involved in co-operation with NGOs. On the contrary, the normal government staff who live on [a government] salary never go to the dancing bars."***

Cheaper massage parlours, popular with participants, other government officials and moto-taxi drivers cost between R5,000 and R15,000. The charge may be dropped to R3000 for regular customers, while sex with a sex worker in a brothel routinely costs R3000. Sex with promotion women<sup>45</sup> is more expensive than sex with a woman working from a brothel. The participants perceive that promotion women who have come from Phnom Penh want to earn 'lots of money'. They stay at guesthouses and ask the guest-house owners to find clients for them, charging R5000 - R15,000 for sex. Guesthouse owners quote much higher prices for sex with women who promote ---- cigarettes - of \$60 to \$100. The participants believe that students from Phnom Penh pay these women \$150 for sex. The participants do not say why they think students would come from Phnom Penh to pay large amounts of money for sex with women from Phnom Penh.

Participants estimate there are 30-40 commercial sex workers in Svay Rieng. They are judged to be aged mostly between 16 and 26, although may be up to 32 years old. They are believed to be mostly of Cambodian nationality, from provinces all over the country. Not

45 'Promotion women' refers to women who are employed by beer and cigarette companies to promote their products, often in bars and restaurants.

many sex workers in Svay Rieng are from the province itself, but participants state that many women from Svay Rieng travel to other provinces to work as sex workers. Sex workers move from one commercial sex venue to another every two to three weeks, as clients like different women.

Participants estimate that there are between 30 to 40 promotion women who operate openly as sex workers. They also mention that some promotion women sell sex 'secretly' when they agree, they quickly get in the cars and go with the men.

#### 4.2.3.b An Evening Out

Commercial sex is usually referred to in the context of an evening out with a group of male friends. As discussed in Section 1.3, such expeditions usually involve eating and drinking, and possibly karaoke or dancing, followed by commercial sex. Men say that they would be shy to go out alone to places such as karaoke or massage parlours; they are worried that they would be 'judged very passionate and greedy' if they did so. None of the participants describe sex as the main focus of an outing with friends.

*"Sometimes our friends ask us to go out with them. Then, we see  
Cambodian and Vietnamese [sex workers]."*

*"As we are friends we want to have a pleasurable time [together].  
We want to eat together. When we are drunk we remember...[sex]. That's it."*

As the above statement suggests, alcohol is not only an important part of the evening out in general, but considered a significant catalyst for commercial sex. Sex when drunk is described as more 'thrilling' than when sober. As the following conversation shows, participants perceive that being drunk is what makes them think of having sex when they are out with a group of friends:

*"When we are drunk, our eyes see all the girls as very pretty. Most men remember sex when drunk."*

*"Yes, that's true. Eighty-five per cent of all men are brave and excited when they  
have drunk some alcohol, until they have taken one [had sex]."*

*"Exactly, when we are drunk our eyes are dazzled and we see all the girls as much  
prettier [than they appear when sober]. Even [if] they are ugly in reality."*

*"Every man has got very similar attitudes. This is the man's life."*

The participants report that men are often drunk by the time they get to a karaoke bar or a massage parlour. They describe how, at a massage parlour:

***“The massage girls just do body massage and squeeze the sexual organs. When the penis becomes strong and is passionate for having sex, they will have sex drunkenly.”***

Another description of drunkenness and sex acknowledges a higher level of agency in initiating sex on the part of the participants:

***“Most of the girls who work there [at the Karaoke bars] are prettier than our wives, and when we are drunk we see them as much prettier, then we want to try new things, we just go.”***

While participants do not discuss how much they have to drink in order for alcohol to have these effects, they do note that sometimes they become so drunk they forget about sex and fall asleep.

There is an interesting contradiction between describing social activities which often involve heavy drinking and commercial sex as 'necessary for life needs' and the manner in which outings of groups of men are often described as an opportunity to enjoy their friendship by eating and drinking together. Going to a sex worker during an evening out, often when drunk, is conceptualised as a casual - almost accidental - occurrence. They present heavy drinking as social requirement that they cannot avoid, and commercial sex as an inevitable consequence of this. Although the participants will talk openly about the attraction of commercial sex, and their perceived need for sex with different partners, they do not acknowledge prior intent in actually having commercial sex.

#### 4.2.3.c Suspicious Wives

The participants report that they would not tell their wives about outings with male friends that end in visits to sex workers, because their wife would blame them and make trouble, possibly trying to prevent them from going. The saying, 'the strict teacher against the tricky student'<sup>46</sup> is quoted by some participants to characterise the man's relationship with his wife. This contrasts with the role of supportive husband and father described by the participants during the first two days of the three-day workshop (Sections 1.2 and 3.2).

Other participants, in contrast, blame the wife in this scenario for making trouble over her husbands' outings, due to her lack of education:

There are a few educated women [wives] that do not make trouble with their husbands. But some women just think that when their husbands go to karaoke bars and massage parlours, there are some things beyond coining and massaging.

***"...some wives are confused that the massage parlours are brothels of sex workers. ...***

***That's why I suggest that CARE and CHC organisations help provide education***

***to women so that they learn about these [things]."***

The participants blame their wives for being misguided enough to think that commercial sex is available at places such as karaoke bars and massage parlours. Yet the participants themselves say that commercial sex is available at these places.

Strategies for avoiding discussing outings with spouses include lying - informing wives that they have to go on a mission for work or that they are visiting friends - and evasion - by going out straight from work. Some participants may tell their wives that they are going out for coining only, as they are not well. If they are spotted in a place where sex services are available, they are likely to try and convince their wives that they were there for another reason - such as coining.

This lack of communication between husbands and wives - and the accompanying attachment of blame - is likely to make it very difficult for serious negotiations for safe sex to be initiated by either partner.

## 4.3 SAFER SEX

### 4.3.1 REASONS FOR AVOIDING INFECTION

AIDS is feared because it is known to be incurable and because contracting AIDS would bring dishonour to the family. Avoiding infection enables the police to

***"avoid hearing the other people say that, 'Her husband died of AIDS'...and [avoid] ... embarrassing the children with the damage to their honour that their parents died of AIDS."***

Avoiding infection with other STDs is also a reason given by the participants for using condoms (see Figure 7). The economic and social consequences of contracting an STD are considered more significant than health consequences, as treatments are perceived to be effective, cheap and available. Figure 8 shows the relative weight attached to the stated potential consequences of not using a condom. The waste of money refers to the cost of curing STDs - as well as the potential cost of children conceived as a result of unprotected sex.

***"We spend less money than we pay for the treatment. If we go to have sex with sex workers without using condoms and after that we are infected with diseases. So we have get it cured and then it takes a lot of money."***

Loss of time is also an economic factor: the time spent seeking a cure or convalescing may prevent the person from working.

Social consequences include the marital problems resulting from a wife discovering her husband has had sex with sex workers, and the embarrassment of contracting STDs, which contribute to a perceived 'loss of honour'.

***"...as men who are not loyal to our wives, [when] going to sex workers we must use condoms so that our wives do not know - to avoid having any diseases that would embarrass us with our wives."***

#### 4.3.2 RISK ASSESSMENT

Discussions with the participants suggest that infection with HIV/AIDS and other STDs is associated with places and people rather than behaviour. Locations where commercial sex is available are coloured red by the participants on their maps of Svay Rieng, to signify that these are 'dangerous places' (see Figure 3). Participants assess the risk of infection from sex with a woman according to the marital status of their female partner and whether or not the woman is a commercial sex worker. Commercial sex workers are perceived to be very likely infected with STDs:

***"...sex workers are believed to be infected with numerous disease germs."***

***"We are afraid that we will be infected with [HIV/AIDS] when we go to have sex with dancing bar women, women who sell sex at hotels and other sex workers."***

The perceived prevalence of infections among commercial sex workers is attributed to the number of partners they have. One participant describes how infection is passed back and forwards between men and commercial sex workers, attributing all responsibility for not preventing this flow of infections to the woman:

***"[Syphilis] is spread to the women first because the majority of the women infected with that [disease] are sex workers at the brothels or [women who] live at a normal housing place but they do that business. ...they individually have sex with three or four men daily. Because of that, the men might transmit the disease to women. After that the other men come to have sex with the women infected with the disease, the men are infected with the disease from the women. That is why it is said that the women are the people who have the disease and transmit the disease to others."***

This convoluted rationalisation of why sex workers are responsible for the spread of HIV/AIDS and STDs is consistent with an understanding that certain places are dangerous rather than that certain activities carry risk, such as penetrative sex without a condom.

Participants consider themselves to be in complete control of their wives' risk of infection with HIV/AIDS and other STDs, as the possibility of married women having sex with men other than their husbands is not countenanced.<sup>47</sup>

***"AIDS is transmitted from husbands to wives"***

***"If we want our wives clean, not affected by any illness, and also pretty, we do not have sex with the sex workers."***

The participants consider that unprotected sex with their wives presents no risk of infection to themselves:

***"Having sex with our wives without using condoms does not affect our health at all."***

It is not clear why the participants consider their wives to be completely free of infection; for example, why they do not perceive any risk of infecting their wives and being re-infected themselves as a result - nor any risk that their wives might become infected from, for example, contaminated blood. They state that sex workers are as concerned to protect themselves from infection from men, and do not seem to find this surprising.

***"We all know that we are afraid that they [sex workers] have diseases; they also afraid that we have diseases too."***

***"We do not know about each other - [do not know] who has got a disease."***

***"We do not trust them, and they also do not trust us as to whether or not the other [person] has a disease or not."***

The police assess the risk involved in sex with women other than their wives or sex workers according to their perception of the number of previous partners the woman has had:

***"... we never go to the sex workers but we often have many partners and some of our partners [may be] HIV positive as they have had many partners before they met us."***

***"...the rich people take more risks with AIDS because they have a lot of money for going out [with different girls]...but the poor people do not have that much money and [so] they do not often go out as often as the rich people."***

<sup>47</sup> Second wives are mentioned as a potential source of infection for men because they may have had many previous partners, or have been sex workers. In answer to a direct question from a researcher about the possibility of married women having sex with men other than their husband, participants replied that this was extremely rare.

The participants consider themselves to be poor, and state several times that they do not have the money to go out - and therefore to have commercial sex - all that often. However, one participant comments that the cheaper locations for commercial sex which are more easily afforded by the participants are the places 'that usually have AIDS'. This comment again reflects a connection between risk and place rather than behaviour.

#### 4.3.3 STRATEGIES FOR AVOIDING INFECTION

The participants identify two strategies for avoiding infection with HIV/AIDS and other STDs which they state are supported by health promotion messages to which they are exposed:

***"The information...is spread through various means like radio, television, newspapers and magazines, and also by medical people who do health education... . Those people always tell us and all the other people to use condoms when we go out and have sex with partners that we do not trust, and that if we want to be free from that we have to have one-to-one love."***

##### 4.3.3.a Condoms

All participants state that using condoms can protect them from HIV/AIDS and STDs:

***"We have to use condoms and always carry condoms in our pockets."***

Condom use is perceived to be advocated by health promotion messages rather than abstinence from sex:

***"We are not prohibited from having sex, we are still allowed to play with that but we are asked to use condoms."***

***"We are openly entitled to do that and we can do whatever we like but we have to use condoms to protect ourselves."***

***"We are not stopped from making love and sentiments but always use [condoms]."***

All the participants state clearly that people who know they are HIV positive should always use condoms in order to prevent themselves from transmitting the virus to other people. However, while they all state that they should protect themselves by using condoms with people whom they perceive as potentially infected with HIV, there is little concept of transferring concept of safer sex practice to protect other people from their own *potential* infection. One of the few comments from the participants that mentioned condoms in this capacity:

***"...after having gone out very often with bad people [commercial sex workers]...  
if we are not healthy as before...we have to go to the hospital and have our  
blood tested for AIDS. When we are told that we are HIV positive, we  
have to think about our wife's health. Then all the times you  
have sex, condoms must be used."***

Some of the participants are concerned about the reliability of condoms as a means of preventing infection:

***"Sometimes the condoms worn on [the penis] break and leak, then they  
and we are really frightened of being infected with the disease."***

One participant attributes the fallibility of condoms to carelessness on the part of the user

***"Sometimes it is not properly used it leaks or is torn that is because we are not careful in using it."***

#### 4.3.3.b One-To-One Partners

The alternative strategy for avoiding infections from sex is to have 'one-to-one partners'. Some participants consider that one-to-one partners is a more reliable strategy than using condoms:

***"If we want to be safer than that we have to have a one-to-one love.  
Because [using condoms]...cannot ensure that we are 100 per cent  
but probably about 90 per cent safe from the disease."***

Husbands and wives are one example given of one-to-one partners. The possibility of a spouse being infected from an earlier sexual partner is not discussed in relation to the participants although blood tests for HIV are known to be required for some young people planning to marry now.

However, one-to-one partners is interpreted much more widely than sexual relationships between married couples. It includes relationships between men and women who plan to marry (- or where the woman thinks they plan to marry), relationships that are not expected to last long, and relationships with women who work in commercial sex locations.

***"When I have no money I never go to the dancing bars. But if I  
have I only go to the one-to-one faithful love."***

The concept of the existence of 'safe' sexual partners based on assumptions about their current sexual behaviour and not necessarily taking their previous sexual behaviour into account:

may well provide the participants - and other people - with a false sense of security regarding their risk of infection. In addition, if the participants - or other men - assess their own risk of infection as negligible in a given sexual relationship, their decision not to use condoms may expose their female partners to infection. Negotiation of condom use is discussed further in Section 4.4.4.

## 4.4 FACTORS AFFECTING CONDOM USE

### 4.4.1 ACCESSIBILITY OF CONDOMS

The participants report that it is very easy for them to access condoms in Svay Rieng, and that they are very cheap. A considerable variety of brands exist. Number One are mid-price range - the cheapest brands of condom are made in Vietnam. Number One are considered to be good quality - tough and soft, and not prone to tearing and leaking. They are widely available in Svay Rieng town, whereas the Vietnamese-made condoms are available in the rural areas of the province. Condoms are provided free in brothels, and sold in guesthouses, hotels, pharmacies, markets and health centres.

The participants report that some condoms cost R1000 each, causing people to wash them out and re-use them rather than throw away something so expensive. The participants note, however, that people in Svay Rieng do not usually use such expensive condoms, although they are available at guesthouses and hotels. They report that these condoms are mainly bought by 'higher-ranking' people from Phnom Penh.

Some condom brands make sex more thrilling for the participants; for example, a brand called Goats Eyes. However, these are very expensive. One type of condom, which costs R5000 for one and is only available in larger pharmacies in Phnom Penh, has many small hard hairs woven into it. If condoms with additional features such as these are likely, in general, to be less safe than standard condoms, then information about avoiding HIV/AIDS and STD prevention should include some guidance on quality indicators for condoms.

The participants report that condoms are not always available in rural areas and this is identified as one reason for not using condoms (Figure 8 shows the reasons identified by the participants for not using condoms). One group ranks unplanned sex equally with being drunk as a reason for having unprotected sex. For example, one participant explains:

***"...sometimes we travel to rural areas and...they allow us to have sex with them. As we are in a hurry, we would have sex without using condoms because we do not have them."***

The participants do not seem to accept any responsibility for not having condoms available. Throughout their discussions of the reasons for not using condoms, the force with which they state that they should use condoms is in sharp contrast to their reported ability - and their perception of their ability - to actually use condoms.

The marital problems caused by wives finding condoms in their possession may prevent the participants from 'always carrying a condom in their pocket' as they advise above

***"Sometimes some of our friends seek ways to embarrass us by hiding some condoms in our pockets. When we are back home and our wives see the condoms in the pockets, then we are...accused by our wives."***

#### 4.4.2 CONDOMS AND SEXUAL PLEASURE

Condoms are perceived by participants to diminish sexual pleasure for both men and women. This appears on the Figure 8 as 'resolve passion needs'. Having sex without condoms is 'more comfortable' and more thrilling than having sex with condoms. Participants describe how condoms make them feel:

***"...numb and sluggish. So having sex without using condoms is more enjoyable."***

***"When we are having sex we do not use condoms because we are very thrilled to have sex. But after having sex, we feel very sorry."***

***"We have reached the highest point of orgasm without using condoms."***

One participant explains that condoms make sex less comfortable and may give men headaches, because they prevent the exchange of bodily fluids

***"...when people have sex using condoms, the man would have headaches as it is believed that the sexual partners are alright with sex when their reproductive fluids, the sperms and the ovum, meet... it makes people have very enjoyable sex. This is because they have exchanged the fluids. In contrast when we use condoms, [fluids do not mix and so] we have headaches."***

It is not stated whether women also suffer from headaches as a result of her male partner wearing a condom.

Condoms are also perceived to add 'distance' to a sexual relationship. For example, the participants describe how people who use condoms.

***"...do not feel very good and friendly with the partners we are with."***

***"Without using condoms we feel very close in sexual relations."***

It is not clear whether 'feeling close' is an important feature of all the participants' sexual relationships.

#### 4.4.3 ALCOHOL

All the participants discussed the perceived influence of alcohol on condom use, although, as can be seen in Figure 8, only one group of participants ranked this as a reason for not using condoms. Being drunk is perceived to reverse the intention stated by the participants of using condoms at all times with commercial sex workers:

***"We do not use condoms when we are very drunk, but when we are just slightly drunk, we still need and use condoms. In contrast, when we are heavily drunk, we would avoid using condoms even we are given the condoms and told to use them."***

Getting drunk and forgetting to use condoms is one of the concerns of the participants about going out with their friends:

***"We are worried that going out very often can cause people to... [be] infected with diseases. Because when we go out and drink very much, and then we can forget the Number One condoms as we are heavily drunk."***

***"...when drunk, sometimes the plastic bags [condoms] are forgotten. Afterwards, we are worried and frightened - I used to be like that."***

***"This is because the people are very careless about the diseases, for example when they are too drunk and then they forget to use the condoms."***

The explanation that men do not use condoms when they are drunk because they forget is contradicted by the statement above that they avoid using condoms when they are drunk.

#### 4.4.4 NEGOTIATING CONDOM USE

Participants state that women who want to avoid infection with diseases have to ask their male partners to use condoms. They state that it is the responsibility of an unmarried woman to ask her sweetheart to use condoms if she wants to avoid becoming pregnant before marriage. They state that this is also a strategy for a woman to avoid becoming pregnant by a man who turns out to have no intention of marrying her.

***"If the woman does not want to get pregnant, the woman has to decide to use the condoms. This can also be a measure to deal with the man who just makes the relationship and then leaves the woman."***

However, the scripts for courtship related by the participants (see Section 4.2.2) imply that it would be very difficult for a woman to implement such a strategy. A woman is expected to have sex with her sweetheart because she believes everything he has told her about his undying love for her. To ask him to use condoms just in case this love turns out not to be undying after all contradicts her very reason for having sex (as identified for her by the participants). In addition, the participants also suggest other non-barrier contraceptive methods, including withdrawal, that would be appropriate for 'sweethearts'.

***"...the women have to tell the men that we are not married yet so you have to use the condoms in order to avoid getting pregnant. ... Sometimes we have sex without using condoms but when we get to orgasm we have to take our sexual organs out of the woman's."***

It could prove difficult for a woman to persuade her boyfriend that condoms were her contraceptive of choice without implying that she thought he was having sex with commercial sex workers, and therefore that she did not trust him.

The participants state that decisions about contraception are made jointly by married couples. They identify condoms, IUDs, contraceptive pills and contraceptive injections as contraceptive methods, although they do not know details of how these contraceptive methods are used - for example, they are not sure exactly where an IUD is placed in a woman's body or how often contraceptive injections are given. A participant whose wife uses the contraceptive pill states that it is important to take it everyday in order to avoid pregnancy. One participant comments that condoms are the best form of contraception for married couples, as they do not cause any health problem. He states that injections make people hot, and he has seen that they can cause weight loss or gain, and that some people also react to contraceptive pills.

Most of the participants suggest that women would know more than them about contraception. All the participants state that they do not need to use condoms with their wives to avoid the transmission of disease. Therefore, it seems likely that a married woman would find it difficult to negotiate condom use with her husband, unless the couple agreed that other contraception presented risks to the women's health and this was an important factor in their decision-making.

The participants state that sex workers want to protect themselves from infection, know how to use condoms, and will request their clients to use condoms. The participants draw no connections between these assertions and their explanations of why they have sex without condoms when drunk:

***Sex workers do know how to use the condoms and they are aware of the issues. They tell us to use the condoms when have sex with them.***

*"They are afraid of being infected with disease."*

*"If we do not use the condoms they do not allow us to have sex."*

Sex workers are perceived as in control of their own risk of infection with STDs and AIDS. The participants perceive themselves as knowing that they 'should' use condoms, but forgetting or avoiding condom use when they are drunk. Drunkenness, like commercial sex, is described as an unforeseen occurrence by the participants, or is explained as the result of irresistible social pressure. The extent to which the participants' perceived lack of control of their risk of infection when drunk impacts on sex workers' control of their own risk of infection is not acknowledged by the participants. It seems likely that sex workers would find it very difficult to negotiate condom use with drunken men who conceptualise drunkenness either as absolving themselves from responsibility for their actions or as preventing themselves from being in control of their actions:

*"If we are heavily drunk, we avoid using condoms even if we are given the condoms and told to use them."*

## 4.5 REPORTED SEXUAL BEHAVIOUR

The participants were asked directly about their sexual behaviour in the last month. Answers were written anonymously on slips of paper.<sup>49</sup> Thus, it was not possible for the researchers to follow-up on the answers. The responses of the participants are tabulated in Appendix 2.

One participant reported that he had paid for sex in the last month, and one participant reported that he had had two sexual partners in the last month. All the other participants reported that they had had one, or no, sexual partners in the last month. Three participants said that they had used condoms in the last month. Two participants stated that they have used condoms when having sex with their sweethearts in the last month. One stated that he has used condoms with his sweetheart(s) in the past.

While all the participants talked openly commercial sex, this reported behaviour suggests that they visit commercial sex workers less than once a month. They do not use condoms with their wives, but some do so with their sweethearts.

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<sup>49</sup> Questions about personal sexual behaviour were asked in a confidential manner - the participants were asked to write their answers to questions on anonymous slips of paper. The answers were recorded by the note-taker, and the slips of paper were then destroyed by the note-taker in front of the participants. This was the only research method used during the three days of research which did not involve open discussion. The closed nature of the questioning meant that it was not possible for the facilitator to follow up on answers.

## 5. CONCLUSIONS

The participants describe their work as having considerable social value. They feel that their salaries are insufficient to meet the day-to-day requirements of family life. Their work as police officers is only one part of their family livelihood. Married men are expected to take considerable responsibility for the material and social welfare of their families, and the policemen wish to portray themselves as dutiful husbands and fathers. Some policemen express a perception that their status as educated males requires them to provide health information to other family members.

There is a substantial discrepancy between what the participants say they should do and what they do. In addition, there is an apparent contradiction between the family-oriented activities which the participants recommend for married men, and meeting their own perceived needs for peer-group-based activities. Socialising with friends not only enables the participants to meet their expressed 'life needs', but is enjoyable in itself.

The participants have serious concerns about aspects of their social life, particularly about excessive alcohol consumption. They are concerned about damaging their health by drinking too much, traffic accidents caused by drunk driving and the role alcohol plays in the participants' failure to use a condom during sex with a commercial sex worker. They report that peer pressure to participate in drinking sessions is very difficult to resist. The limited control the participants describe over this aspect of their lives is in contrast to the sense of leadership implicit in their descriptions of their role in the family. Conceptualisations of alcohol dependency and addiction are not clear from the discussions.

The participants know that HIV/AIDS is an incurable and terminal illness which can be transmitted through sex. It is possible that there are some misconceptions about links between vulnerability to infection and a person's state of health. They are also aware of several other STDs, although their knowledge of symptoms and disease progression is often inaccurate. STDs other than HIV/AIDS are not considered to be serious and the participants are unaware of any direct link between STDs and HIV/AIDS transmission.

The participants are unclear about how diseases are transmitted through sex, and this is likely to make it very difficult for them to assess the risk involved in different sexual activities. If sex is conceptualised as referring only to peno-vaginal intercourse, people may infer from information that HIV/AIDS is not transmissible through activities such as oral or anal sex.

No participants report actually knowing or meeting a person with HIV/AIDS. There is considerable social stigma attached to HIV/AIDS, and at least some stigma attached to STDs.

largely due to the association of these diseases with commercial sex. Condoms are also strongly associated with commercial sex workers.

The health-seeking behaviour of the participants is determined by a complex series of decisions and evaluations. Traditional medicine is popular for treating STDs because it is cheap and believed to be effective. A perceived lack of confidentiality may deter the participants from seeking testing or treatment for HIV/AIDS or STDs.

The context of the participants' evaluation of the treatment options for STDs is one of limited knowledge and misinformation. *An underestimation of the risks of having an STD, both directly and as a catalyst for HIV transmission, prevents them from making fully informed decisions.* The participants assess the efficacy of different treatments experientially, either by drawing on *the experience of others, first-hand experience or by accessing a series of different treatments until the patient is satisfied that the treatment has been successful.*<sup>51</sup> Confusion about the difference between HIV and AIDS, and lack of knowledge about asymptomatic phases of *different STDs are likely to give the participants misplaced confidence that they - and their sexual partners - are free from infection, and that treatments have been effective.*

If Western medical treatment is accessed, ceasing treatment once the patient believes it to have been successful may lead to non-compliance with recommended courses of medication, increasing resistance to drugs.<sup>52</sup>

The participants have been exposed to health promotion messages through a number of different media. They interpret these messages as sanctioning commercial sex provided they use condoms, and as recommending one-to-one partners as an alternative strategy for avoiding HIV/AIDS. The participants differentiate between the quality of different condoms, but their comments about a brand of condoms that has small hairs woven into suggest that they may not have clear guidelines for evaluating condom quality. One-to-one relationships are interpreted quite widely, and does not necessarily refer to a mutually monogamous relationship, nor necessarily take account of previous sexual partners either person may have had.

Risk assessments of sexual activities are also based on the social norms dictating sexual behaviour, leading to potentially dangerous assumptions about other people's sexual behaviour - for example, the number of sexual partners they have had. STDs are perceived as predominantly men's diseases (with the important exception of commercial sex workers). It is not clear why this is the case. It is clearly understood that HIV/AIDS and other STDs can be transmitted from men to women as well as women to men. Commercial sex workers are held responsible for the spread of HIV/AIDS and other STDs. It is not explained why the participants do not consider HIV/AIDS and other STDs to be as prevalent among women who are not sex workers as they are among men, as a result of being infected by their husband or sweetheart.

51 Or, presumably, until the patient feels he/she can not afford further treatment.

52 No objective assessment of treatments or health services was made during this research. The quality of the Western medical advice available to participants was not investigated.

Social norms governing sexual behaviour are also likely to affect the ability of people to negotiate for safer sex. For example, if sex between sweethearts depends on mutual declarations of trust, it may be difficult for either partner to express concern about the possibility of infection as this might be taken to doubt the sincerity of their partner. Women who have sex with their boyfriends are expected by men to be more concerned about the possibility of pregnancy than the possibility of infection. While it may seem that this would enable them to negotiate for condom use, men's knowledge - not always accurate - of non-barrier contraceptive methods may make this difficult.

There appears to be little communication between husbands and wives regarding safer sex decisions. Married women are assumed to be faithful to their husbands. Husbands are likely to conceal their extra-marital sexual activity from their wives for fear of being blamed and domestic strife. The participants do not seem to consider the possibility of using condoms - or discussing condom use - in order to protect their wives from infection, unless they know they have an infection.

The participants' analysis of some of their behaviour patterns does not always directly acknowledge responsibility either for their actions or the potential consequences of their actions for other people. For example, the participants describe visiting sex workers as an unplanned - unforeseen - addition to an evening out with friends as a result of drunkenness. This is despite the fact that multiple partners are stated to increase passion and desire and avoid the negative health impact of too much sex with the same partner.

Drunkenness, in particular, is perceived to prevent men from controlling their actions. The participants state that they should, therefore, avoid drinking if they wish to avoid the perceived negative consequences of drinking. They do not consider this to be easy. The identified strategies for controlling or avoiding alcohol consumption are negotiation with friends who are perceived as pressuring them, and will-power. It seems that the participants consider themselves responsible for getting drunk, but may not consider themselves responsible for what they do while they are drunk.

# FIGURE 1: FREE-TIME ACTIVITIES

*'Free-time' means time when the participants are not working as policemen. This list was prepared by one group of policemen, who then ranked the activities in order of importance.*

**1 = most important activity**

1. help do work in the house
2. maintain house
3. clean house, sweep up rubbish around house
4. teach children
5. take family members to visit beautiful places
6. physical exercise
7. learn foreign languages
8. work in the rice-fields and make vegetable beds
9. help look for firewood, carry water
10. help wash and iron clothes
11. look after: cows; buffaloes; pigs; chickens; ducks
12. help with the family business
13. help feed animals
14. catch fish
15. help harvest the dry season rice
16. go to enjoy traditional festivals and ceremonies
17. meet friends and drink alcohol, be happy
18. eat soup
19. sing karaoke songs
20. drink coffee and watch videos
21. take partners to visit beautiful places
22. take sweethearts to visit beautiful places<sup>53</sup>
23. go to brothels
24. have a massage
25. dance at bars
26. play cards
27. play billiards
28. play boules

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<sup>53</sup> The participants were concerned that partners might be understood as 'friends' rather than sweethearts, and so decided to put both terms.

# FIGURE 1A: FREE-TIME ACTIVITIES

*'Free-time' means time when the participants are not working as policemen*

**When I am free from my government work, I usually help do housework as follows:**

*"We usually help do housework in order to improve our daily living. On nights that we are not on duty, we teach our children."*

*"Sometimes we ask some friends to visit other friends. We occasionally gather friends to go to the 'Heart-Cooling' place for dancing for fun."*

*"We often take our family to visit some other places."*

*"As we sometimes eat and drink very much, our health is often destroyed and therefore Cambodian social values are badly affected."*

*"So, free-time can cause us to make some progress and sometimes it can make us face bad consequences."*

*A collective statement prepared by one group of policemen*

<sup>54</sup> The 'Heart-Cooling' place is a popular restaurant and dancing bar.

# FIGURE 2: VENN DIAGRAM

This diagram was prepared by one group of participants to illustrate the relative importance to their lives of different institutions and services. The central circle represents the group of participants. Each of the other circles represents an institution or service. The relative importance of the institutions and services is shown by the relative size of each circle and the relative proximity of this circle to the central circle. See section 1.3.1 for an explanation of 'importance'.

\*'Hygiene' refers to condom use, rather than a particular institution or service.



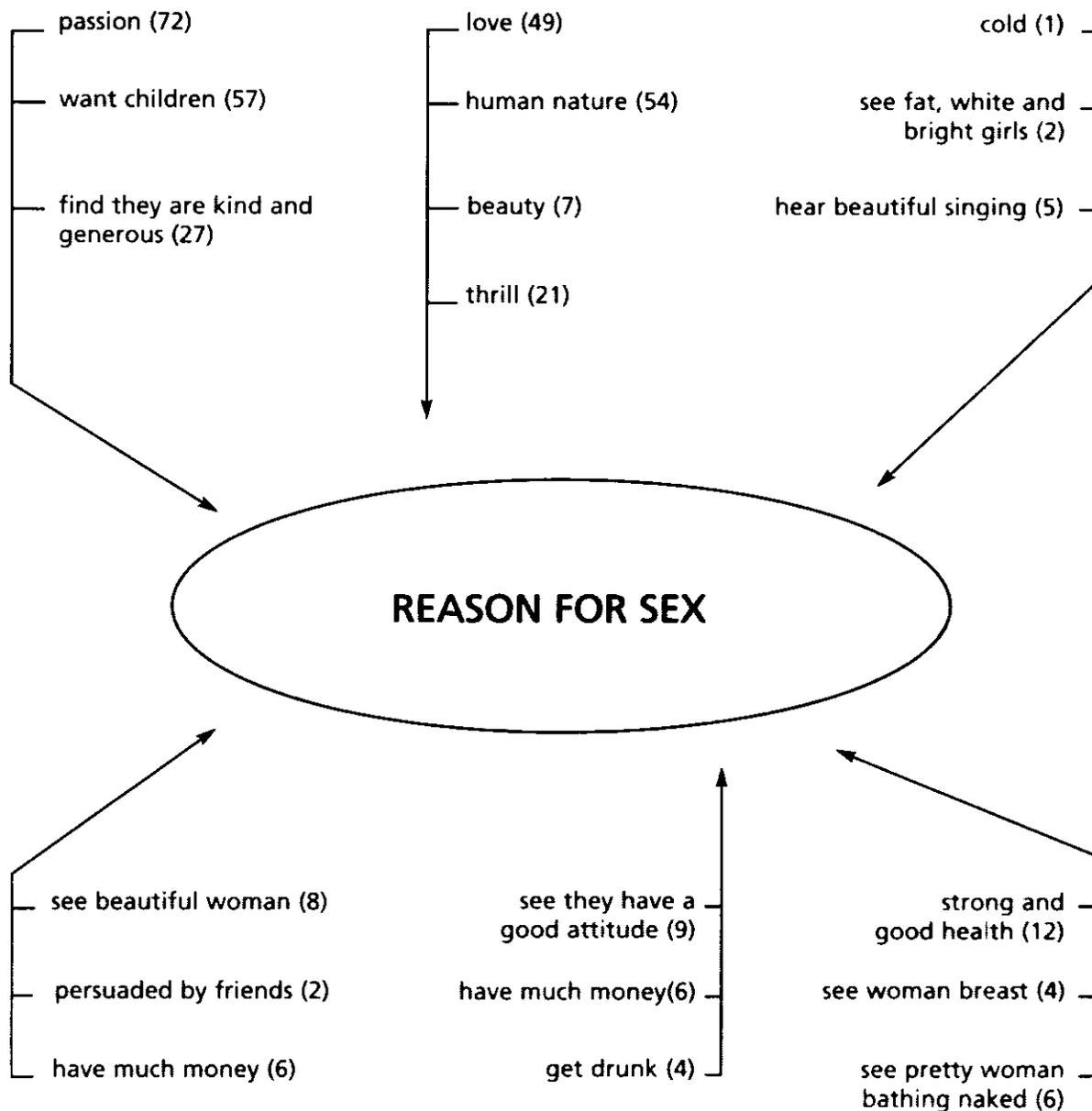




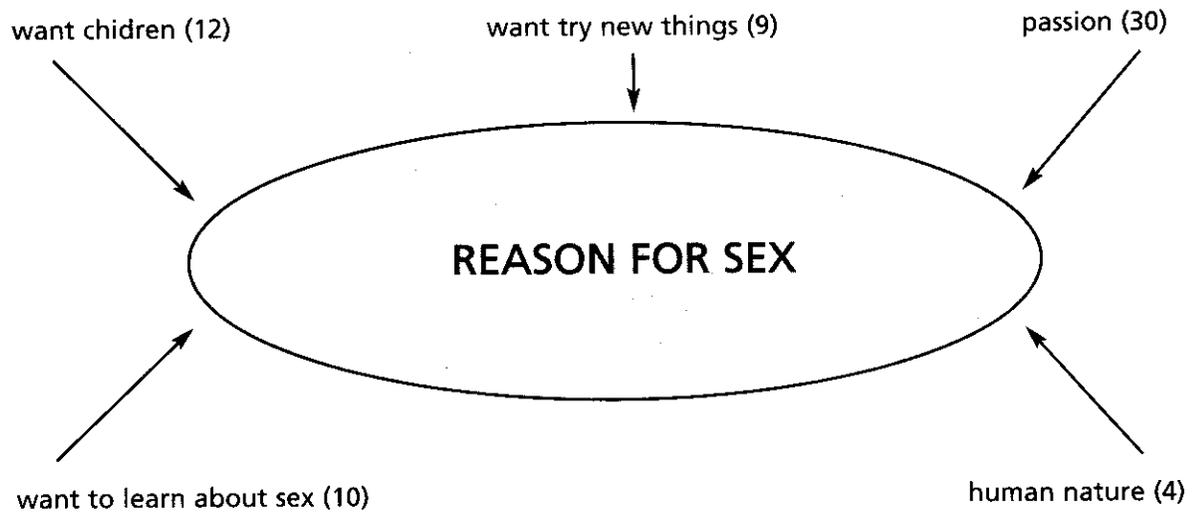
# FIGURE 4: REASONS FOR SEX

Arrows going into the circle represent reasons for sex. Each group scored each reason for importance the higher the number, the more important the reason.

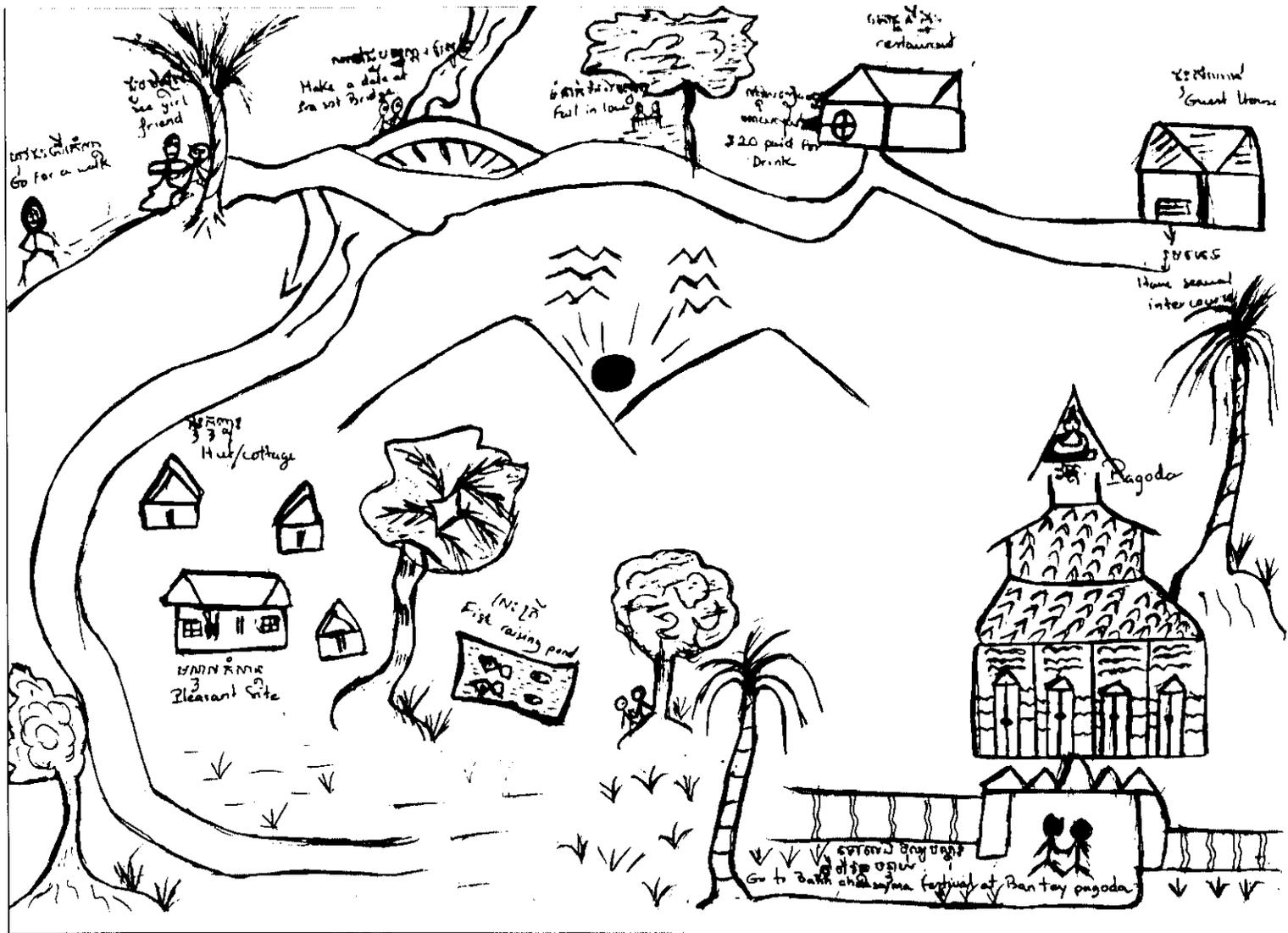
## GROUP 1



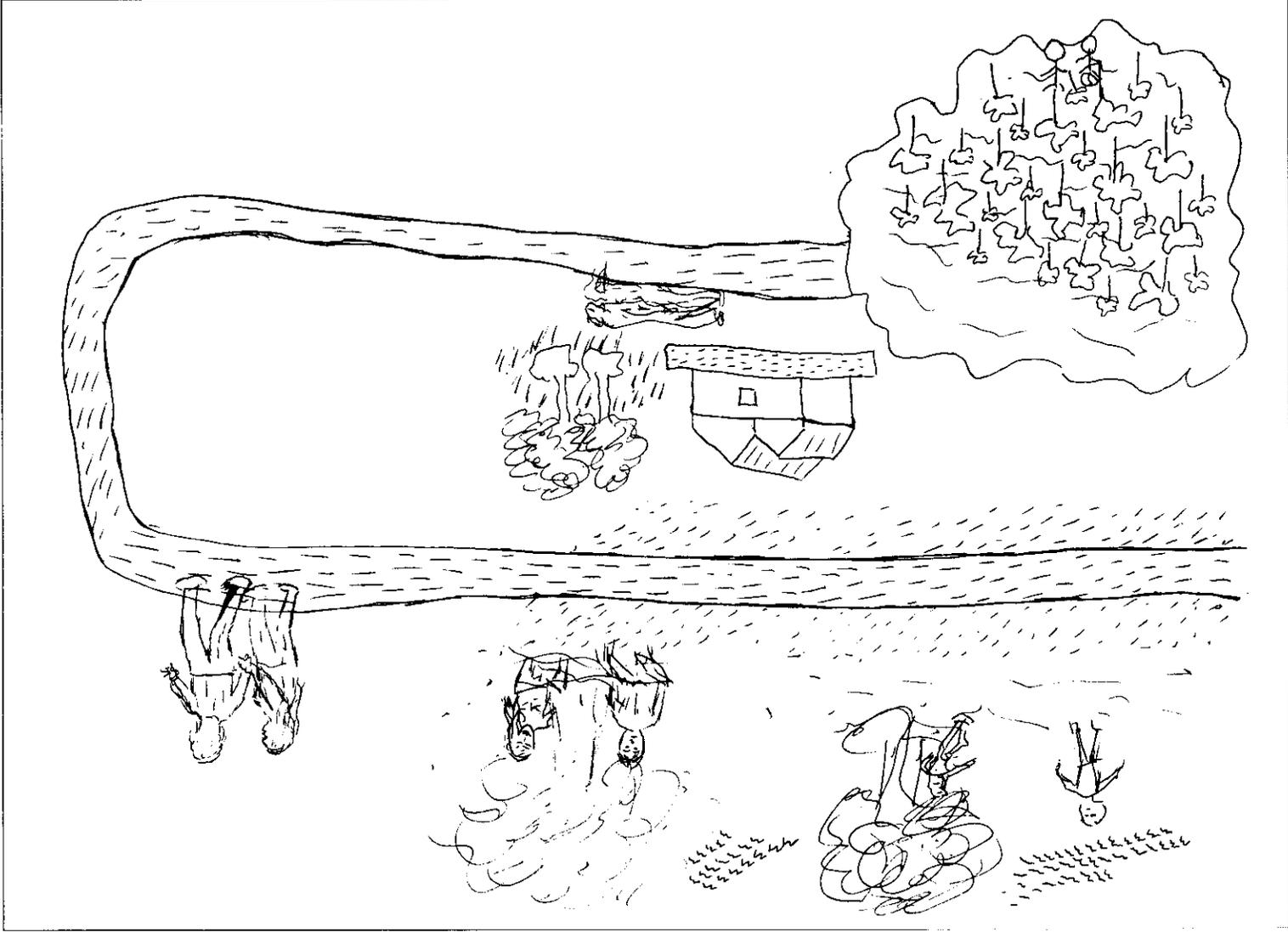
**GROUP 2**



**FIGURE 5:**  
PICTURE STORY



# FIGURE 6: PICTURE STORY

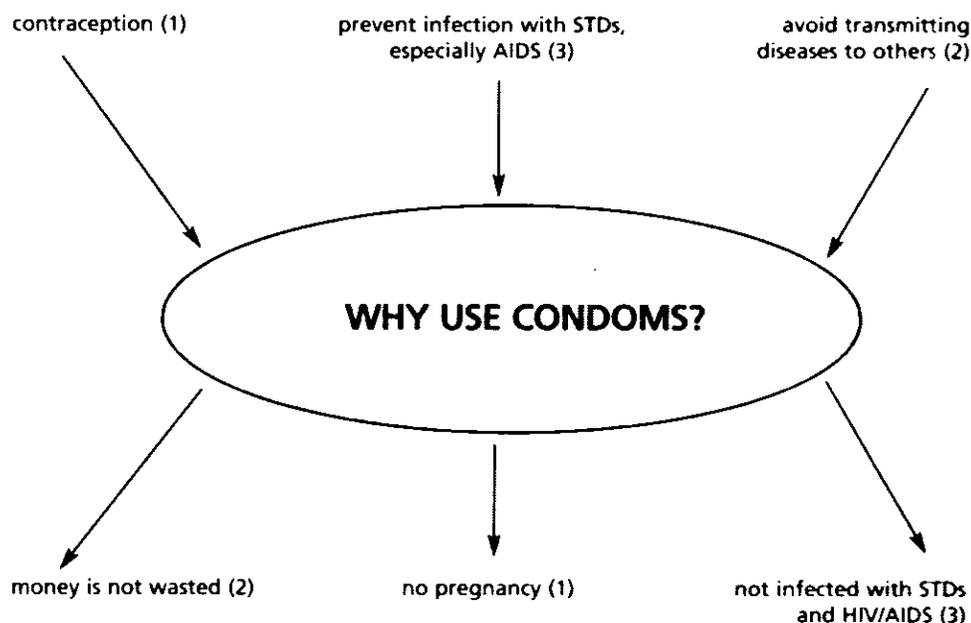


# FIGURE 7: REASONS AND CONSEQUENCES OF USING CONDOMS

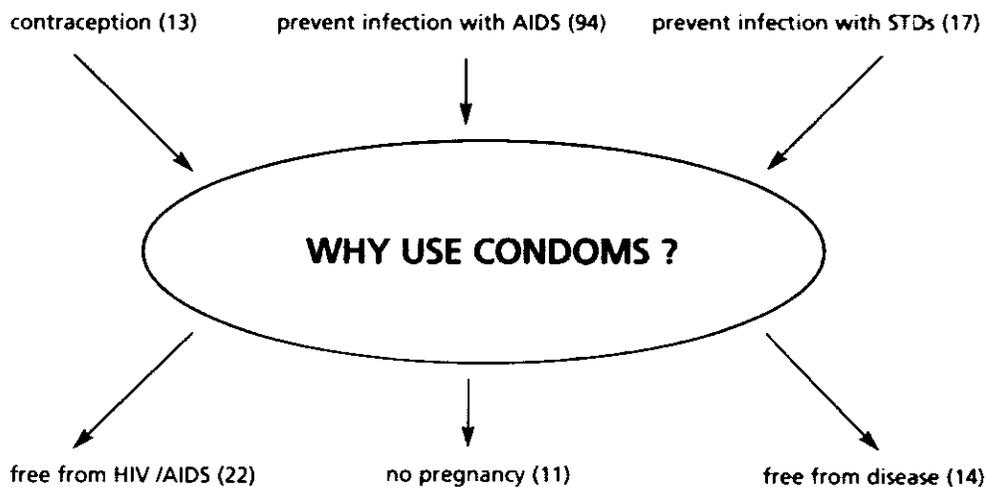
Arrows going into the circle represent reasons for using condoms. Arrows pointing out of the circle represent the consequences of using condoms.

Each group scored each reason and consequence for importance: the higher the number, the more important the reason or consequence.

## GROUP 1



## GROUP 2

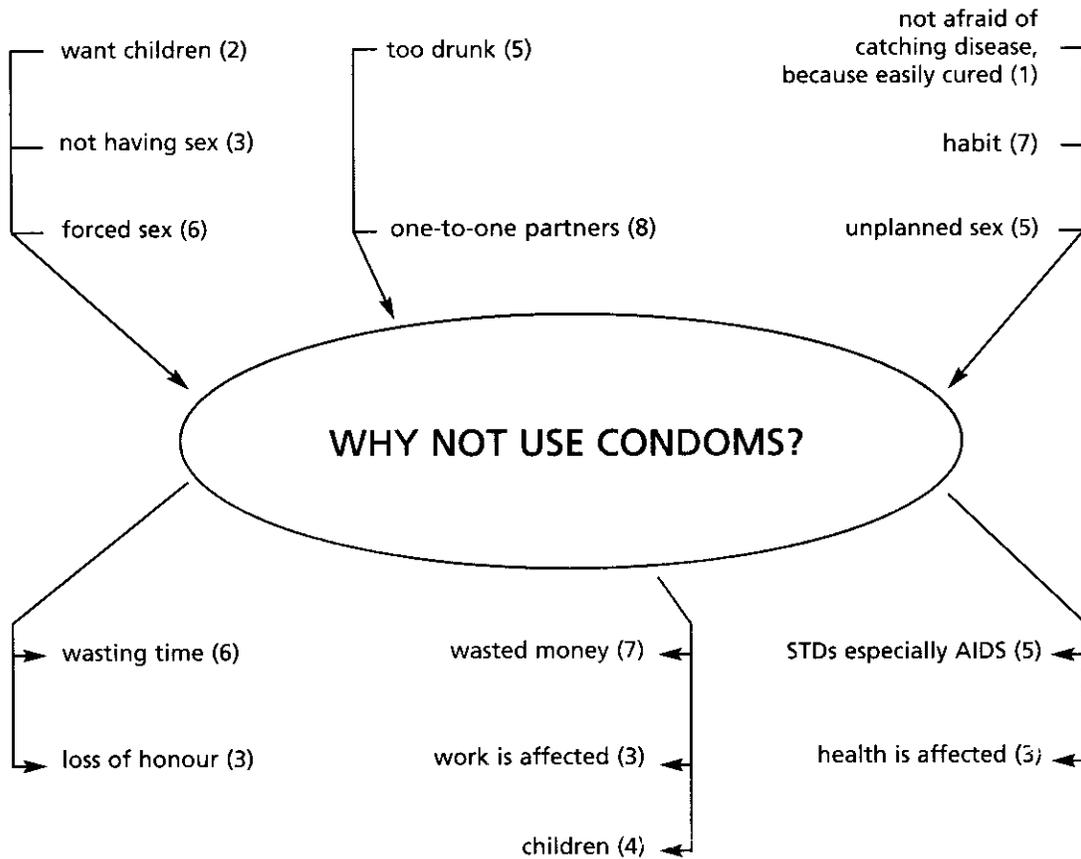


# FIGURE 8: REASONS AND CONSEQUENCES OF NOT USING CONDOMS

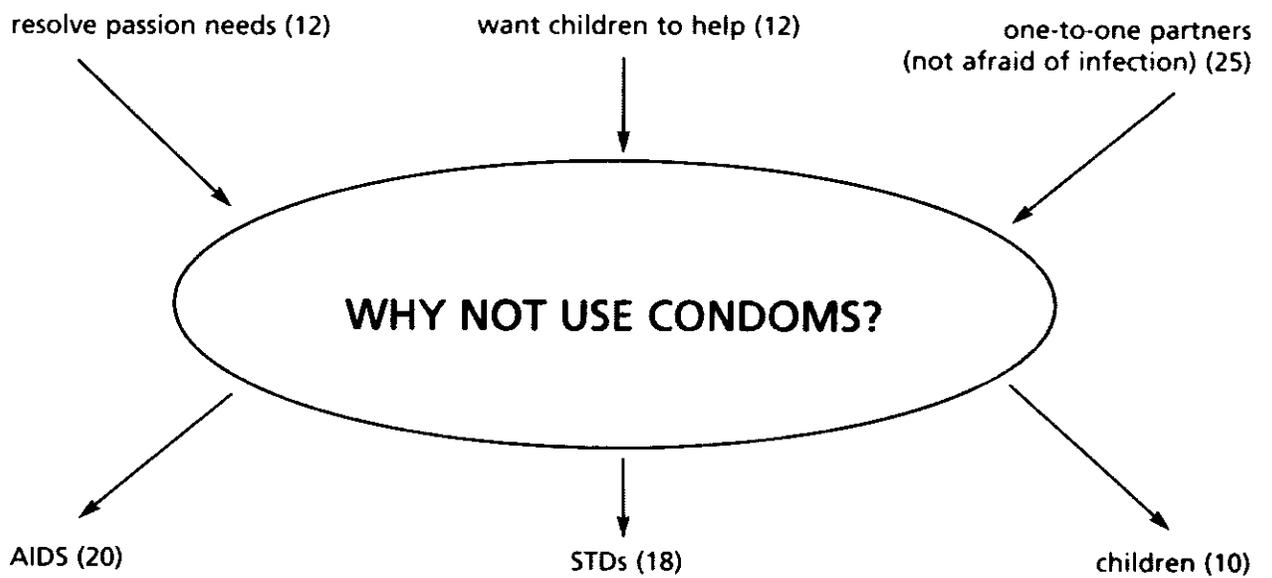
Arrows going into the circle represent reasons for not using condoms. Arrows pointing out of the circle represent the consequences of not using condoms.

Each group scored each reason and consequence for importance: the higher the number, the more important the reason or consequence.

## GROUP 1



**GROUP 1**



# TABLE 1: SEXUAL HEALTH PROBLEMS: SYMPTOMS, PROGRESSION AND TRANSMISSION

Hepatitis A,B,C	Hepatitis C is the most dangerous	Transmissible through sex, sharing cutlery, drinking water, sharing clothes.
flesh covering the end of the urethra (men)		This is a congenital condition and is not contagious
fleshy growths on reproductive organs	'cauliflower-like' growths on the end of the penis, sometimes blocking the exit to the urethra and preventing urination. These growths may be painful and itchy.	Transmitted through sexual intercourse. Men are particularly vulnerable to infection from a woman who has a vaginal discharge if they have bruises on any part of their penis .
seed gonorrhoea	Difficult to urinate, waist may be slightly painful; may have temperature; sediment visible in urine; may be slightly incontinent; hair goes grey	Some participants believe this to be a sexually transmitted disease. Most believe that it is caused by eating or drinking unclean food or water. The impurities form small hard 'seeds' or stones. These seeds are believed to cause infection either by moving about in the kidney, or by falling into the bladder, from where they may also move to block the urethra.
hidden syphilis	asymptomatic until certain foods are eaten: for example, if 'Kapa' duck <sup>55</sup> is eaten, the symptoms of syphilis will appear 3 - 4 years later. At the time of eating the duck, a fever will occur. Later symptoms are joint pain. It is difficult to diagnose until this symptom occurs. Other symptoms are weight loss; temperature	Transmitted through sexual intercourse
HIV/AIDS	<p>Initial symptoms are bad colds, frequent diarrhoea, fever and weight loss. HIV/AIDS may be suspected if 'the state of health changes a lot and often'. Other diseases will affect the patient in the later stages of the disease. The policemen have heard that the time from infection to death may be as long as ten years. One participant states that:</p> <p>all the symptoms that appear on the AIDS patients are the same as those of the other skin diseases and leprosy. And it is believed that the leprosy results from hidden syphilis.</p> <p>All the policemen state that people may have HIV/AIDS with no visible symptoms - they may appear 'pretty and healthy'. Blood tests are known to be a foolproof way of diagnosing HIV or AIDS, and are reported to be available at public and private hospitals within the province.</p>	<p>Both groups of policemen identified the following transmission routes for HIV/AIDS:</p> <ul style="list-style-type: none"> <li>• peno-vaginal sex</li> <li>• un-sterilised syringes</li> <li>• blood transfusion</li> <li>• manicures and shaving (when un-sterilised implements accidentally cut the skin)</li> <li>• from mother to unborn child</li> <li>• breast-feeding</li> </ul> <p>The AIDS virus is known to be contained in blood, and contamination with infected blood is identified as the cause of infection in all the transmission routes listed above except sexual intercourse.</p> <p>Some participants state that AIDS can be transmitted through oral sex and 'sucking mouths', but this is disputed by others</p>

<p>impotence (men)</p>	<p>weak or dead penis, usually affecting men at 40-45</p>	<p>Caused by</p> <ul style="list-style-type: none"> <li>• becoming sexually active at a young age</li> <li>• having sex too often</li> <li>• taking too many medicines</li> <li>• unequal testicles</li> </ul> <p>some people cannot bear not having sex often. When we have sex a lot we become wear and then gradually our penis becomes impotent because it is over-worked</p>
<p>kidney infection</p>	<p>Hot on one side of the body, very painful around the kidneys, fever, dizziness, urine is a red colour due to being stored in the kidney for many hours</p>	<p>Caused by urinating infrequently</p>
<p>urinating difficulty</p>	<p>Urinating is difficult and painful. Men experience the urge to urinate and cannot or pass only a small amount of urine at a time</p>	<p>Caused by drinking un-boiled water. Some participants state that it is a sexually transmissible disease, others that it is not contagious</p>
<p>rice-water gonorrhoea</p>	<p>Pain on urinating. The last drops of urine look like the juice produced when rice is cooked. Other symptoms are fever, hot inside the body, and headaches. As the infection becomes more severe, more and more difficulty is experienced in urinating and the penis may be damaged</p>	<p>Symptoms in women include vaginal discharge, a sloping back and coughing. Many participants believe this to be a sexually transmissible disease. Some state that it is not contagious but caused by kidney infections or poor health. The rice-water discharge is understood to be the result of an infection in the bladder</p>
<p>syphilis</p>	<p>Swollen penis and groin, causing men to walk awkwardly in a manner that they perceive to be noticeable to other people. temperature, discharge when urinating, hot urine</p> <p>If left untreated, syphilis may eat the reproductive organs and may prove fatal</p> <p>Symptoms in women include vaginal discharge, sloping backs and coughing, temperature, hot urine</p> <p>Some participants state that infection with syphilis causes painful suffering which can be alleviated through sex. Therefore, men and women suffering from syphilis will have sex with as many people as possible</p>	<p>Usually transmitted through sex - aided by the desire of people suffering from syphilis to have sex with as many people as possible (see symptoms)</p> <p>It may also be transmitted by urinating in a place where an person infected with syphilis has urinated. The germs are believed to travel up steam from the urine and infect the reproductive organs</p>
<p>tiem lar</p>	<p>small lumps inside the vagina and around the forepart of the penis</p>	<p>Evolves from hidden syphilis, triggered by eating certain foods, and then becomes cancer. It is also caused by becoming sexually active at a young age</p>
<p>unequal testicles</p>	<p>May become hard and painful in cold or windy weather. The patient may also be impotent</p>	

## TABLE 2: WOMEN'S HEALTH PROBLEMS

PROBLEM	SYMPTOMS	CAUSE	TREATMENT
abortion	an abortion can cause bleeding, infection, and the forepart of the uterus to break; can cause vaginal discharge		
uterine infection		Due to sex after the woman has had an illness	
prolapsed uterus		Caused by pushing very strongly to deliver first child	
post-part relapse		not related to sex	
creeping uterus	If not treated quickly, the uterus can move out of the belly		traditional herbs - are very effective in treating this - boil them and drink the water
irregular menstruation	weight loss; pale skin	Caused by bad health, working too hard, frequent illness, mal-nourishment	
torn vagina	causes infection, leading to a temperature; the condition will deteriorate if not treated	Caused by: - delivering the first baby - first sex - rough sex - the penis being too big for the vagina	stitches at hospital
vaginal discharge	pain; sloping back; cough - some participants say that it is the uterus that coughs	Causes of vaginal discharge are reported to be: - lack of hygiene - heavy workload - constant temperature - the result of damage to the vagina during delivery which leads to infection, causing a discharge  Vaginal discharge may also be a symptom of STDs	

**Table 3:** Each group of participants listed sexual health problems that affect men, and ranked each disease according to their perceptions of its relative severity and frequency

## MEN'S SEXUAL HEALTH PROBLEMS

PROBLEM	SEVERITY 1 = most severe		FREQUENCY 1 = most frequent	
	Group 1	Group 2	Group 1	Group 2
	blocked urethra	–	4	–
fleshy growths on reproductive organs*	7	8	8	7
gonorrhea*	–	3	–	6
seed gonorrhoea*	4	–	6	–
liver disease A,B,C *	transmissible by sex, but not identified as a sexual health problem. Hepatitis C is the most dangerous			
hidden syphilis*	–	2	–	2
HIV/AIDS*	1	1	7	8
impotence	–	7	–	4
kidney infection	–	6	–	3
urinating difficulty*	9	5	2	1
rice-water gonorrhoea*	5	–	5	–
swollen penis	6	–	3	–
syphilis*	2	–	1	–
tiem lar*	3	–	4	–
unequal testicles	8	–	9	–

\* all or some of the participants state that the disease is transmissible through sexual intercourse

**Table 4:** Each group of participants listed sexual health problems that affect women, and ranked each disease according to their perceptions of its relative severity and frequency

## WOMEN'S HEALTH PROBLEMS

PROBLEM	SEVERITY 1 = most severe		FREQUENCY 1 = most frequent	
	Group 1	Group 2	Group 1	Group 2
	creeping uterus	–	1	–
fallen uterus	–	7	–	7
fleshy growths on reproductive organs*	–	–	–	–
HIV/AIDS*	1	–	9	–
infected uterus	–	5	–	4
irregular menstruation	–	7	–	1
urinating difficulty*	7	–	2	–
rice-water gonorrhoea*	6	–	7	–
uterus makes a noise	–	3	–	3
syphilis*	2	–	6	–
tiem lar*	9	–	8	–
torn vagina	8	6	3	5
uterus problem	4	–	5	–
vaginal discharge	3	4	1	2
vaginal infection	5	–	4	–

\* all or some of the participants state that the disease is transmissible through sexual intercourse

# APPENDIX 1: GENERAL HEALTH CONCERNS

*The illnesses in this table were listed by each group of participants and ranked for severity and frequency.*

DISEASE	SEVERITY 1 = most severe		FREQUENCY 1 = most frequent	
	Group 1	Group 2	Group 1	Group 2
AIDS*	1	1	22	10
bad cold**	-	16	2	1
bronchitis	12	-	12	-
cancers**	25	4	21	8
children's health — slow growth	-	-	-	-
cholera	2	-	-	-
diarrhoea	-	-	4	-
environment — can affect health	-	12	-	11
eye problems	14	-	18	-
fainting	3	-	1	-
fever	22	-	2	-
flesh growths	21	-	29	-
going out — the younger generation**	-	13	-	10
gonorrhoea*	19	-	25	-
haemorrhoids	4	6	24	7
head-ache	-	7	-	6
health damage due to eating out and dancing a lot**	-	9	-	14
heart attack	10,16	-	15	-
high blood pressure	11	-	13	-
infertility*	-	3	-	16
kidney problems*	17	-	11	-
leprosy	26	-	28	-
life — worried about	-	15	-	9
liver illness**	5	2	7	3
lung — enlarged	-	-	14	-
lung problems	-	-	9	-
malaria	6	-	16	-
measles	23	-	26	-
mental problems	9	-	23	-
planter's wart	29	-	20	-
poisonous bites, especially snakes	20	-	27	-
polio	-	11	-	13
tape-worms	28	-	8	-
skin diseases**	-	14	-	4
stomach-ache**	8	5	6	3
stomach-ache due to over-eating	-	8	-	5
syphilis*	18	-	17	-
tetanus	13	-	-	-
tooth-ache	24	-	19	-
tuberculosis	15	-	10	-
typhoid	7	-	5	-

# APPENDIX 2:

## CENSUS OF SEXUAL BEHAVIOUR

Question	responses	
Total number of participants	14	
Have you ever had sex?	No 1	Yes 13
How old were you when you first had sex?	Age 18 20 21 23 24 25 28	No. of responses 1 3 1 1 4 3 1
With whom did you first have sex?	Partner fiancée sweetheart wife woman	No. of responses 1 2 10 1
Did you want this first sex?	Yes 14	
How old were you the second time you had sex?	Age 18 20 21 22 24 25 27 29 30	No. of responses 1 1 2 1 4 1 2 1 1
How many people have you have sex with in the last month?	No. of partners no sex 1 partner 1 sex spouse 2 partners	No. of responses 1 8 1 1 1
With whom did you have sex using a condom in the last month?	No. of times no sex 1 partner 1 sex spouse 2 partners	No. of responses 1 8 1 1 1
How many times did you have sex using a condom in the last month	No. of times no sex 0 2 2 (with spouse) 2 or 3 4 10	No. of responses 1 8 1 1 1 1 1

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With whom did you have sex using a condom in the last month?*	<u>Partner</u> no sex did not use condoms sweetheart	<u>No. of responses</u> 3 3 1
With whom do you use a condom when having sex?*	<u>Partner</u> Commercial sex Worker sweetheart	<u>No. of responses</u> 6 1
With whom did you have sex without using a condom?	<u>Partner</u> no sex wife unclear response	<u>No. of responses</u> 2 11 1
Have you paid for sex in the last month?	no sex no yes "I had no condoms and no money" I had no problems for having sex"	<u>No. of responses</u> 1 10 1 1 1
How many times have you paid for sex in the last month?	<u>No. of times</u> no response 0 1	<u>No. of responses</u> 1 12 1

\*One facilitator asked about sex with a condom within the last month. The other facilitator asked about sex without a condom in general. Hence, it is not possible to combine the responses from the two groups.

These responses were given anonymously, and in answer to a pre-determined list of questions. Thus, it was not possible to probe answers. It seems probable that the participants became more comfortable answering questions when they saw that the answers were remaining confidential. The questions were planned on this basis. This might be one explanation why, for example, one participant stated that he had never had sex, but all participants stated the age at which they had first sex.

Two participants wrote ambiguous replies about the age which they had first had sex, which as explained above, it was not possible to clarify with this research tool:

***"I was 28 years old when I had first had sex with a woman."***

***"I had sex for the first time with a woman when I was 23 years old."***

# APPENDIX 3: GLOSSARY OF ILLNESSES

AIDS	ជំងឺអេដស៍
blocked urethra	ស្មុះរុន្តនោម
bronchitis	រលាកទងសួត
cancer	មហារីក
cholera	អាសន្នរោគ
cold	ផ្តាសាយ
creeping uterus	ស្បូនលូន
dengue	គ្រុនឈាម
diarrhoea	រាក
eye problems	ជំងឺ/បញ្ហាភ្នែក
fainting	ខ្យល់ត
fallen uterus	ស្បូនស្រុត
fever	គ្រុនក្តៅ
fleshy growths on reproductive organs	ដុះសាច់/សាច់ដុះ
gonorrhoea	ប្រមេ
seed gonorrhoea	ប្រមេគ្រាប់
haemorrhoids	ឫសដូងពាត
head-ache	ឈឺក្បាល
heart attack	ខ្សោយបេះដូង
hepatitis A, B, C	ជំងឺថ្លើមមានប្រភេទ A, B, C
hidden syphilis	ស្វាយក្រាប
high blood pressure	ជំងឺលើសឈាម
HIV	វីរុស HIV
impotence	ខ្សោយប្រដាប់បន្តពូជ(លិង)
infected uterus	រលាកស្បូន
infertility	គ្មានកូន(គ្មានលទ្ធភាពបង្កើតកូន)

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irregular menstruation

រដូវមិនទៀង

kidney infection

រលាកតំរងនោម

kidney problems

ជម្ងឺតំរងនោម

leprosy

ជម្ងឺឃ្នង់

liver disease

ជម្ងឺថ្លើម

lung - enlarged

ហើមសួត

lung problems

ជម្ងឺសួត

malaria

គ្រុនចាញ់

measles

ជម្ងឺកញ្ជិល

mental problems

ជម្ងឺស្មៃប្រសាទ

nettle-rash

កន្ទាលត្រអាក

plantar's wart

ជម្ងឺឫស

polio

ជម្ងឺស្លិតដៃជើង

rice-water gonorrhoea

ប្រមេទឹកបាយ

tape-worms

តេនញ៉ា

skin disease

ជម្ងឺសើរស្បែក

stomach - ache

ឈឺក្រពះ

stunted liver

ថ្លើមក្រិន

swollen penis

ហើមលិង្គ

syphilis

ជម្ងឺស្វាយ

tetanus

ជម្ងឺតេតាណូស

tiem lar

ជម្ងឺទាមឡា

tooth-ache

ឈឺធ្មេញ

torn vagina

រំហែកទ្វារ

tuberculosis

ជម្ងឺរមេង

typhoid

គ្រុនពោះវៀន

ulcers

របៀងកូនកណ្តុរ

unequal testicles

ពងទក

urinating difficulty

ទាស់នោម

uterus makes a noise

ស្បូនលាន់

uterus problem

ជម្ងឺស្បូន

vaginal discharge

ធ្លាក់ស

vaginal infection

រលាកទ្វារ



# RECOMMENDATIONS

The participants have a considerable knowledge of HIV/AIDS and STDs, and they are concerned about protecting themselves and their families. However they require more detailed information, in order to counter misinformation and to make fully informed choices about protecting themselves from HIV/AIDS and other STDs. However, sex takes place within a social and attitudinal context which strongly affects the ability of people to use knowledge to protect themselves.

It is recommended that participatory sessions are used as part of a strategy to address the above needs. Participatory education sessions provide a supportive environment in which the participants' learning needs can be specifically identified and addressed. The participants reported enjoying this approach during the research. Importantly, participatory sessions would enable the participants to explore the social and attitudinal framework within which they make decisions and, potentially, the impact these decisions may have on other people. Participatory sessions would provide a forum for the development of negotiation skills and strategies which can be transferred to different situations - for example, peer pressure to join drinking sessions.

The following table presents specific recommendations for inclusion in any educational activities:

PROBLEM	ANTECEDENTS	RECOMMENDATION
Participants do not have sufficient knowledge of how infections are transmitted through sex to assess which sexual activities carry a risk of infection.	<ul style="list-style-type: none"> <li>Limited knowledge about the human reproductive system and some misinformation that infections are transmitted when the sperm and ovum meet</li> <li>Some participants apparently conceptualise sex as referring only to peno-vaginal sex. They may conclude that this is the only form of sexual activity through which infections are passed</li> <li>Some participants believe that a person's vulnerability to infection with disease is determined by his/her state of health</li> </ul>	<p>Information and education about HIV/AIDS specifically addresses:</p> <ul style="list-style-type: none"> <li>Human reproductive system in order to clarify misunderstandings about the transmission of infection (and provide knowledge likely to be useful more generally - for example on contraceptive choice and negotiation)</li> <li>How infections are transmitted through sex in order that people can assess which sexual practices carry a risk of infection. This is particularly relevant in a context where it may be difficult to discuss some sexual activities openly</li> </ul>

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	<ul style="list-style-type: none"> <li>• <i>Confusion</i> between the difference between HIV and AIDS is likely to cause confusion about asymptomatic infection with HIV.</li> <li>• <i>No participants are aware</i> of the possibility of asymptomatic infection with STDs. Information and education about HIV/AIDS specifically addresses:</li> </ul>	<ul style="list-style-type: none"> <li>• The concept that 'well' people are not vulnerable to HIV. Details of what does make a person vulnerable to HIV may be an effective way of exploring this concept.</li> <li>• The difference between HIV and AIDS should be made clear, including details of the possible timeframes for the disease progression and which stages are likely to be symptom-free.</li> </ul>
<p>Participants' assessment of the implications of infection with STDs is based on limited knowledge.</p>	<ul style="list-style-type: none"> <li>• Participants do not know of the link between STD infection and infection with HIV.</li> <li>• Participants have very limited knowledge of the progression of STDs. Ineffective treatments may therefore be believed to have been successful because the symptoms of disappeared.</li> </ul>	<p>Information and education about HIV/AIDS and STDs should address:</p> <ul style="list-style-type: none"> <li>• The link between STDs and HIV transmission.</li> <li>• Detail about symptoms and progression of different STDs.</li> </ul>
<p>Participants may use condoms which make sex more 'thrilling' under the impression that these condoms also offer protection from disease</p>	<p>Participants do not appear to be aware of indicators for condom quality</p>	<p>Information and education on condom use should address:</p> <ul style="list-style-type: none"> <li>• Positive quality indicators</li> <li>• Particular features that are likely to make a condom unsafe, based on an investigation of different condoms available in Svay Rieng.</li> </ul>

<p>Criteria such as cost, perceptions of treatment efficacy, and confidentiality are likely influence participants to choose traditional medicine as a cure for STDs. This treatment is not proven to be effective against STDs</p>	<ul style="list-style-type: none"> <li>• Traditional medicine is the cheapest option, and cost is a crucial factor in health-seeking behaviour</li> <li>• Traditional medicine is believed to be effective (see above)</li> <li>• The stigma attached to infection with STDs due to association with commercial sex may deter men from seeking treatment from services providing Western medicine which are not perceived to be confidential</li> </ul>	<p>The possibility of providing people with information about effective treatment for STDs could be explored because treatment options are narrowed down before medical help is sought</p> <p>Alternatively the possibility of cooperating with traditional doctors to provide effective treatment could be explored</p>
<p>The stigma of HIV/AIDS is likely to</p> <ul style="list-style-type: none"> <li>• Be a factor deterring people from opting to have an HIV test</li> <li>• Negatively affect the quality of life of people living with HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Association of HIV/AIDS with commercial sex</li> <li>• Perceived lack of respect for confidentiality of some blood-testing facilities</li> <li>• Fear of HIV/AIDS</li> </ul>	<p>Care should be taken that no project activities inadvertently reinforce stigma</p> <p>Information, education, and communication about HIV/AIDS should address the issue of stigma. Participatory sessions would be one appropriate forum for this. The possibility of inviting - and supporting - people living with HIV or AIDS to facilitate discussions should be explored</p>
<p>The participants are concerned about their alcohol use, on health grounds, as a cause of traffic accidents and as a cause of unprotected sex with commercial sex workers</p>	<ul style="list-style-type: none"> <li>• Peer pressure</li> <li>• Inclusion of alcohol in peer-group outings</li> <li>• Drinking is usually described to precede visits to commercial sex workers</li> <li>• Participants avoid or forget condoms when they are drunk. The participants perceive less control over their actions when drunk</li> </ul>	<p>Participatory education sessions should include the development of strategies, including negotiating skills, for managing alcohol consumption</p>

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<p>'One-to-one partners' is perceived to be an alternative strategy to condom use. One-to-one relationships are not necessarily mutually monogamous, nor do they necessarily take account of either partners previous sexual partners.</p> <p>The idea that sex within a one-to-one relationship is safe is likely to make it very difficult for people who would like to use condoms to negotiate condom use with their partner.</p>	<p>The risk of infection is associated almost entirely with people and places rather than with behaviour: for example, risk is associated with commercial sex workers rather than with unprotected penetrative sex.</p> <p>Women are expected to trust their sweetheart completely before agreeing to sex with him.</p>	<p>Any project activities which discuss one-to-one partners as a potential strategy for avoiding HIV/AIDS should address the issues of partners.</p> <p>The likelihood that the link thus created between condom use and mutual trust will increase the difficulty of negotiating condom use for some people should be borne in mind if this strategy is to be advocated and addressed in any participatory education sessions.</p>
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