HEALTH RISK BEHAVIORS OF PALESTINIAN YOUTH: FINDINGS FROM A REPRESENTATIVE SURVEY

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ABSTRACT

There is little systematic information about many health risk behaviors among Middle Eastern youth. This study provides estimates of levels and patterns of risk behaviors from a large-scale representative survey among Palestinian youth—among the first of its kind in the region--targeting 2,500 individuals age 15-24 in the West Bank and East Jerusalem. 22·4% of male youth aged 20-24 and 11·6% of females reported having tried alcohol (8·1% and 3·6% for male and female youth 15-19). 10·5% of male youth age 20-24 and 4·3% of females report trying drugs (3·8% and 1·6% for males and females 15-19). 9·3% of unmarried male youth and 6·7% of unmarried female youth age 20-24 report having had sexual intercourse, although almost one quarter of both report any sexual experience. Tobacco use is very high, even among younger youth (45·4% of males and 21·2% of females 15-19 smoke), and interpersonal violence (fighting) is also significant. Risk behaviors are higher among males, older youth, and in urban areas (especially Jerusalem) and refugee camps compared with rural areas. Palestinian youths' engagement in alcohol, drug use and sexual activity including intercourse tends to be at the low end of the range of findings from other regions but the opposite is the case for smoking and interpersonal violence. While smoking is of particular concern, prevention outreach for all behaviors should be directed at subgroups and areas identified as highest risk.

INTRODUCTION

Relatively little is known about key health risk behaviors among youth in the Middle East and North Africa (MENA), leaving public health authorities in the region unprepared to deal with emerging public health threats at a time of major social changes. Rates of tobacco use among younger adolescents age 13-15, for whom systematic data are available, are higher in MENA than in other regions other than Latin America and the Caribbean (*1*). Although youth-specific data are lacking, the use of injecting drugs has been noted in many countries, including Lebanon, Libya, Morocco, Oman, Saudi Arabia, and Tunisia (*2*), and there is evidence of significant recent increases in the use of amphetamines, opioids, and other drugs, particularly in the Gulf States (*3*). With regard to sexual activity among youth, a rising age of marriage throughout the region as well as increases in rates of sexually transmitted infections *(2,4)* suggest increasing rates of sexual activity outside of (and before) marriage. In Morocco, 40 per cent of reported STIs are among 15 to 29-year-olds (*5*).

Youth in the Occupied Palestinian Territories (OPT) of the West Bank, East Jerusalem, and Gaza are experiencing similar risks, including particularly high rates of tobacco use *(6,7)*. Drug use, especially in East Jerusalem, is a growing concern *(8).* Youth unemployment, considered a risk factor for drug use *(9,10),* is very high (26% and 55% in West Bank and Gaza, respectively, for those 20-24)*(11)*. A further potential risk factor facing Palestinian youth is the stress of sustained political conflict and economic hardship. An understanding of the patterns and causes of youth health risk behaviors will enable policymakers to develop and target appropriate prevention programs *(12).*

Existing studies of youth in the OPT and the region have serious drawbacks that limit our understanding of the prevalence and patterns of most risk behaviors. These studies mostly use school-based samples of adolescents rather than representative, random samples of youth that include out of school and older youth, who may be at greatest risk. Existing surveys also typically do not cover many key risk behaviors (in particular sensitive ones such as sexual activity) or do so only in terms of perceptions regarding peers, not the youth's own engagement.

The Palestinian Youth Health Risk Study addresses this gap and to our knowledge is the first in the region to collect large scale, representative data on youths' risk behaviors including smoking, alcohol and drug use, sexual activity, and interpersonal violence. The study was designed to investigate (1) levels and patterns of these behaviors as well as mental health among Palestinian youth, (2) youths' perceptions of the risks and benefits of such behaviors and their expectations about the future, and (3) the relationship of exposure to violence and conflict to mental health, future orientation, and engagement in risk behaviors. This paper presents findings on the prevalence of risk behaviors among youth aged 15-24, considering variations by gender, age, and location. Location is a potentially important determinant given the differences between rural and urban areas of the OPT—and between them and refugee camps—with respect to cultural attitudes, access to alcohol and drugs, and economic and political tensions.

METHODS

Study population and sampling: The survey targeted a representative sample of 2,500 youth age 15-24 in the West Bank and East Jerusalem, reflecting the objective of permitting reliable comparisons across gender and rural-urban divisions. A stratified two-stage random sample was drawn from the 2007 population census, with strata formed by crossing the 12 governorates with

urban, rural, and refugee camp location. Within strata, 208 survey clusters (census enumeration areas) were randomly sampled with probability proportional to size. Within each cluster, 14 households with youth in the appropriate age range were sampled using a modified random walk. Implicit stratification ensured equal numbers of male and female youths. Where households had multiple youth, the participant was selected using Kish tables *(13)*.

Extensive formative research, including focus groups and in-depth interviews with youth as well as extensive pre-testing of survey questions, was used to determine culturally appropriate approaches to interviewing and question wording, sequence, and response formats. The survey asked questions on a range of other topics before coming to sensitive issues about behaviors, and asked first about behaviors of general peers and close friends of the respondent before asking about their own activities. Substantial efforts were made to develop procedures to ensure that youth were comfortable discussing sensitive topics. Interviewers were strictly instructed to ensure that the youth interview was conducted in a private room or other private area (e.g., the roof of the house). Youth could choose to be interviewed at a local youth center or other outside location, though few did so. Interviewers were matched to respondents by gender. To accommodate sensitivities, questions on sexual activity were not asked of minors (under 18). Field-testing of interview procedures, survey logistics and the questionnaire was carried out in an urban area, a rural community, and a camp setting.

As the formative work indicated a lack of comfort or trust with computer assisted self-interview, interviewing was done face-to-face, with one partial exception. Youth initially had the option of taking a self-administered (paper) questionnaire (SAQ) for questions on sexual activity that retained the face to face format, but with the answers written rather than spoken aloud and then placed by the youth in a sealed envelope. Soon after the start of the fieldwork, the SAQ was

instead randomly allocated to ascertain if the mode mattered for responses, to be assessed in future work.

Youth consent/assent and (for minors) parental consent was obtained for the interviews. The study was approved by RAND's Human Subjects Protection Committee. Refusal rates among youth were low—11% for the survey overall—and that rate partly reflects high (about 30%) refusals in East Jerusalem.

Data analysis. Analysis of group differences in behavior by subgroups was done primarily using Pearson chi-square tests. Separate analyses were performed by gender using STATA version 13, and incorporating the two-stage survey design, in particular to allow correlations of standard errors within sample clusters.

RESULTS

Sample characteristics

In keeping with the overall demographic profile of the OPT, there are more individuals in the younger age group (15-19): 1,419 (57.2%) vs. 1,062 aged 20-24 (42.8%) (Table 1). However, males aged 20-24 make up only 40% of all males, while the older female group accounts for 45·7% of all females. This is likely explained by older male youths being more likely to be living away from home, or if living at home, being unavailable for interview even after several visits. About one quarter of the sample are classified as refugees (Table 2), that is, descendants of individuals who lost land or livelihood during the 1948 or 1967 conflicts. Most refugee families do not actually live in refugee camps, which can be rural or urban.

As shown in Table 2, youth in camps are less likely to be in school, and have lower grade attainment. Among males 15-24, while 60·4% of urban respondents and 64.1% of rural are in school, only 44·8% of those in camps are (p=0·019 and 0·006 for comparison of camps with urban and rural areas); the difference for females are smaller and not statistically significant (p=0·253 and 0·200). Rural respondents are less well-off than urban residents as indicated by an asset index constructed from data on consumer durables*(13)* (p=0·001 and 0·00, for males and females, respectively). The index appears lowest for camp residents but the study lacks power for detecting differences between camps and the other areas.

Health risk behaviors

Rates of non-response rates ("No answer" or "Don't know") on individual questions were generally very low—under 1%. Rates were somewhat higher (though under 5%) for questions on current drug use, asked of those who indicated that they had tried drugs.

Smoking: Prevalence of all health risk behaviors are shown in Table 3. With respect to tobacco use, 71·5% of older male youth report current smoking (cigarettes or water pipe) while 45.4% of younger male youth do . Rates are lower for females but still significant: 31.2% for older and 21.6 % for younger females (p=0·00 for male-female difference for both age groups). Tobacco use is lower in rural compared with urban areas.

Alcohol use: 22·4% of male youth aged 20-24 reported having tried alcohol; rates in urban areas and camps (26% each) are double that in rural areas (13·2%; p=0·002 and 0·039, for comparison or rural with urban areas and camps). Rates among female youth aged 20-24 are substantially lower, but with a similar pattern by area: (14.6% in urban areas, 12·8% in camps, and 3·5% in rural areas). Among youth 15-19, 8·0% of males and 3·6% of females reported ever trying

alcohol, again with higher shares in urban areas and camps. Slightly less than 10% of older male youth, and 3·4% of younger male youth reported *current* alcohol consumption (the last 30 days), compared with 4·1% of older females and 1·2% of younger females.

Drug use: 10·5% of males aged 20-24 reported having tried any kind of drugs including marijuana or hashish, pills, inhalants, and cocaine or heroin compared with 3·75% for younger male youth. Only 4·2% of older female youth and 1·6% of younger female youth reported ever using drugs. As with alcohol, self-reported drug use is markedly higher in urban areas and camps than in rural areas. The most common drugs tried are marijuana/hashish (57%), inhalants (42%) and pills (14%). Among those who had tried drugs, about one third of both the younger and older male youth (32·1% and 34·6%, respectively) said they currently used drugs of some kind; for females who ever tried drugs, 29·2% of those aged 20-24 and 9·1% of those aged 15-19 said they currently use them. This implies that about 3·6% of all older male youth and 1·1% of younger male youth, and 1·2% of older females and 0·15% of younger females, currently use drugs.

Sexual activity: 24·5% of older (20-24 years old) unmarried male youth and 21·5% of younger non-minor (18-19 years old) unmarried male youth reported having had sexual activity, defined as "romantic kissing, touching private body parts, or sexual intercourse." Male-female differences are not statistically significant (p=0·432 for younger males vs. younger females, 0·288 for older males vs. older females). Rural-urban differences appear pronounced for males: for older males, the shares are 27.4% in urban areas, 14·5% in rural areas, and 38·2% in camps (p=0·030 for urban vs. rural, p = 0·292 for urban vs. camps for this group).

Experience of sexual intercourse specifically is substantially lower. Among unmarried males, 9·5% of older (20-24 years old) youth and 5·6% of younger (18-19 years old) youth reported having had sexual intercourse (SI). Corresponding shares are 6·9% for older females and 4·1% for younger females. Male-female differences are not statistically significant, but rates of SI experience are markedly lower in rural areas than urban areas and camps.

Phone sex (sexting) and internet sex (defined as interaction with another person, not merely viewing sexual material) among unmarried youth of both genders is more common than self-reported physical sexual contact: 38·0% of older and 33·3% of younger (age 18 and 19) males reported having ever engaged in either phone or internet sex; 29·6% of older female youth and 23·4% of those aged 18-19 reported having done so.

Interpersonal Violence: Among youth aged 15-19, 56·0% of males and 29·3% of females reported engaging in a physical fight with someone in the last year. Among 20-24 year olds, 38·4% of males and 21.0% of females reported have been in a fight (p=0·000 for males vs. females in both age groups). Among all youth reporting any fighting, 42% report one incident in the last year, with most of the rest reporting 2-5 incidents. For both age groups there is higher prevalence in urban areas than rural (p = 0·049 for urban vs. rural for younger youth, p = 0·000 for older youth).

DISCUSSION

Levels of risk behavior in international perspective

This study is the first to collect population-based data on Palestinian—and perhaps any Middle Eastern—youth on a comprehensive range of health risk behaviors. Comparisons with studies from other regions are therefore of particular interest. These comparisons, discussed in detail

elsewhere *(13),* show the prevalence of most self-reported risk behaviors in our sample of youth to be at the low end of the range of findings from countries in other regions, likely reflecting the conservative social context of this study. In the U.S., self-reported drinking was 34% for boys and 36% for girls age 13-18 *(14),* and 41% / 30% in South Africa for 14-18 year olds *(15),* compared to 3·4% of boys and 1·2% of girls aged 15-19 in our sample. More in line with our findings, in Tehran (Iran) 17% of boys aged 13-18 report trying alcohol*(16)* (8% of males in our sample 15-19 reported doing so). Comparisons for drug use and sexual activity reveal a similar pattern of relatively low rates in OPT*(10).*

However, Palestinian youth show comparatively very high levels of smoking. Even among younger youth aged 15-19, 45% of males and 22% of females aged 15-19 reported smoking. Tobacco use among young Palestinians is well above the average for countries in the Eastern Mediterranean based on cross-country Global Youth Tobacco Surveys of 13-15 year olds (*17*) and has aptly been characterized as an epidemic (*6*). Levels of interpersonal violence also appear high, comparable to findings among South African secondary students, of whom 39% of boys and 25% of girls reported being in a fight in the last six months*(15)*; our findings for male and female youth aged 15-19, over a reference period that is twice as long, are 56% and 29%, respectively. In the U.S, participation in fighting is lower: 30·2% (males) and 19·2% (females) among secondary students during the last 12 months *(14).*

Assessment of validity of self-reports

The survey relies on what youth report to interviewers about their behaviors, not objective measures of these behaviors. Despite efforts to ensure respondents felt comfortable answering sensitive questions, under-reporting of risk behaviors in this conservative environment remains

an important potential limitation of this study. It is noteworthy that responses about general peers' engagement (youth of the respondent's age and sex in their communities) suggest mean levels of risk behavior substantially higher than implied by responses about own behavior, while showing similar patterns across age, gender, and location (Table 4). Means for shares of friends engaging in each behavior in contrast are similar to means for own engagement though somewhat higher. For example, as seen in Table 4, 9·1% of male youth aged 20-24 say they currently drink, compared with 13·0% for friends (p=0·000) and 22·5% for general peers. Studies from the United States and elsewhere find similar disparities between descriptive peer norms and self-reported alcohol and drug use *(18-20).* This divergence is due either to underreporting of one's own behavior or overestimating (or over-reporting) peers' engagement, or both. The fact that respondents' estimates of close friends' engagement in risk behaviors—which they should know fairly accurately—are lower than their estimates for general peers suggests that general peers' engagement is overestimated. However, youth may understate friends' behavior (as with their own) if they believe socially undesirable behavior of friends reflects badly on them. Research using biomarkers means suggest underreporting of own drug use in the United States *(21).*

Since the potential bias in self-reported behavior will likely be downward, and any bias with respect to peers' activities is expected to be upward, these two estimates likely bound the true prevalence of a behavior. This range suggests that prevalence of most health risk behaviors is still modest but not trivial (and is high for smoking and engaging in violent behavior).

Patterns across subgroups

Engagement in risk behaviors is consistently higher for male youth, for older youth, and in urban areas and refugee camps (compared with rural areas). Rural location may inhibit engagement because drugs and alcohol are less available, cultural stigma is higher, and it is harder to be discrete or anonymous in a village setting. Although the study was not powered to detect variation across urban areas, the data suggest substantial variation here as well; in particular, Jerusalem stands out for its high prevalence of youth alcohol use, drug use, and sexual activity *(13)*. This governorate consists of J1 area (East Jerusalem), annexed by Israel in 1980, and J2, mostly urban areas that formally remain in the West Bank. In addition to close access to drugs or alcohol from Israel, several factors may contribute to the high levels of risk behaviors in these areas. East Jerusalem is marked by economic depression, poor social services, and significant social and political tensions, while many parts of J2 are essentially not covered by either Israeli or Palestinian law enforcement authorities, permitting the development of a thriving drug trade *(22, 23)*.

Regarding sexual activity, while experience of sexual intercourse among unmarried youth seems rare, sexual activity overall is not. Phone and internet sex are fairly common for both genders and among both older and younger youths. These forms of interaction pose no direct health risk; the question is whether they are a substitute for actual sexual contact, which is harder for young people to arrange discreetly, or a complement to (or a determinant of) physical sexual relations. For both young men and women, there is a positive association of sexting/internet sex with having had intercourse ($p=0{\cdot}000$ for both). Future research will attempt to assess whether this relationship is causal.

CONCLUSION

The experience of the Palestinian Youth Health Risk study demonstrates that it is possible to carry out population-based surveys of youth on highly sensitive behaviors in conservative contexts of the Middle East. Given the lack of systematic information on these behaviors in the region, similar surveys should be carried out elsewhere, both to understand current prevalence and monitor changes over time.

Outreach and risk prevention programs for Palestinian youth are relatively undeveloped, as they are in the region generally (*24*). Our findings provide some guidance as to where such programs should be targeted. Male youth, especially older ones, are the most likely to engage in health risk activities. Programs should therefore make particular efforts to engage male youth, but should not ignore female youth, who also engage in these behaviors, if to a lesser extent. Urban youth and those in camps (many of which are essentially low-income urban neighborhoods) are clearly at greater risk for these behaviors and this should be reflected in outreach efforts. Of particular concern for programming for all groups of youth are high levels of tobacco use, which has clear long term health implications. Interpersonal violence also appears high and should be of concern to policymakers; in addition to direct health impacts through injury, it may lead to significant negative emotional outcomes.

Regarding the kinds of prevention programs that would be most effective, currently there are few models from the region of programs that have been rigorously tested and/or scaled up. With careful consideration of the specific MENA context—including high levels of stigma and the need to reach older youth who have left school--experience from industrialized nations and other regions can provide guidance (*25, 26*). For example, with regard to tobacco use, in addition to education, price increases as well as advertising bans have been shown to reduce youth smoking

in other contexts (*25*, *27, 28*). In the area of sexual and reproductive health programming for youth, some programs have been introduced in MENA countries. These include peer (youth-to-youth) education programs such as the Youth Peer Education Network implemented in Tunisia and other countries; anonymous telephone hotlines to make information readily accessible confidentially; and the use of social media for youth-friendly discussion and education (*4, 24*). Each of these has the potential, among other benefits, to be able to reach out of school youth. Evaluation of a range of prevention approaches to youth risk behavior in OPT and elsewhere in the region are needed—as is more effort to monitor risk behaviors, which can inform these efforts. Future work with the present data will investigate the determinants of risk behaviors, including for example exposure to violence, mental health, and assessment of risks, and thus provide additional guidance to the development of prevention programs for Palestinian youth.

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Table 1 -- Composition of the sample by gender, age and location

		Male			female		
		all	**15-19**	**20-24**	**all**	**15-19**	**20-24**
urban	Number	811.00	490.00	321.00	810.00	433.00	377.00
	Share (column)	*0.65*	*0.66*	*0.65*	*0.65*	*0.64*	*0.66*
rural	Number	334.00	198.00	136.00	334.00	191.00	143.00
	Share (column)	*0.27*	*0.27*	*0.27*	*0.27*	*0.28*	*0.25*
camp	Number	96.00	58.00	38.00	96.00	49.00	47.00
	Share (column)	*0.08*	*0.08*	*0.08*	*0.08*	*0.07*	*0.08*
All	Number	1241.00	746.00	495.00	1240.00	673.00	567.00
	Share (column)	*1.00*	*1.00*	*1.00*	*1.00*	*1.00*	*1.00*
	Share (row)	*0.50*	*0.30*	*0.20*	*0.50*	*0.27*	*0.23*

Table 2 -- Socio-demographic characteristics of the sample

		male			female		
		all	**15-19**	**20-24**	**all**	**15-19**	**20-24**
N		1241	746	495	1240	673	567
Refugee (%)	Refugee	25.38%	23.06%	28.89%	26.37%	27.04%	25.57%
Currently in school (%)	all	60.19%	78.69%	32.32%	64.76%	85.29%	40.39%
	urban	60.42%	79.80%	30.84%	64.81%	85.91%	40.58%
	rural	64.07%	81.31%	38.97%	66.47%	84.29%	42.66%
	camp	44.79%	60.34%	21.05%	58.33%	83.67%	31.91%
Year of schooling		11.29	10.54	12.42	11.93	10.89	13.24
Married (%)	all	2.58%	0.00%	6.46%	22.34%	4.61%	43.39%
	urban	2.96%	0.00%	7.48%	22.47%	4.62%	42.97%
	rural	1.50%	0.00%	3.68%	21.86%	4.19%	45.45%
	camp	3.13%	0.00%	7.89%	22.92%	6.12%	40.43%
Working (%)	yes	31.02%	16.09%	53.54%	6.05%	1.04%	11.99%
Living arrangement %							
	with parents	96.78%	98.93%	93.54%	78.71%	94.95%	59.44%
	With spouse in own household	2.10%	0.00%	5.25%	17.74%	3.57%	34.57%
	Other*	0.64%	0.67%	0.61%	3.06%	1.19%	5.29%
Father's Education - Secondary or higher							
	Urban	56.23%	58.16%	53.27%	47.65%	54.04%	40.32%
	Rural	59.58%	63.13%	54.41%	58.98%	62.30%	54.55%
	Camp	48.96%	50.00%	47.37%	43.75%	44.90%	42.55%
Mother's Education - Secondary or higher							
	Urban	53.14%	59.18%	43.93%	45.56%	51.50%	38.73%
	Rural	47.60%	48.99%	45.59%	40.72%	47.64%	31.47%
	Camp	45.83%	51.72%	36.84%	40.63%	40.82%	40.43%
Asset Index	Urban	0.226	0.236	0.212	-0.013	-0.013	-0.012
	Rural	-0.057	-0.074	-0.032	-0.324	-0.275	-0.388
	Camp	-0.085	-0.073	-0.105	-0.398	-0.283	-0.517

Note: * "Other" includes "Living with my spouses' parent(s)", "live with other relatives" and "live with friends"

Table 3 - Prevalence of health risk behaviors by age, sex and location (%)

	Males				Females			
	all	urban	rural	camps	all	urban	rural	camps
Current smoking								
15-19	45.44%	46.53%	41.92%	48.28%	21.55%	26.79%	9.95%	20.41%
20-24	71.52%	77.57%	56.62%	73.68%	31.22%	36.60%	16.08%	34.04%
All	55.84%	58.82%	47.90%	58.33%	25.97%	31.36%	12.57%	27.08%
Ever use alcohol								
15-19	8.04%	9.80%	4.04%	6.90%	3.57%	4.62%	1.05%	4.08%
20-24	22.42%	25.86%	13.24%	26.32%	11.64%	14.59%	3.50%	12.77%
All	13.78%	16.15%	7.78%	14.58%	7.26%	9.26%	2.10%	8.33%
Current alcohol use								
15-19	3.35%	4.49%	0.51%	3.45%	1.19%	1.85%	0.00%	0.00%
20-24	9.09%	11.21%	3.68%	10.53%	4.06%	5.04%	1.40%	4.26%
All	5.64%	7.15%	1.80%	6.25%	2.50%	3.33%	0.60%	2.08%
Ever use drugs								
15-19	3.75%	4.29%	2.02%	5.17%	1.63%	1.85%	0.52%	4.08%
20-24	10.51%	13.08%	2.94%	15.79%	4.23%	5.31%	0.70%	6.38%
All	6.45%	7.77%	2.40%	9.38%	2.82%	3.46%	0.60%	5.21%
Current drug use (as % of those ever use drugs)								
15-19	32.14%	33.33%	50.00%	0.00%	9.09%	12.50%	0.00%	0.00%
20-24	34.62%	38.10%	25.00%	16.67%	29.17%	35.00%	0.00%	0.00%
All	33.75%	36.51%	37.50%	11.11%	22.86%	28.57%	0.00%	0.00%
Had any sexual activity (unmarried only and 18 or above)								
15-19	21.52%	23.90%	10.34%	35.00%	24.87%	27.61%	19.61%	16.67%
20-24	24.51%	27.36%	14.50%	38.24%	20.87%	21.86%	21.79%	10.71%
All	23.50%	26.15%	13.23%	37.04%	22.39%	24.07%	20.93%	12.50%
Had sexual intercourse(unmarried only and 18 or above)								
15-19	5.49%	6.92%	1.72%	5.00%	4.06%	4.48%	1.96%	8.33%
20-24	9.33%	12.16%	2.29%	11.76%	6.85%	8.84%	2.56%	3.57%
All	8.02%	10.33%	2.12%	9.26%	5.79%	7.16%	2.33%	5.00%
Had internet or phone sex (unmarried only and 18 or above)								
15-19	33.33%	32.70%	32.76%	40.00%	23.35%	26.12%	15.69%	25.00%
20-24	37.96%	41.55%	27.48%	47.06%	29.60%	32.56%	20.51%	32.14%
All	36.39%	38.46%	29.10%	44.44%	27.22%	30.09%	18.60%	30.00%
Engaged in a fight last year								
15-19	56.03%	57.35%	53.03%	55.17%	29.27%	30.48%	24.08%	38.78%
20-24	38.38%	41.43%	30.15%	42.11%	20.99%	24.67%	10.49%	23.40%
All	48.99%	51.05%	43.71%	50.00%	25.48%	27.78%	18.26%	31.25%
Was ever hurt or injured in a fight								
15-19	30.97%	33.67%	26.77%	22.41%	16.79%	17.78%	14.14%	18.37%
20-24	26.67%	26.48%	24.26%	36.84%	13.58%	16.18%	7.69%	10.64%
All	29.25%	30.83%	25.75%	28.13%	15.32%	17.04%	11.38%	14.58%
Ever hurt or injured someone else								
15-19	40.75%	43.27%	33.84%	43.10%	14.12%	14.78%	10.99%	20.41%
20-24	36.57%	37.38%	30.88%	50.00%	11.82%	14.32%	4.90%	12.77%
All	39.08%	40.94%	32.63%	45.83%	13.06%	14.57%	8.38%	16.67%

Table 4 - Perceptions of friends' and peers' behavior (% engaging in risk activities)

		Males				Females			
		all	urban	rural	camps	all	urban	rural	camps
Current smoking									
15-19	Friends	54.07	53.40	52.19	66.09	16.87	18.71	11.52	21.53
	Peers	63.99	63.72	60.28	79.18	20.08	23.19	10.60	28.52
20-24	Friends	76.38	76.98	72.06	86.84	27.61	32.71	13.05	31.21
	Peers	80.36	80.45	78.76	85.26	28.78	34.13	11.66	39.11
Current alcohol use									
15-19	Friends	6.41	7.28	3.72	8.19	1.93	2.62	0.70	0.68
	Peers	13.00	13.37	10.86	17.27	5.54	7.36	1.11	7.12
20-24	Friends	13.02	15.26	7.16	14.91	6.71	8.22	2.33	7.97
	Peers	22.47	25.11	15.24	25.53	10.86	13.26	3.11	15.16
Current drug use									
15-19	Friends	1.03	1.23	0.00	2.87	0.25	0.31	0.18	0.00
	Peers	7.60	8.53	3.78	12.71	4.19	5.65	0.55	6.32
20-24	Friends	3.98	5.10	1.23	4.39	2.12	2.57	0.70	2.90
	Peers	13.17	15.24	8.51	12.15	8.10	10.14	0.96	14.05
Current sexual activity, unmarried (intercourse)									
15-19	Friends	4.20	3.99	4.73	4.17	9.79	8.94	10.67	14.07
	Peers	7.68	7.74	7.03	9.31	10.64	12.38	5.32	17.30
20-24	Friends	11.80	13.58	7.45	13.06	20.81	22.18	16.11	25.98
	Peers	14.15	15.37	11.74	11.82	15.21	18.41	5.10	20.00

Notes: 'Friends' refer to three closest friends of the respondent. % for each respondent is calculated as the number reported to engage in the behavior divided by 3. 'Peers' refer to general peers in the community of the same age and sex of the respondent.