“New Generation” Models for Asia's Youth: Strengthening Networks and Building Capacity
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“New Generation” Models for Asia's Youth: Strengthening Networks and Building Capacity

Spring 2003

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### Acronyms

<table>
<thead>
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere</td>
</tr>
<tr>
<td>CHED</td>
<td>Cambodian Health Education Development</td>
</tr>
<tr>
<td>CSCS</td>
<td>Cooperation for a Sustainable Cambodian Society</td>
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<tr>
<td>CWC</td>
<td>Cambodian Women’s Clinic</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>GFW</td>
<td>Garment Factory Worker</td>
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<tr>
<td>GMAC</td>
<td>Garment Manufacturers’ Association of Cambodia</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local Nongovernmental Organization</td>
</tr>
<tr>
<td>MHD</td>
<td>Municipal Health Department</td>
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<tr>
<td>MOC</td>
<td>Ministry of Commerce</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MOWVA</td>
<td>Ministry of Women’s and Veteran’s Affairs</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
</tr>
<tr>
<td>PAC</td>
<td>Pharmacy Association of Cambodia</td>
</tr>
<tr>
<td>PATH</td>
<td>Program for Appropriate Technology in Health</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Office</td>
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<tr>
<td>PHV</td>
<td>Peer Health Volunteer</td>
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<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WDA</td>
<td>Women’s Development Association</td>
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<tr>
<td>YSRH</td>
<td>Youth Sexual and Reproductive Health</td>
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Finally, the time, effort, experience, and contributions of those involved in the programs have instilled the document with a greater richness and vitality, which will hopefully translate into practical tips for others engaging in similar initiatives in Asia and beyond.
Introduction

Asia’s youth, a large and growing segment of society, represent the future of their countries’ development. Over half the world’s population is under the age of 25, and four out of five young people live in developing countries. Population momentum from past high fertility in Asia has created the largest cohort of youth in history. In many countries in the region, young people between the ages of 10 and 24 represent 30 percent of the population. It is during these critical years of transition from childhood to adulthood that individual aspirations and capabilities are determined, that young people develop their adult identity, mature physically and psychologically, and move towards economic independence.

Throughout this transition, the sexual and reproductive needs of young people are diverse and complex. While this is generally a healthy period of life, social changes and influences, socioeconomic conditions, mobility, family situations, and exposure to new lifestyles and people, make young people susceptible to health risks associated with early and unwanted pregnancy, unsafe abortions, and sexually transmitted infections (STIs), including HIV.

The past five years have witnessed a surge in interest in the sexual and reproductive health of young people, driven by the global HIV/AIDS epidemic and increased rates of unwanted pregnancy. With this interest comes increased investments in programs to address the needs of young people, a growing body of evidence about effective programs, and more coordinated action and mobilization of human resources. The field, however, is just entering its own adolescence and much remains to be learned about how to effectively improve the health and development of young people.

The case studies in this document explore “new generation” program models that seek to actively engage young people in programming, build the capacity of adult stakeholders to better respond to youth needs, and strengthen partnerships and networks to build a broader base of support for the implementation of youth programs. The first case study documents the experiences of the Program for Appropriate Technology in Health (PATH) in Thailand as it moved from HIV/AIDS activities to more youth-centered programs. Three innovative models were developed to: 1) promote life skills for healthy sexual development and HIV/AIDS prevention; 2) engage the media in responsible reporting on issues of sexuality and HIV/AIDS; and 3) improve the quality of services and referrals to youth in drugstores and pharmacies. The second case study documents a joint initiative by PATH Cambodia and Cooperative for Assistance and Relief Everywhere (CARE) International in Cambodia to create a linked program with similar program components. Both case studies emphasize the processes of capacity building and network strengthening, and offer reflections for future work.

1 The World Health Organization (WHO) defines adolescents as individuals between 10-19 years of age. The broader term “youth” encompasses 15-24 years old.
Framework for Youth Programming

The three broad strategies described below, when employed simultaneously, can have maximum impact on young people’s reproductive health (RH):

- Increase knowledge, encourage healthy attitudes, develop skills, and form or change behaviors of youth.
- Improve the social environment so that young people are supported to make healthy decisions and programs and services are able to operate.
- Increase access to and utilization of youth programs and health services.³

Each strategy corresponds to different outcomes and program activities, as described in Table 1 below. The effectiveness of program approaches and strategies has been the subject of a number of reviews and program documentation efforts conducted over the past five years. While these reviews have made important contributions in helping to distill what program types produce certain outcomes, there remains an enormous gap in understanding how and why effective programs work. The case studies included in this document outline a number of the processes in intervention development and describe the challenges, successes, and failures in delivering program interventions.

Table 1—Framework for Youth Programming

<table>
<thead>
<tr>
<th>Goals</th>
<th>Outcomes</th>
<th>Program Types</th>
</tr>
</thead>
</table>
| Create a safe and supportive environment for youth sexual and reproductive health (community and institution) | • Support for youth and youth programs  
• Change in social norms  
• Modified policies and regulations | • Policy and advocacy  
• Mass media  
• Social marketing  
• Community mobilization  
• Peer outreach and mobilization |
| Develop knowledge, skills, attitudes, and behaviors of youth (individual and interpersonal) | • Information  
• Support (counseling)  
• Skills  
• Communication  
• Safe and healthy behaviors | • Peer outreach (information, referrals, condoms and contraceptives, counseling)  
• Sexuality and health education sessions  
• Life-skills development  
• Recreation and youth centers  
• Mass and interpersonal media  
• Parent programs |
| Increase access to and use of youth programs and services | • Coverage  
• Access  
• Acceptability | • Peer outreach  
• Social marketing of products  
• Voluntary counseling and testing  
• Modified service delivery for youth  
• Pharmacy services  
• Youth corners |

³ This framework is based on work supported by the FOCUS on Young Adults Program, which classified and evaluated a range of programs for YSRH (Bond and Magnani, 2000; FOCUS on Young Adults, 2001).
“New Generation” Program Responses

As the field grows and expands, newer generation program models are being developed and tested. These models, based on theory and evidence, extend beyond the provision of information and services to young people, and address their social context and developmental needs. Different organizations and programs have their own approaches to developing innovative models. Many of these models have yet to demonstrate effectiveness through rigorous evaluation, but they show promising results in reaching youth, creating dynamic and engaging messages and activities, and utilizing natural channels of communication and health-seeking resources. The two case studies featured in this document describe several “new generation” approaches situated within the framework above: participatory and life-skills-based approaches to sexuality and HIV/AIDS prevention; advocacy with the media and private sector; and working with private sector health service providers to meet the needs of young clients.

Participatory Learning and Life-skills Methodologies

Teaching and learning methodologies such as participatory learning and life-skills pedagogies have infused the practice of adolescent sexual and reproductive health education in some areas. Research has found that individuals learn best in an environment of active involvement and participation. The principles of participatory learning hold true for both adults and youth. Many of the participatory activities that are used for training adults in sexual and reproductive health can also be used for helping youth acquire the basic knowledge and skills they need to protect themselves from STIs, HIV, and unintended pregnancy.

The life-skills pedagogy has also received greater attention and application in youth sexual and reproductive health (YSRH) programs. This pedagogy develops activities and issues that correspond to sets of life skills, such as:

- Decision-making and problem-solving.
- Critical thinking and creative thinking.
- Communication and interpersonal skills.
- Self-awareness and empathy.
- Coping with emotions and stress.

Skills-based approaches are gaining recognition because they teach young people alternatives for action.

The two case studies provide examples of how these approaches have been adapted and introduced in two different settings: schools and the workplace (factories). In each case, the process of introducing the approaches involved intensive development and testing of curricula using participatory approaches, training of adult or peer facilitators, and provision of coaching and follow-up.

In the Thai case study, curricula and training packages were developed by PATH staff for use by secondary and tertiary school teachers. The case study focuses on teachers’ roles in addressing issues of sexuality and HIV/AIDS, and the challenges and benefits gained by
teachers who delivered the curriculum. In the Cambodia case, a similar approach was developed for female garment factory workers (GFWs). The GFW curriculum was developed by CARE, delivered by staff of local nongovernmental organizations (LNGOs), and supported by the creation of informal peer networks within the factories. The role of international nongovernmental organizations (NGOs) in each case was to provide technical, managerial, and financial oversight.

**Advocacy**

Advocacy can be simply defined as “actively supporting a cause and trying to get others to support it too.” Such efforts in YSRH are critical because they play an important role in ensuring that programs are enacted, funded, implemented, maintained, and replicated. Ideally, youth programs should have support at all levels. Therefore, advocacy strategies must vary to reach a range of different audiences including donors, policy-makers, media representatives, government officials, community leaders, religious leaders, school principals, teachers, parents, and youth. At times, a program may even need to advocate within its own organization to gain support for YSRH initiatives. While a critical component of YSRH programming, advocacy efforts are often inadequately funded. In both case studies, advocacy efforts supplemented other program efforts; in the case of PATH Thailand, this was done without additional budget support and was thereby necessarily opportunistic.

Advocacy efforts in Cambodia focused on workplace policies to improve occupational health standards in garment factories. This was done so partners could develop a shared understanding of the law, and so that minimum standards were upheld in implementing health regulations. “Organizational advocacy” by CARE was necessary to gain trust and access to the factories to deliver other interventions. This involved frequent visits, meetings, and the development and distribution of organizational promotional materials.

Media advocacy promotes social, rather than individual, change in order to legitimize certain behaviors or change social perceptions or norms about particular behaviors or issues. Since media largely shapes public perceptions and debate, influencing how media portrays issues should be a key component of a broader intervention strategy.

In the field of YSRH, media advocacy has been used to stimulate debates on positive sexuality; to portray youth as responsible, contributing members of society; to address stigma; and to stimulate social debates on reproductive health and rights issues such as abortion rights and access to emergency contraception (EC). Media advocacy has also been used to create messages about responsible parenting and responsible sexual behaviors. In some cases, media advocacy is tied to activism.

Media advocacy efforts in the Thailand case study were developed to stimulate social debate about sensitive issues of sexuality, HIV/AIDS education and attitudes toward people living with HIV/AIDS, and to encourage more responsible coverage of these issues. Activities included developing a newsletter to share with the media, organizing discussion forums on sensitive issues and inviting members of the media to cover these issues, and conducting joint field-site activities with journalists. These activities helped PATH establish legitimacy as an authoritative resource on the topics. In both cases, developing partnerships with and mutual understanding of the perspectives of others (private businesses and the media) were critical in initiating any advocacy activities.
Working with Private-sector Service Providers to Meet the Needs of Young Clients

Much of the discussion relating to health services for young people is whether or not they are “youth-friendly.” Youth-friendly services have been defined as those with “policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clientele for follow up and repeat visits.” Attention has focused on the “supply” side of service delivery, with relatively little attention paid to the natural “demand” by young people for services within the private sector.

Drugstores and pharmacies are the primary point of contact for many youth seeking RH advice and care. The RxGen Program developed by PATH Thailand was designed to improve both the supply and demand for youth-friendly services through training, consumer education, and development of referral networks to social and health services. In Thailand, PATH worked with the Community Pharmacy Association, universities, the Ministry of Public Health, and other local service organizations. In Cambodia, PATH employed a similar approach with private pharmacists and clinics, in partnership with the Pharmacists’ Association of Cambodia and the Phnom Penh Municipal Health Department. Given the existing demand for services in pharmacies, drugstores, and private clinics, both case studies describe measures to improve the quality of services by providers through training and follow-up, and to strengthen referral networks to ensure adequate management of sexual and RH problems.

Promoting Multisectoral Collaboration

Youth RH programs that offer the most potential in developing and sustaining health behaviors are those that combine multisectoral approaches and prolonged attention to building community partnerships in which adolescents are active participants. Multisectoral approaches imply that programs involve multiple components that can target multiple risk factors or build on multiple protective factors. The critical issue in multisectoral programs concerns less the elements of the individual components, and more the establishment of complementary programs, collaboration, and cooperation required to bring about effective linkages between components. Each of the case studies discusses the individual components of multiple strategies, as well as efforts to build linkages between components.

Strengthening Partnerships and Networks

Multisectoral approaches to youth programs require strong and enduring partnerships and building networks among youth, within communities, and among organizations. Fostering partnerships and networks can help to improve the social environment through policy and

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advocacy activities, by developing referral systems, and by identifying channels through which to scale up innovative and effective program strategies. Networks and partnerships with youth and youth-serving organizations can collectively:

- Mobilize communities and address sensitive issues.
- Create linkages among families, communities, and institutions.
- Develop referral systems.
- Increase access to programs and services by combining resources.
- Create demand for services.
- Advocate for supportive policies.
- Share information, knowledge, and materials.  

Effective partnerships and network building require the following:

- Having a shared vision or mission.
- Maintaining linkages with key stakeholders.
- Collaborating with community partners.
- Mobilizing public, private, and nongovernmental organizations.
- Using leadership, team-building, negotiation, and conflict resolution skills.  

Applications of principles from the literature on effective partnerships and networks to youth programming have been limited. Many YSRH programs engage informally in networking and partnership activities. However, the types of partnerships and conditions under which they are formed vary significantly. The case studies herein help to address some of the following questions:

- What are the added benefits of a multisectoral strategy with links to services and community support?
- How can the process of institutional and community mobilization strengthen links between health promotion/education and service utilization among young people?
- What are the costs associated with multisectoral programming?
- How are effective partnerships created and maintained?
- How are effective partnerships managed?

In the Thailand case study, partnerships were established among PATH, LNGOs, teachers, and school administrators; journalists and editors; and pharmacists and drugsellers. The success of each individual program component required that PATH first establish strong partnerships with each type of stakeholder, and then facilitate linkages among them. Once these linkages were strengthened, PATH was able to withdraw from its coordinating role and continue to provide technical follow-up and support.

In Cambodia, PATH and CARE similarly established partnerships with local organizations to implement each individual program component. Further attempts were made to link the components and target beneficiaries through appropriate referral networks for garment

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workers. Moving beyond an individual organization’s linkages with local partners to a broader linking of partners across components has proved challenging; however, early indications are that these linkages help to increase utilization of quality services and improve referrals.

**Building Capacity**

The stated objective of many donors is “not just to improve health status or individual behavior during a project’s lifetime, but to ensure that local entities – organizations, groups and even health systems – can maintain these improvements over time, independent of external support.” To move toward this goal, building capacity and strengthening the institutions is critical. Capacity can be measured in terms of intermediate outcomes in a system – existence of strategies; organizational performance; responsiveness in planning; skills and competencies – and in the changes in community norms and practices that contribute to health. We may consider capacity to be established when:

- Communities and constituents (youth, families) set priorities, identify and contribute to developing solutions, and establish networks for diffusing solutions.
- Management, procurement, production, quality assurance, and monitoring systems are in place and operational.
- Personnel, including health service providers, educators, and managers, have adequate knowledge and skills to carry out youth interventions.

In YSRH programming, three key capacity priorities emerge:

- **Strengthening local leadership** to promote, advocate for, and implement youth programs.
- **Building human resource capacity**, often among adult stakeholders who can influence the positive development of young people.
- **Fostering partnerships and networks** to build a critical mass for programming and to strengthen linkages among multiple program components.

The case studies emphasize the second priority, building human resource capacity, particularly among adult stakeholders. In both the Thailand and Cambodia case studies, capacity-building efforts focused on local partner organizations, NGOs, teachers, journalists, and service providers to improve:

- Understanding of young people and how their lifestyles are related to their sexual and reproductive health needs.
- Skills to ensure that technical information is used and adopted.
- Interpersonal relationships and communication to encourage follow-up, mentoring, and sharing of experience.

In both cases, capacity-building efforts involved training that used interactive learning approaches, intensive follow-up and coaching, and network strengthening for reinforcement and support.

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Conclusion

While the case studies do not emphasize the actual improvements in health and behavioral outcomes achieved by these program models, they provide valuable insights into how to bring about changes in sexual and reproductive health behaviors among youth, improve quality of service delivery among providers and increased utilization of services by youth, and improve the broader social climate for youth health. The lessons and reflections presented are derived from an on-going, iterative learning process. Both organizations and their partners are committed to continuing their work with youth, and to further expanding the reach of these models. As they do so, further lessons will be learned about how to modify the approaches, how to continue introducing new innovations, and how to strengthen broader systems in order to scale up and sustain these successes.

13 These outcomes are referenced and have been reported elsewhere.
Youth Sexual and Reproductive Health Programming in Thailand: Changing the Change Agents

“The toughest challenge in sexual health education lies in changing the ‘change agents’—teachers, health workers, policy makers and the media”

—PATH report “Programming for HIV Prevention in Thai Schools” Annual Program Report #3, p. 14

Introduction

In Thailand, being a teenager is increasingly complicated as the country becomes more urbanized and industrialized. Interactions between women and men are less restricted than in the past, and there are larger gaps in experience between generations. Young people now have access to a much greater range of information and ideas, particularly as many of them leave their rural communities during adolescence to work or study in Thailand’s cities. With these opportunities and experiences also come risks and consequences—young people are more likely to become sexually active before marriage and hence must manage the risks of unplanned pregnancies and HIV/AIDS. At the same time, adults are struggling to understand how to respond to the changing needs and lifestyles of these youth.

The Program for Appropriate Technology in Health, (PATH) is an international nongovernmental organization (NGO) that has been working in Thailand since 1980. Building on a decade of experience developing HIV/AIDS interventions with different target populations, PATH now focuses much of its work on youth, recognizing that the majority of new infections occur among young people between the ages of 15 and 24.

Conducting HIV/AIDS prevention programs revealed the extent to which this group’s unsafe sexual behavior was connected to some deep, underlying issues. Youth are confused and uninformed about sex, while adults are confused about young people, and this confusion is symptomatic of a broader societal unease about gender norms and expectations. Reaching out to young people requires that efforts be based on a solid understand-
ing of what they want and need. This may be a standard best practice with any “target
group,” but it is particularly critical when young people are shaping their ideas and
behaviors about sex.

The youth programs developed by PATH have been part of an on-going learning process,
based on a commitment to respecting the ideas and capabilities of young people and with
an awareness of how broader social trends influence behaviors. Program strategies are
still evolving, as experience is applied and modified to reflect rapidly changing styles and
trends among youth.

PATH has focused its efforts on building the capacity of adults in strategic positions of
influence in young people’s lives. They need to understand how their influence can be
positive, and be equipped with the skills and attitudes to provide young people with the
support and guidance they need. This approach has helped a biology teacher learn how to
facilitate sexuality education activities and a counselor explore why a teen wants to buy
emergency contraceptive (EC) pills.

PATH has also expanded partnerships and networks to create an environment in which
young people can easily access the information, services, support, and guidance they
need. For example, working with journalists to develop more positive and informative
coverage of youth lifestyles has influenced policy-makers to better understand and create
policies that address young people’s needs.

This paper reflects lessons gained while creating a set of model approaches that respond
to youth sexual and reproductive health (YSRH) needs in Thailand. The discussion
focuses on three separate but complementary experiences that speak to the main goals of
youth programming:

- Developing knowledge, skills, attitudes, and behaviors of youth.
- Creating a safe and supportive environment for YSRH.
- Increasing access to and use of youth programs and services.

We begin with a brief overview of the status of young people in Thailand, including both
social factors and health risks. The next section briefly reviews PATH’s work with sexual-
ity education, media advocacy, and youth-friendly drugstores. The third section describes
how each of these three approaches contributed to building capacity and mobilizing
support through partnerships and networks.

**Young People’s Sexual and Reproductive Health in Thailand**

Traditional expectations for young people are clear in Thai society—they are supposed to
study hard in school and be respectful of their elders, particularly in listening to and acting
upon the advice of parents and teachers. Yet, as in many countries, advice is often pre-
scriptive with young people—do this, don’t do that—as if, like empty vessels, they are to
be filled with the wisdom and experience of previous generations. At the same time,
young people are exposed to an array of experiences outside the traditional bounds of

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1 FOCUS on Young Adults. Advancing Young Adult Reproductive Health: Actions for the Next Decade. End of Program Report.
school and family. They are a primary market for advertisers, and a host of communication technologies are geared to and used by them, from interactive computer games to text messaging on mobile phones. While many families struggle to find time together, it is relatively easy for youth to meet up with friends after school or work, go shopping, play sports, or go to clubs. Young people who are starting to develop their own ideas and life goals are challenged to make sense of the differences between adult expectations and opportunities with friends, without a clear sense of where to go for help and guidance.

Youth get inadequate support and confusing information about sexual behavior and the resulting health risks. Premarital sexual activity is a sensitive topic, particularly for women, and thus it is difficult to determine exactly how widespread premarital sexual activity is. A recent survey in Central Thailand among 19-year-old college students found that 61 percent of males reported ever having had sex, while 29 percent of female students reported ever having had sex. Among those who reported having had sex, the mean age of first sex for males was 17.5 and 18.5 for females. Another recent survey of vocational students ages 15-21 in Northern Thailand found that 48 percent of male students and 43 percent of female students reported ever having sexual intercourse. Both of these studies used ACASI, a computer-administered data collection technique that is thought to increase the validity of self-reports of adolescent sexual behavior. A large survey in Bangkok using self-administered questionnaires found 15 percent of female students and 24 percent of male students reported ever having sex.

With sexual activity come risks of HIV/AIDS and unwanted pregnancy. Although Thailand has seen a decrease in HIV incidence, the country still has an adult HIV prevalence of 2.15 percent, making it one of the more severe epidemics in the Asian region. Among young people between the ages of 15 and 24, HIV prevalence in 1999 was between 1.5 and 3.3 percent for women and 0.5 and 1.9 percent for men. In Thailand, Cambodia, and Burma, HIV prevalence among youth is greater than one percent.

HIV/AIDS awareness and prevention campaigns in the mid-1990s have effectively contributed to high levels of awareness of the disease, and most young people get some form of HIV/AIDS education in school. Yet while awareness may be high, this has not translated into high levels of condom use among young people. Only 30 percent of students in the Central Thailand study reported condom use the last time they had sex, similar to results in Bangkok. Young people are now more likely to have sex with regular or casual partners than with commercial sex workers. Yet, because of complicated issues around trust and negotiation, they may see less of a need to use condoms.

A more immediate concern to many young people is unplanned pregnancy. Because abortion is illegal in Thailand under most conditions, it is difficult to determine abortion

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rates among adolescents and young adults. However, it has been estimated that 4 to 5 percent of sexually active adolescents have terminated a pregnancy. A recent study seeking to better quantify abortion rates estimated that 30 percent of women seeking abortion-related services at government hospitals were under the age of 20. These women were seeking treatment primarily for complications from poorly performed abortions.

Young people’s sexual health needs are clear, but effective responses to them have taken some time to emerge. Many parents and teachers worry that if they talk with young people about sexual development or how to prevent pregnancy and HIV/AIDS, they will be “showing the nuts to the squirrels,” as a Thai saying goes. Instead, young people get the information they want from friends, magazines, the Internet, and pornography. A recent behavioral surveillance study in Bangkok found that a sizable number of students in secondary and vocational schools—almost 40 percent of girls and approximately 80 percent of boys—had some exposure to pornography, whether it was from videos, books, or on the Internet. Gender norms also influence the information and messages young people receive. Girls are frequently told to preserve their virginity, while boys have more license to become sexually active, as long as they are “gentlemanly” about it.

The following section discusses PATH’s experiences developing youth program models that address key questions of how to build young people’s skills, create a more supportive environment, and provide quality services for youth.

Complementary Responses to Youth Sexual Health Needs

Youth sexual and reproductive health programs that offer the most promise for sustaining behavior change are those that combine multisectoral approaches and prolonged attention to building community partnerships in which adolescents are active participants. As stated above, these approaches involve building healthy decision-making skills among young people, creating a social environment that supports them, and ensuring that they have accessible services that meet their real needs. The social, cultural, economic, political, and legal context colors and shapes how these approaches originate, develop, and get implemented.

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From Hired Boats to Child-centered Learning: The Importance of Teachers

Working with Thailand’s school system can ensure that large numbers of young people have access to the information they need to make healthy decisions about sexuality and reproductive health (RH). Indeed, most young people get some of their information about HIV/AIDS from school programs, but this has not yet translated into the widespread practice of protective skills and behaviors. Some features of the Thai school system make implementing effective comprehensive sexuality education challenging.

Teachers are accustomed to a great deal of authority in the classroom, and didactic teaching styles such as lecturing and reading from texts are commonly used to convey information. Teachers have traditionally received a great deal of respect in Thai society in their role as caretakers of the nation’s future, conveyers of knowledge, and keepers of morality. They are sometimes called “hired boats,” meaning that parents put their children into their teacher’s care, and it is the teacher’s responsibility to carry the children across the dangerous waters of childhood and adolescence. The children are expected to sit there and not fall out of the boat.

Effective models of comprehensive sexuality education have the potential to change this. To learn how to practice safe behaviors, students must become actively involved in the learning process in order to develop decision-making and communication skills as well as positive attitudes and self-esteem. The teacher’s role becomes one of facilitating an open and safe environment in which young people can explore issues of concern, get the information they want, and think through the implications of their attitudes and experiences. The teaching methods employed in comprehensive sexuality education could support the government’s child-centered learning policy, but the sensitivity of the subject matter has made it difficult to move beyond basic facts of anatomy and hygiene to broach more sensitive or complicated topics.

Thailand’s strong social norms about appropriate sexual behavior have made it difficult for many teachers to determine how to teach these subjects out of a fear that they will be scrutinized closely by other teachers, parents, and even their students for having a lot of knowledge about “those things.” Many are also concerned that sexuality education itself might be immoral or that they could be accused of immorality if they taught the subject.

PATH has implemented comprehensive sexuality education in secondary and tertiary schools in Thailand. In conjunction with a World Bank HIV/AIDS prevention and care project implemented by a consortium of NGOs in Bangkok, PATH worked with a local NGO, Siam-Care, to introduce a sexuality education curriculum into 26 secondary schools.
schools in the city. Seventy-one guidance counselors were trained to implement the curriculum that reached 4,778 eighth-grade students.

In collaboration with the Population Council, PATH implemented and evaluated a comprehensive sexuality education curriculum to determine if it could positively influence young people’s attitudes and behaviors in school settings. The curriculum was developed and tested in the Rajaphat Institutes, four-year colleges that specialize in teacher training, thus opening up the possibility of influencing Thailand’s next generation of teachers. Thirty-five teachers at three schools were recruited into the project on a voluntary basis, eventually reaching over 1,200 students.

In both projects, staff worked closely with teachers and young people to assess information and skills-building needs and to develop the curricula. Teachers were also trained beforehand in participatory learning techniques and the concept of sexuality education. For both the Rajaphat Institute instructors and secondary school teachers, the training goals included:

- Understanding young people and their environment.
- Introducing the goals and content of sexuality education.
- Exploring attitudes and values toward HIV/AIDS and sexuality.
- Experiencing participatory learning and child-centered approaches and introducing the process of behavior change.
- Understanding curriculum objectives and learning activities.
- Gaining key skills in facilitating HIV/AIDS and sexuality training.

The training particularly focused on instructors’ attitudes toward young people and on building facilitation skills.

While the process in both projects was fairly similar, PATH’s work with secondary schools in Bangkok and the Rajaphat Institutes differed in a few respects. The work with the Rajaphat Institutes was part of a focused HIV/AIDS intervention, so the content of the curriculum had a heavy emphasis on HIV/AIDS prevention, with only some coverage of other RH topics, and information was geared to a young adult audience. The secondary schools project had to communicate to a younger audience, and the content of the curriculum included topics such as puberty and sexual development.

**Getting the Message Out: Working With the Media**

Young people in Thailand consistently cite the media as a key source of information about sex. These media messages (which are often inaccurate) have a strong influence on how young people perceive sexuality. Portrayals of sexual matters are often sensationalized to entertain as much as to inform, and always with competing market share at stake. Messages tend to contribute to social stereotypes that encourage men to think about performance and virility, while women are told to be modest and virtuous. Journalists and other
media professionals may themselves have misconceptions or inadequate information about sex, and as a result, produce incomplete, contradictory, and vague reports on the subject.\textsuperscript{13,14}

There are gaps between what gets covered and the variety of sexual lifestyles commonly found in Thai society. This mismatch between norms and reality makes it difficult to communicate openly about sexuality, especially HIV/AIDS and unplanned pregnancy risks. Furthermore, reporting based on stereotypes reinforces stigma, denial, and discrimination.

Media advocacy is the strategic use of mass media to advance social or public policy initiatives. This approach aims to stimulate debate and promote responsible portrayals and coverage of health issues, and engage the media as partners in defining new social messages. Opening a more public debate on sexuality, both the social norms that influence behavior and Thai society’s diverse reality, has been PATH’s primary media advocacy goal to date, and it is critical to the organization’s broader youth strategy. Facilitating social debate and open discussion makes it easier to provide young people with correct information, opportunities for skills-building, and quality services.

While there is a clear rationale behind media activities, PATH’s media advocacy work has required taking advantage of opportunities as they come along. PATH’s work with the NGO consortium, Bangkok Positive, involved an outreach strategy that initially focused on promoting positive ideas about living with HIV/AIDS in order to counter other messages that contributed to fear and stigma. Activities associated with Bangkok Positive opened up other opportunities for PATH to work closely with journalists and other media professionals on a broader range of issues. The organization’s name became more recognized and the staff developed greater internal capacity to respond to news groups.

\textbf{Reaching Youth With Services: Drugstores for Young People}

Quality health services are a third critical component in meeting YSRH needs. Young people in Thailand want access to safe, clean, friendly, and affordable health services, but as in many other countries, they have a difficult time accessing them. Reproductive health


\textsuperscript{14} PATH. Bangkok Positive, Progress Report #3 for the period of January 1 to March 31, 2001.
services in the formal health care system are primarily geared to married couples, and most providers treat young clients poorly, often making the assumption that they should be more concerned about studying than finding a partner. Clinic hours, whether at public or private sites, are generally inconvenient for young people, and few in-school adolescents have enough money to pay medical fees. At the same time, adolescents are often unaware of where to go for health services and nervous about explaining their concerns to adults in positions of authority.

Given these barriers to access, young people in Thailand do what many other Thais do when they do not have a lot of time or money for health care—they go to the drugstore where a range of RH services and products are readily available. Drugstores are attractive to adolescents because they can offer fast, affordable, and anonymous service. These services usually take the form of a quick business transaction—with young clients already having a particular product in mind and hoping to get the item without attracting too much attention or scrutiny.

There are two main categories of drugstores in Thailand: stores with a professionally trained pharmacist on staff and drugstores operated by non-pharmacists. The Ministry of Public Health estimates that almost 80 percent of drugstores in the country fall into this second category, and most pharmacist-operated stores are concentrated in urban areas. Legally, only pharmacists can dispense most high-end pharmaceutical agents, such as narcotics, while drugstore personnel without professional training are supposed to limit their services to pre-packaged drugs and drugs without serious side effects. In practice, pharmacists are rarely behind the counter for the duration of drugstore working hours, and whether in a pharmacy or a regular drugstore, anyone working at the counter when a clients walks in will dispense what is requested.

While drugstores can meet the basic needs of many young people, the quality of these services varies. Though some drugstore personnel see young clients primarily as customers and respond to their customer demands, others have attitudes about young people’s sexual behavior that are as judgmental as those of health care providers in the formal sector. The primary difference is that client-provider interactions in drugstores are faster, with fewer questions asked. Drugstore personnel often ignore young people’s privacy concerns or may make assumptions about what is best for them without first consulting them.

Safety is another key quality concern for drugstores. Many of the sexual health-related products that clients ask for are “off-label” or based on folk beliefs rather than scientific research. If dispensed improperly, they can be dangerous. Short interactions with the customer, a desire to please, and lack of training can limit drugstore personnel’s ability to provide comprehensive, accurate information and recommendations for these goods. There is also concern over minimal enforcement of regulatory standards for prescribed drugs.

For over a decade, PATH has worked closely with drugstore business networks and the provincial Public Health Office (PHO) to improve the capacity of drugstores to conduct syndromic management of sexually transmitted infections (STIs) and treatment of opportunistic infections for HIV/AIDS. Many of the clients seeking services at project drugstores

were in their late teens and early twenties. After conducting a rapid situation analysis with drugstores in three provinces, PATH and its drugstore partners discovered that young people used a range of products and services to address their reproductive and sexual health-related concerns.

Some of these products could be dangerous if used incorrectly. Others were ineffective, such as “anti-gonorrhea” medication that customers requested to prevent STIs. The assessment also revealed serious gaps in the service system for young people. Young clients with more serious cases were rarely referred to other health care providers. At most, they might be told to go see a doctor. At the same time, a host of private and public services were potentially available to young people, but they preferred drugstores, because they were either not aware of these services or they were nervous about seeking help in the formal system.

PATH’s RxGen project was an effort to improve the quality of RH services at Thai drugstores by introducing the concept of youth-friendly services:

*Youth-friendly services occur when healthcare personnel are aware of current adolescent sexual and reproductive health issues and can provide relevant advice*
and information in a communicative and non-judgmental manner, with respect for privacy and confidentiality. These services should also include a supportive referral system and a warm and welcoming physical setting that also provides privacy for the client and provider.

Project partners were identified at the provincial level based on pre-existing relationships with local drugstore business networks, the provincial PHO, and academic pharmacists. Sites were selected in each of Thailand’s regions to account for potential differences in service use. In each of the target provinces, project staff worked with their local partners to identify potential drugstores. These were selected on a voluntary basis, primarily due to their membership in local drugstore business networks, and some drugstores volunteered because they were interested in attracting new customers. In total, nineteen stores were recruited into the project. The majority had pharmacists on staff. In each province, PATH staff supported their local partners to build the capacity of project drugstores in providing youth-friendly services and helped these partners link the drugstores to other local services.

In developing complementary strategies to respond to young people, two principal needs emerged:

- Developing the capacity of adults to respond to young people.
- Strengthening and mobilizing partnerships and networks to support youth and implement programs.

The next sections discuss lessons in capacity building and network strengthening related to each approach.

**Building the Capacity of Adult Change Agents to Understand and Respond to Youth**

In each of the three approaches, capacity-building efforts targeted adults—teachers, journalists, and service providers—to positively influence young people. Capacity-building efforts focused on:

- Understanding young people and how their lifestyles are related to their sexual and reproductive health needs.
- Building skills to ensure that information was being used and adopted.
- Establishing good interpersonal relationships to encourage follow-up, mentoring, and sharing of experiences.
Content and Process in Preparing Comprehensive Sexuality Educators

Whether in secondary or tertiary institutions, supporting teachers to become sexuality educators involved two key tasks: developing a curriculum to engage young people in learning about sexuality and RH, and preparing teachers to use the curriculum. Focus group discussions and in-depth interviews helped staff understand the language young people used and the questions to which they wanted answers, while working with the teachers helped project staff understand some of the barriers they would have to address during trainings. In designing the curriculum, theory as well as previous experience led the team to emphasize participatory approaches that would get students involved in learning. Both of the curricula used the concept of experiential learning, as well as a set of principles for effective sexuality education programs developed in the United States. Over time, the team also came up with their own set of principles for a good sexuality education curriculum:

- Personally relevant
- Simple and clear
- Fun
- Practical
- Responsive to youth’s needs and interests
- Thought provoking
- Educational

Providing information about HIV/AIDS or unplanned pregnancy is not sufficient to lead young people to adopt healthy behaviors. Learners need the opportunity to assess their attitudes, think about what influences their behavior, and practice new skills.

Comprehensive sexuality education activities should enable young people to think about and personalize content. Project staff sum up the ultimate goal of the curricula they developed as helping young people think, analyze, and make decisions, as illustrated in the diagram above. Young people in Thailand are usually told what to do, and this practice is a major factor in their confusion about whether to become sexually active and what sexual activity actually means. The team strived to create a process with the curricula that would help students think critically about what was expected of them and what they actually wanted. Instead of just focusing on refusal skills, project staff wanted students to be able to accurately assess risks and consequences of unintended and unsafe sexual activity and then think through strategies they could act on. This might range from avoiding intimate settings with a partner to negotiating condom use. The point was for the students to be able to make healthy decisions.
The objectives and process of the curriculum should be easy to understand and use, especially if teachers are not initially comfortable teaching comprehensive sexuality education.

A clearly designed curriculum will assist educators who lack confidence in their ability to teach sexuality and HIV/AIDS education. The learning objectives of each module and activity within the curriculum need to be well defined, so teachers understand how to use the materials and how the lesson plans contribute to the overall objectives of the curriculum. When following up with some of the Rajaphat Institute instructors, project staff found that some of the beginning ice-breaker activities they had used were hard to understand. This initial confusion set the tone in some classrooms, making it difficult to engage the students, and it took several sessions before classroom camaraderie could be developed. Piloting, seeking feedback, and refining activities can help with this issue.

While students are generally enthusiastic about participatory learning, they have a range of needs and learning styles.

One of the most intriguing outcomes of the Rajaphat Institute experience was that the curriculum seemed to have the strongest effect on young women. In assessing attitude and behavior changes, young women who were not yet sexually active were more likely to report positive attitudes towards condom use and people living with HIV/AIDS, and improved communication about HIV/AIDS with their partners after the intervention. Sexually active females in the intervention group were more likely to report using condoms in the last four months than those who did not participate in the intervention. Sexually active young men, who in theory would be one of the key target groups for the work, did not report substantial changes in attitudes or behaviors after the intervention was completed.

There are two different interpretations of this outcome. First, it could be that since the curriculum designers and majority of teachers were women, there may have been an unconscious bias towards what women want to know in the curriculum. Another interpretation is that young women without sexual experience had the most to gain from the intervention, as it is difficult for girls to learn about sexuality without appearing promiscuous. Some of the sexually active young men stated that what was in the curriculum was not new information for them. If they were not learning something new, they may have been less inclined to think about how they could apply the lessons in their personal lives.

Further, students may also need time to become comfortable expressing themselves and engaging in classroom activities. The Rajaphat Institute project worked with slightly older students, who were accustomed to the traditional “chalk and talk” approach. Students who had an instructor with reasonable facilitation skills ended up more likely to demonstrate positive changes than students who had either an outstanding teacher or a poorly-skilled teacher.

Even with a clear curriculum, educators still require training to become familiar with potentially sensitive content and new teaching methods.

The primary challenge in training is finding time in between teachers’ busy schedules and multiple commitments. Three days was about as much time as the team could get to train teachers. The training particularly focused on instructors’ attitudes toward young people
and on building facilitation skills. Instead of using the traditional Thai teaching style of “this is right, that is wrong,” the training asked teachers to think of themselves as facilitators who could open up a dialogue with their students. Teachers learned to adapt how they communicated with their students and presented information so that listening and asking probing questions with an open mind were more important than having full technical mastery of the subject. Several of the faculty agreed afterwards that if they had not been through the training, they probably would not have been able to teach the curriculum. They needed time to become comfortable talking about sexuality and sexual behavior as well as to practice teaching the topics. A better understanding of what they were comfortable with helped them communicate with their students later on.

It is challenging for many teachers to simultaneously implement a new teaching style and become comfortable teaching a sensitive topic.

Despite training and follow-up, some teachers found it difficult to be comfortable with the interactive techniques included in the curriculum. These educators had to radically change their roles in the classroom from being the absolute authority to becoming a facilitator and coach. This meant that they had to accept a diversity of opinions and that they might not have answers to students’ questions. For educators who have spent most of their careers lecturing and commanding respect, it can be demoralizing to say “I don’t know” to a group of students. Many of the facilitators felt they had to put substantially more time into preparing to teach the modules than usual and, for some, it was a stressful experience.

Not everyone can be a sexuality educator. It takes courage, an open mind, understanding, and respect for young people’s needs.

Some of the teachers had their own misconceptions about reproductive and sexual health prior to the training. Teachers’ age—whether young and unmarried or older and close to retirement—had an effect on whether they felt comfortable talking with their students. Unmarried women teachers felt that they would be judged if they demonstrated “too much” knowledge about sexuality, while older teachers found it challenging to adopt new practices after decades of experience. As a result, some skipped over topics that they felt were embarrassing, such as condom demonstrations.

In general, secondary school guidance counselors had an easier time picking up the subject matter and methods of teaching than the Rajaphat Institute instructors, who came from a range of backgrounds. The guidance counselors were usually closer to their students and faced less pressure to have their students perform well on tests. Their counseling skills also helped. Similarly, one of the Rajaphat Institute instructors found that the participatory techniques in the curriculum were quite similar to the methods she used in her psychology classes. One secondary school teacher found it most important to just

“The training aimed to change attitudes towards sex that are deeply rooted in each individual. It is difficult to change attitudes among teachers in particular. If teachers do not attend the training-of-trainers workshop and want to use the curriculum, I think they have to be very open-minded. For me, even though I had attended the three-day workshop and I understand, it’s still difficult to change some values.”

— A sexuality educator
try out the curriculum and see what happened, despite the fact that he was nervous beforehand. While the curricula were designed to introduce experiential learning to the students, the concept also seemed to work with the teachers.

Mentoring and supportive relationships between program staff and teachers help to reinforce learning.

Systematic follow-up with teachers strengthened their confidence. With the Rajaphat Institute group, observations of classroom sessions and mid-course and wrap-up meetings with all of the instructors solicited reflections on the experience of teaching the curriculum. In both secondary and tertiary schools, teachers appreciated the support and contact as they did not feel that they were “going it alone in the wilderness” as they tried out the curricula. A friendly face and someone who could provide feedback and suggestions often gave teachers the encouragement they needed. Meetings with teachers from other schools were also popular, allowing teachers to learn how other sites were faring in their efforts to implement sexuality education. These meetings were an opportunity to share experiences, and they helped the teachers build relationships that continued after the projects ended.

Learning to Work With the Media Toward Responsible Coverage of Sensitive Topics

Media advocacy is a relatively new approach to youth programming and, as such, project staff was less experienced in this area. Without a specified project budget, media activities have been less systematic than some of the organization’s other efforts. Capacity-building efforts were focused within the organization, and with local NGO partners, building on relationships with journalists to better understand how to collaborate with common purpose.

Building capacity to work with the media involved three key tasks:

• Developing a better understanding of the needs, constraints, and interests of the media in order to reach out to them more effectively.

• Establishing legitimacy and expertise on the subjects at hand.

• Developing strategies to sensitize journalists and other media to the depth and complexity of sexuality and HIV/AIDS in Thailand.

If media advocacy is going to work, both sides need to understand each other’s interests. In order to build an understanding of the media, and improve skills in writing about experiences, a workshop on writing news and working with the media was organized for a consortium of NGO partners under the Bangkok Positive project. The project introduced a newsletter as a starting point for reporting news and other information among consortium members. Professor Ruj Kosombut, a media consultant and professor of journalism, and other trainers worked with NGO staff to identify newsworthy stories, frame issues, and write news following journalistic standards. Professor Ruj also invited a few senior journalists to talk with the group about the profession of journalism and their own experiences in identifying and covering the news. This brief event helped the PATH staff get to know a couple of leading journalists and to begin developing relationships with other media professionals.
Building capacity requires follow-up and support. When follow-up and support are not available, switch strategies.

While the workshop helped build relationships, the NGO partners were not able to communicate about their activities as planned, due to time constraints and heavy workloads. With the support of a few other organizations, PATH program staff took on the task of producing the newsletter, re-envisioning it as a positive source of information about youth, HIV/AIDS prevention, and living with HIV/AIDS. PATH staff took the lead on covering youth and sexuality stories, the Center for AIDS Rights covered human rights, and the AIDS Access Foundation focused on care and treatment. PATH staff still worked with other members of the consortium in identifying stories, but they tried to distill this experience into content, rather than ask other partners to do the writing.

Reporting on activities can lend legitimacy to an organization.

As they gained experience in producing the Bangkok Positive newsletter on a regular basis, PATH started receiving requests for it from outside the consortium. Other NGOs, teachers, media, and hospitals throughout the city wanted to be on the distribution list. Many support groups for people living with HIV/AIDS were particularly enthusiastic about it, because it was one of only a handful of publications in Thailand that consistently presented the message that AIDS is a disease with which people can live. Eventually, producing Bangkok Positive had the unexpected effect of helping program staff further develop relationships with journalists. The consistency and quality of Bangkok Positive’s content helped demonstrate the organization’s commitment to covering sexuality and HIV/AIDS issues in Thai society, and PATH started developing a reputation as a consistent source for news. Journalists would usually follow up independently on stories covered in the newsletter, but program staff was asked more frequently to give interviews.

In developing a strategy, in-depth interactions and the incentive of a story are key ways to reach busy media professionals.

With relatively few journalists in Thailand, most social sectors actively reach out to journalists in order to get their perspective covered in the press. Therefore, it can be difficult to track down journalists and ask them to cover issues in a different light. A “mini study tour” was the most effective strategy for sensitizing journalists to how media coverage can portray sexuality and HIV/AIDS in a more positive and educational light. As part of a workshop for journalists covering social affairs, teams of NGO workers and journalists visited Bangkok’s red-light district and other venues where casual and commercial sex occur. The following day, the NGOs and journalists discussed these tours and worked together to shape poignant human interest stories with accurate and responsible messages.
For many of the journalists involved, these study tours were an eye-opening experience and the discussions with NGOs gave them the opportunity to write more in-depth stories than usual. Journalists came away from the experience with important collegial relationships with NGO staff and fresh stories that had a new perspective.

Editors are critical gatekeepers in shaping how a story is covered. While the NGOs got better at writing news articles and started to work more closely with journalists, they discovered that despite their efforts, they still faced a key barrier in getting their perspective covered. Getting to know reporters who cover different beats, such as health or social affairs, is a good start in building relationships with the press, but editors have the final say in whether a story is printed and how it is “spun.” Program staff found that reaching out to editors required patience but increased the likelihood of getting content published in a manner consistent with objectives.

Stimulating debate about a sensitive topic requires preparation and a clear message. It may be easier to anticipate and manage controversy if the underlying objective is clearly articulated.

A second strategy in working with the media was organizing special events that brought sensitive issues into public discourse. In organizing the events, program staff invited a broad range of media professionals, contacting advertising and entertainment media in addition to their established press contacts. Staff found it necessary to work closely with speakers to shape their presentations prior to events, in order to ensure that relevant points were brought out clearly and that speakers could relate back to the theme of an open exploration of HIV/AIDS, stigma, and sexuality. Even then, it was extremely difficult to predict how the discussions would go.

After the events, project staff monitored newspapers to assess how the events were covered, and each time some dramatic headlines were generated. One woman’s story about not being sexually satisfied in her marriage was translated into a headline in a major newspaper about women demanding the ability to have as many partners as men. Professor Ruj, the media consultant, observed that stories journalists picked up on at the event were massaged and edited back in the newsroom by an editor who was more concerned about generating a headline that would sell than in thinking through the social consequences of the banner. On the other hand, the content of some of the articles with outrageous headlines actually provided factual information and responsible commentary.

The level of controversy generated by some of these events raises the question of whether just stimulating public debate on an unspoken issue is the right strategy. Many of the journalists and their editors did not know the organizations or understand the objective of the events. Without an in-depth understanding of why a public discussion of sexuality might be socially valuable, it is relatively easy in the sensationalized world of Thai journalism to turn an offbeat story into a media circus. Program staff hoped that by hosting an open forum for people who have few outlets to share their experiences, the stories would speak for themselves. While this approach did not necessarily backfire, a more targeted approach in future work might ensure that concerns about gender equity, open communication, and respect for diversity are more clearly highlighted.
Personal stories give meaning to social issues.

One reason the fora generated so much controversy and debate was that real people were willing to openly talk about their experiences. Many of their revelations went against common expectations of gender roles and sexual behavior. The staff worked hard to find personal stories that conveyed the issues they wanted to cover in each forum. Data on the AIDS epidemic or on rates of premarital sexual activity can be used to indicate the extent of the issue, but numbers do not captivate an audience nearly as well as a personal story. In order for people to think positively about sexuality and what young people need, they must be personally engaged. Stories with a human interest angle do that far better than a roll call of numbers.

Strengthening Drugstore Personnel’s Capacity to Serve Youth

There were three components to strengthening the capacity among drugstore personnel to better serve youth clients:

- Strengthening the technical information drugstore personnel use to provide young people with safe and effective RH services and products.
- Promoting positive attitudes towards serving youth.
- Building communication skills.

Based on these three areas, a manual entitled “Youth-friendly Drugstore Services: Improving Youth Sexual and Reproductive Health: A Manual for Community Pharmacists” was developed to support training and serve as a job aid.

Technical training should focus on accurate information and issues of quality and safety.

The technical training for pharmacists focused on updating them about information on key problems and related products. Service guidelines were developed to deal with:

- Preventing pregnancy (oral contraception and condoms).
- Regulating menstruation.
- Treating reproductive tract infections.
- Dispensing other RH-related products.

Technical training was geared to pharmacists, rather than to personnel in non-registered drugstores, due to legal registration restrictions. However, specifically focusing technical information to pharmacists meant that non-pharmacist drugstore personnel, those most in need of better technical training, were missed. Non-pharmacists may dispense a range of drugs without an extensive background in the risks and side effects of what they provide. Pharmacists were encouraged to share what they learned with their non-pharmacist colleagues, although this strategy relied on the commitment of individual pharmacists and made later monitoring and evaluation efforts more challenging.
Drugstore personnel need training and support in learning to respect young people’s privacy concerns and non-judgmental communication with youth clients.

As with teachers, drugstore personnel also need time to internalize these concepts and learn how to practice new skills. Interactive games, case studies, and other participatory techniques helped drugstore trainees think about having a more positive attitude towards youth in a service setting. It was initially useful to posit this process in a business framework—better customer service would encourage satisfied customers to return to that particular drugstore. But as drugstore personnel began to understand the context of young people’s health problems and saw how drugstores could help, they became more committed to providing youth-friendly services for the sake of promoting better YSRH.

Because young people prefer to go to drugstores, many drugstore personnel were already seeing cases of unplanned pregnancy, confusion about oral contraceptives, and plenty of anxiety about buying condoms. Before becoming involved with the youth-friendly service concept, many of the personnel were judgmental about these cases. Capacity-building efforts helped them put the cases they were seeing into a broader context and gain a perspective on how to better meet the special needs of their younger clients. One of the areas that project staff stressed during training and in follow-up activities was respect for young people’s desire for privacy and confidentiality. Drugstore personnel were encouraged to find an out-of-the-way place in their stores to hold conversations with young clients and to develop service logs that did not record these young clients’ names.

Improving communication skills can enable drugstore personnel to better identify young clients’ needs and concerns, and respond appropriately.

Previous projects with drugstore personnel promoted two-way communication to improve the quality and safety of services. In working with youth, PATH and their drugstore partners found that it was critical for service personnel to develop good communication and counseling skills, particularly when serving young clients. These skills include:

- Interviewing
- Listening
- Summarizing
- Informing

Drugstores can provide counseling to youth clients, but messages must be concise in order to be conveyed in a short timeframe.

Young clients are not always forthcoming about who they want to buy the product for or why, because they are nervous or embarrassed. Initial training introduced drugstore personnel to the concept of two-way communication, encouraging them to start a dialogue with their clients in order to find out more about their clients’ medical histories and intended use of medication. As the project progressed, personnel asked for a greater focus
on counseling skills. Some of the cases that they saw were both complicated and sensitive, particularly situations where a young woman wanted to induce menstruation or seek an abortifacient because she thought she was pregnant. Drugstore personnel found that they needed more in-depth counseling strategies to develop their confidence in handling these cases. However, these strategies needed to be timely. The drugstore setting is also not conducive to extended counseling sessions, since other customers must be served and few drugstores have space for private conversations. As a result, PATH staff and their local partners worked with drugstores to develop rapid counseling techniques and easy-to-use protocols, so drugstore personnel could quickly convey information and advice to clients.

Finally, PATH worked with their partners in each project province to develop follow-up activities to the trainings in order to support the drugstores’ application of new skills and information. For some of the drugstore personnel involved, this was a new experience, because they were accustomed to going to a variety of training sessions without any follow-up, and it took some time and encouragement to get these drugstores to adapt their services. Site visits by local resource people, such as academics from nearby schools of pharmacy, helped to reinforce the trainings and provided drugstore staff with an opportunity for on-site problem-solving. The next step in the project, building and mobilizing referral networks, also gave drugstore personnel a regular opportunity to share experiences.

Mobilizing Relationships and Networks for a Supportive Environment

Building the capacity of adult change agents to better understand and support young people is critical. Positive relationships with parents, teachers and other adults, friends, and broader institutions can strongly influence decisions, health behaviors, and outcomes among youth. These connections serve as a foundation upon which young people enter adulthood.

Health promotion for young people involves creating supportive environments and social systems that protect them from risk and promote healthy behaviors. Strengthening relationships and mobilizing networks between and among adults and youth can help to create a broader movement of change and support, and expand innovative program approaches. This section offers reflections on how to strengthen relationships and networks to improve youth programs.

Supporting Sexuality Educators to Become Advocates for Youth

Something exciting happened while the teachers PATH staff had trained were using their new skills in participatory learning and sexuality education—they got to know their students better. Teachers in both the secondary schools and Rajaphat Institutes reported that their students would come up to them in the hallway between class sessions to ask what was on the agenda for next week. This is not common among deferential Thai students, and the students’ enthusiasm was an important motivating factor for teachers who were struggling to become comfortable with the content of the curriculum and with the process of teaching it. Because the curriculum was participatory, students had a greater opportunity to express themselves, so teachers gained a deeper insight into what was going on in their students’ lives than either the curriculum training or standard class-
room interactions could provide. Some students continued to approach their teachers after the completion of the course, sometimes just to keep in touch and sometimes to seek advice.

Some of these interactions with students continued to shock teachers, but most of the teachers who shared these stories stated that they felt better equipped to handle them. A few secondary school teachers talked about being consulted on how to talk with a boyfriend or girlfriend about sex, and some of the Rajaphat Institute instructors ended up helping with unintended pregnancy cases. Having some experience teaching a sexuality education curriculum did not lead teachers to radically alter their attitudes about sexual behavior. However, when they experienced more open lines of communication with their students, most of the teachers recognized that their students’ willingness to consult them, and their responsibility to help, were more important than whether or not they personally approved of what their students were doing.

Better relationships with students can be an important motivating factor for teachers and may inspire them to continue to teach sexuality education.

Although the Rajaphat Institute project in particular was developed to assess whether a school-based intervention could have a measurable effect on young people’s condom use, this change in teacher-student relationships may arguably be a more profound and more lasting outcome. These relationships help to create a more supportive environment for young people, since it is important that young people know how to ask for help and where to go. While it is often difficult to sustain changes in condom use over time, students can continue to talk to teachers they trust after the curriculum ends, and teachers may be inspired to find other opportunities to use their new skills.

The school environment, especially school administrators, can have a strong effect on whether it is possible to conduct sexuality education, but links across schools can help teachers support each other.

One critical factor in being able to replicate or expand activities was whether school administrators supported the concept. While teachers were teaching the curricula, some reported that their colleagues were not supportive of their work, and they had to field questions such as “why are you wasting your time teaching that?” and “are you sure you can teach that topic?” While this lack of support might be demoralizing, their ability to teach sexuality education ultimately hinged on the degree of administrative support for their work. One of the Rajaphat Institutes was unable to implement follow-on activities, because the administrative team changed and instructors lost their primary link to school decision-makers.

Despite this degree of uncertainty, motivated teachers continued to find ways to be involved in sexuality education. Some teachers boldly pushed for openings at their schools, while others helped friends at other schools. Having an informal network of

“...It’s like being full after eating rice. Once you find out all about it (sexuality education), you don’t need to go and try it out or find out about it from somewhere else... In fact, it makes you think that really sex is not such an easy matter to negotiate – there are plenty of hassles that can result. As for those people who are thinking of doing it (having sex) or already have done it, they will get more information and know better how to protect themselves. But if the teacher hides this stuff, students are left to find out for themselves as best they can.”

—A secondary school student
friends at other schools gave teachers a forum to share experiences and to host joint events. Most important, however, was once these teachers started teaching sexuality education and saw how well it worked, they did not want to stop.

Setting a Public Agenda on Sexuality, HIV/AIDS, and Youth

Mobilizing media also required establishing relationships with journalists and tapping media networks. Through these relationships and networks, specific messages and content were introduced. The project team in Bangkok Positive began to create their own news in order to start setting an agenda on how sexuality and HIV/AIDS should be framed in the media.

Specific messages can be introduced through fora and demonstrations.

PATH’s usual strategy for introducing content into the public domain has been through hosting media events, as described above. Fora on youth, HIV/AIDS, and stigma and sexuality have been organized to stimulate discussions about sensitive issues.

For example, at a PATH-organized youth forum at Thailand’s national conference on HIV/AIDS, the team asked some of the participating youth groups to bring along some of their sex information sources. Most of the materials were pornography, and these magazines and videos were turned into a powerful demonstration of how Thai youth learn about sex in the absence of adult support and guidance. The journalists covering the conference picked up on the exhibit, and the story made the front pages the next day.

Different media outlets have different audiences. When building media relations, think about whom you eventually want to reach.

The project staff involved in media advocacy had strong connections with specific media outlets such as the Bangkok Post, Matichon, and Krungthep Thurakij, all widely regarded newspapers with excellent reputations. However, these are the newspapers of Thailand’s middle class. Are these the right media outlets to meet the goal of creating a more supportive environment for healthy decision-making and sexual and reproductive health? Bangkok’s working class, as well as many farmers in the countryside, tend to prefer more tabloid-style newspapers with graphic pictures and loud headlines. The tabloid-style papers have much higher circulation numbers than the middle-class newspapers, and based on the sheer size of their distribution, the tabloids can be influential in breaking stories and setting the tone of debate. Furthermore, adolescents and young people are not likely to regularly read newspapers. They tend to prefer magazines, television, and the Internet. The emphasis on building relationships with media outlets that report news also means that messages only reach a limited audience of the broader media industry, resulting in missed opportunities to directly influence the information young people receive.

On the other hand, teachers, doctors, government officials, and policy-makers—critical gatekeepers for youth and sexuality initiatives, all read the Bangkok Post, Matichon, and Krungthep Thurakij. The stories and perspectives carried in these newspapers have great capacity to influence public debate because people with influence read them. With a good deal of self-awareness, staff have also suggested that their successes in building
relationships with middle-class newspapers may be because they are themselves well educated and middle class. Perhaps the way that they framed issues is more relevant to a middle-class audience, or they are more capable of communicating in a manner that the middle class understands. In the absence of solid evaluation data on media capacity to influence attitudes and behaviors, slight improvements seen in how the media cover sexuality and HIV/AIDS suggest that PATH’s efforts to create good media relations are having some effect in shaping how messages are reported.

**Building Commitment Through Referral Networks**

The importance of personal relationships and connections came across in a different way in PATH’s work with drugstores. The team working with provincial drugstores saw that creating links between drugstores and other social and health services would be a key strategy in providing drugstores with the technical support to improve their services. Referral systems can also be crucial in supporting youth clients, since drugstores can send cases beyond their capacity, such as suspected syphilis cases, to counseling or medical centers prepared to accept their referrals. The RxGen Project initially set out to put together a few referral networks to improve the quality of drugstore services. Somewhere along the way, the various organizations within each network developed a sense of commitment to their other network members and to the concept of youth-friendly services. Pulling together a range of different organizations all related to serving young people helped network members better understand the issue of YSRH and how, as a network, they were more than the sum of their individual network members.
Results of the situation analysis showed that drugstores were not linked to other services available to young people, particularly the formal health care system, youth-serving NGOs, and social welfare services. These services often had a greater capacity to handle complicated cases than the drugstores, but they were not as accessible. Project staff worked with coordinators in each target province to identify potential partners and explore needs and interests in building youth-friendly networks. In each province, PATH staff and the local coordinator introduced the concept of youth-friendly drugstore networks to relevant agencies and worked to recruit these organizations into the network. Some of these other service organizations were interested in the prospect of building a referral network for young people’s RH, but others were initially hesitant to work closely with drugstores, seeing them primarily as businesses without a significant role in health or social services.

Not surprisingly, the youth-friendly service networks took some time to develop. The range of YSRH needs that drugstores deal with made it difficult for network members to determine how to focus their efforts and develop appropriate referral protocols. Well into the project’s implementation, PATH suggested that the networks focus on addressing unplanned pregnancies. While drugstores could handle most cases related to emergency and oral contraceptive use as well as STI syndromic management, the services necessary to support cases of unplanned pregnancy were beyond the scope of an isolated drugstore. Network members began to see more clearly how they could link their services to direct these cases to trained physicians, as well as counseling centers and social services.

Referral Protocol for Cases of Unwanted Pregnancy

- **Drugstore**
  - Screen and assess clients’ needs
  - Provide correct information
  - Provide basic counseling services
  - Recommend/refer clients to counseling clinics

- **Counseling Services**
  - Provide full counseling services
  - Suggest options for decision making
  - Refer to/coordinate with other resources to meet clients’ needs
  - Provide information on contraception

- **Social Services**
  - Provide social support, emergency homes, foster care
  - Provide information on contraception and maternal and child health care
  - Provide vocational training for young mothers
Because abortion is illegal in Thailand under most circumstances, many women will go to a drugstore as a first step when their period is late, looking for something to induce menstruation in hopes that this will take care of the problem. Several products are available, including high-dose hormone regimens and some herbal tonics. No abortifacient regimen has been tested for safety or efficacy. The Ministry of Public Health took the drug mifepristone off drugstore shelves when it came to light that the drug was being used to induce abortion. However, less scrupulous drugstores can charge high prices for unregulated products purported to induce menstruation or abortion, despite the potential danger of their use.

Rather than dispensing ineffective or dangerous abortifacients, youth-friendly drugstore networks developed protocols to encourage clients to first get a pregnancy test and then seek counseling and other services in the event of a pregnancy. Promoting the use of pregnancy tests was a strategy to balance drugstores’ business interests, as they could sell the tests in lieu of lost income from not selling abortifacients, and to maintain client satisfaction by providing something tangible to the client. The joint activity of developing the protocol also helped build bridges between network members who might have been hesitant to work with the drugstores. In each province, clients would receive an anonymous referral card at a participating drugstore, and if the client showed the card to a health care provider in a participating organization, that service provider was instructed to streamline check-in procedures and send the client directly to a skilled counselor.

Network members made a point of holding regular meetings together as the project progressed, meeting at least every two or three months. These meetings were an important mechanism for communicating within the network and/or determining whether the referral protocol was working, since they could see whether clients had moved from the drugstores to the counseling center. The meetings also helped build a sense of camaraderie among network members. PATH initially did much of the meeting coordination, although project staff encouraged local coordinators and other members to take on the responsibility of setting agendas and managing logistics. Eventually the networks built up a significant enough commitment to the process that when RxGen was completed, the networks in both provinces continued working together without direct PATH involvement.

Building a network takes vision, coordination, and sometimes diplomacy. Most important, network members need to agree on the reason they are coming together.

Coordinating and managing any network is not without its challenges, and is generally more difficult when it involves sensitive issues such as abortion. One drugstore owner, who was also prominent in the provincial drugstore business network, eventually dropped out of the project because he felt that the subject of unplanned pregnancy was too sensitive and being associated with the project might hurt his business. Another prominent drugstore owner continued to dispense menstruation-inducing drugs, seeing it as a lucrative opportunity. Other members of the network felt that this practice went against the spirit of their work together, and wanted him to leave the group. However, they felt uncomfortable asking him to do so, since he was a well-respected businessman in the province. PATH, in the capacity as coordinator of the network, ended up with the difficult
task of asking him to go. This example highlights the need for a coordinator and catalyzer to build and maintain the network.

Network members saw the benefit of working together, but as these organizations operated in somewhat different sectors with little natural overlap, it took someone with vision to bring them together. PATH wanted to hand over some of its responsibilities to local coordinators sooner, but these coordinators and other members saw PATH as a key link and wanted to its continued involvement. However, network members continued meeting after the project ended, suggesting that the group was in fact building its own capacity for sustainability.

Networking across sectors can help members broaden their perspectives and build commitment.

As the networks continued meeting, they began to see that by working together, they had an enhanced capacity to reach out to young people in a range of settings. They wanted to expand their activities beyond a service focus to include outreach to young people. Essentially, youth-friendly networks had worked together to improve the services that members of the network provided, and they wanted young people to know about and use them. Because it took time to get referral procedures in place, the youth-friendly networks did not begin focusing on outreach activities until the end of the project. However, network members began acting as resource people in schools and workplaces to talk about YSRH needs and to inform their audiences about the improved services. Some network members also helped local public health officials with the Ministry of Public Health’s own youth-friendly policy. As the project was being phased out, the networks continued to discuss outreach opportunities that they could organize jointly. By learning from each other, members of the network became mobilized to address young people’s health needs.
Conclusion

Outcomes, Achievements, and Next Steps

Building capacity and mobilizing support have led to several accomplishments. Some positive changes have been documented, but the scope of YSRH needs in Thailand suggests that there is plenty of work left to do.

PATH’s work with the Rajaphat Institutes had the benefit of a rigorously designed evaluation that included qualitative and quantitative data. Some of the key findings among students included the following:

- Statistically significant increase in condom use among sexually active students.
- Better knowledge of condom use, particularly among young women.
- Less embarrassment about buying condoms.
- Increased communication among partners about HIV/AIDS.
- Increased positive attitudes towards people living with HIV/AIDS.

From pre- and post-tests with teachers at the Rajaphat Institutes, as well as observations and interviews, PATH and the Population Council found:

- Increased knowledge and understanding of HIV/AIDS.
- More positive attitudes towards young people’s sexuality and towards people living with HIV/AIDS.
- Increased interest in and willingness to use participatory and interactive learning methods.
- Stronger facilitation skills.
- Increased communication and better relationships with students.
- Greater commitment to teaching issues of sexuality and HIV/AIDS. ¹⁶

The project with secondary schools in Bangkok had a smaller-scale evaluation, so it was not possible to demonstrate consistent behavior change among the students. Nonetheless, PATH found increased knowledge and better attitudes toward sexual and reproductive health among students, increased help seeking, and better teacher-student relationships. Teachers became more skilled in participatory methodologies and showed a greater commitment to teaching sexuality education.

It is more difficult to measure changes in the media, but a few achievements related to media advocacy work are worth noting. The staff at PATH greatly increased their own capacity to cover the issues they are concerned about, so PATH and other NGO partners are now viewed as organizations to go to for information and press interviews on youth sexual health. They also managed to consistently and professionally produce an informative newsletter that shaped the stories journalists covered. While a few of the efforts generated some controversy, this has contributed to greater public debate about gender norms and expectations of youth in Thai society. These issues are not going to go away any time soon, but growing awareness and public debate can help spur efforts to address the problem.

¹⁶ These findings are reported in more detail in an upcoming report by HORIZONS.
At the service level, the evaluation of RxGen found a number of positive outcomes:

- Client satisfaction scores using a simulated client assessment were consistently higher in project drugstores than in control stores.
- Participating drugstore personnel were more likely to practice history-taking, use interpersonal communication skills, disseminate information and give advice, respect client privacy, display positive attitudes toward clients, and provide appropriate referrals.
- A consistent increase in adolescent clients at participating drugstores over the period of time for which data were collected.
- An increase in referrals to counseling centers using their streamlined referral process.17

These achievements were part of the reason why the networks continue to work together. These experiences and outcomes have contributed to an overall learning process about how to develop effective program approaches for youth. Plans for further development and expansion are underway for each approach. The school-based sexuality curricula and training process are being replicated and expanded in other settings, either through expanded instructor training, extension of training from Rajaphat Institutes to secondary school teachers, or on-going use and adaptation of existing curricula. A longer-term collaboration plan with the Ministry of Education to scale up the training and curriculum is underway.

A more deliberate multi-level policy and media advocacy strategy is also under development so that PATH can further translate experiences into policy change. This strategy involves public education, policy dialogues, and continued media interactions.

The RxGen Project led to an expanded network of providers that is now connected to teachers, leading to a linked approach. Further innovations also resulted. Toward the end of the RxGen Project, PATH developed a website that supported the Ministry of Public Health’s Youth Corner policy at their Health Promotion Centers. This website has since been spun off from the Ministry, and PATH now has a dedicated web team that hosts chat sessions, a Question & Answer board, and other helpful content about youth sexual health on the website www.teenpath.net. The web team is in the process of developing a set of interactive computer games that will be uploaded onto the website and distributed on CD-ROM.

**A Final Thought**

The experiences discussed above are three different stories, and they each had their own pitfalls and successes. What pulls them together as part of a comprehensive approach to YSRH programming?

One of the themes through PATH’s work in Thailand has been a willingness to push boundaries in how youth, sexuality, and sexual health are usually addressed. This willingness is founded on a deep personal commitment by staff to promote healthy sexuality and youth empowerment, and an organizational mandate to innovate. These projects have

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taken some risks, asking people to talk about difficult issues and trying new approaches in their established professions.

The settings in which these approaches were introduced presented considerable constraints to implementing approaches based on ideas like “youth empowerment” or “healthy sexuality.” Working with drugstores continues to be somewhat controversial, given their nature as part of the informal health system, while the education system has an articulated conservative function that works to preserve traditional values. Given the pressures to sell news and the difficulties of reaching busy journalists, it might be tempting to give up on working with the media.

Encouraging change agents in young people’s lives to seriously consider new ideas and new ways of doing things required a respect for the work that these people do, and a willingness to get to know how they go about their work. It might be easy to adopt the attitude that these adults are too old or too set in their ways to understand young people and it would be more rewarding to work with youth themselves, since young people are quick to learn and excited about new ideas. Yet just as adults need to understand and respect youth for their ideas and contributions, youth advocates need to understand and respect those adult change agents who have a great potential to positively influence young people’s lives.

Finally, respect, understanding, and new ideas will not go anywhere without on-going support and follow-up, made easier through the creation of networks. For example, drugstore personnel became more committed to making referrals and providing youth-friendly services, because they could talk about the cases they were seeing with other members of the referral network and jointly develop ways to make the services better. Likewise, teachers gained moral support and shared training techniques through an informal network.

The challenges in expanding the positive results of these efforts to millions of young people remain. Building a core of committed and capable individuals and organizations, and linking them to each other to strengthen their efforts and influence policy and public opinion, are critical to the success of these activities.
TO THOSE WHO ARE ADVOCATES FOR THE SEXUAL HEALTH OF YOUNG PEOPLE

We are here to listen... not to work miracles.

We are here to provide honest information... not to tell them what we want them to think.

We are here to help them identify their alternatives... not to decide what they should do.

We are here to discuss steps with them... not to take steps for them.

We are here to empower them to discover their own abilities... not to rescue them and leave them still vulnerable.

We are here to help them access resources... not to take responsibility for solving all their problems.

We are here to care about their health and well-being... not to judge them for their choices.

WE ARE HERE TO SUPPORT HEALTHY DECISIONS!

Promoting Partnerships with the Private Sector in Cambodia: The Sewing A Healthy Future Initiative

CARE International and PATH in Cambodia
NGO Networks for Health

Introduction

This is a new era for young Cambodians. After almost three decades of civil war—and the systematic destruction of infrastructure and state under the Khmer Rouge regime—the country is finally on the road to recovery. With renewed political stability and increasing economic growth come opportunities to break the bonds of poverty. Young people are taking advantage of these opportunities and making lifestyle changes, including traveling to the cities in search of employment and perhaps a better life.

The explosive growth of the garment factory industry in Cambodia has created a burgeoning job market for these young people, particularly women. Thousands of girls, some as young as 16, seek positions as sewers, cutters, or folders at the many factories located in and around the capital city of Phnom Penh.

City life is full of wonder, with its busy streets, colorful markets, and interesting people. It also offers the new migrant increased freedom to make independent decisions and to engage in activities normally closely moderated in village settings. Such independence brings with it risks and consequences, however, and young people may be poorly prepared to confront the choices open to them in a responsible and safe way.

In a time of profound social change, sexual mores and behaviors have become more confused and increasingly complex. Young Cambodians need support to learn about, explore, and discuss their sexuality. They also require assistance to make informed sexual decisions that protect their health and reduce their vulnerabilities for reproductive health problems, such as sexually transmitted infections (STIs) including HIV/AIDS.

The Cooperative for Assistance and Relief Everywhere (CARE) International and the Program for Appropriate Technology in Health (PATH) are two international nongovernmental organizations (NGOs) that are committed to improving the reproductive health status of Cambodian youth. Both organizations have been active in the country for many years and have extensive experience in youth sexual and reproductive health (YSRH) programming. In 2001, the organizations embarked on a joint endeavor to respond to the urgent sexual and reproductive needs of garment factory workers (GFWs). Emphasis was
placed on the development of a multisectoral network—comprising the public and private sectors—as the best way to improve the quality of YSRH programs and empower factory workers to safeguard their health. The project was aptly titled Sewing a Healthy Future.

This paper outlines some of the experiences and lessons which have emerged from the Sewing a Healthy Future initiative. The first section provides a brief overview of the changing Cambodian context and the factors that place GFWs at risk for sexual and reproductive health problems. The second outlines the Sewing a Healthy Future response, including a description of how partnerships were created and networks mobilized; the capacity-building measures of local nongovernmental organizations’ (LNGOs) staff, health providers, and factory peers; the establishment of referral systems for youth-friendly services; and the advocacy efforts to improve the broader social and policy environment. The final section of the report considers the achievements of the initiative and the replication of the program in other contexts.

YSRH Issues in Cambodia: What Are Young People Facing?

Garment Factory Workers in Cambodia

Peou’s Story

Peou, a 21-year-old Khmer woman from the Cambodian province of Prey Veng, brushes her hair back nervously as she recounts the move from her village to Phnom Penh. “My family was very, very poor,” she explains. “We had little rice to eat and there was no money for my brothers to attend school. I am the eldest daughter so it is my duty to help my family.”

On a sunny May morning, Peou and a neighbor summoned the courage to leave the familiar surroundings of their village to seek work in Phnom Penh. “I was sad to leave my family, but also excited to see the big buildings of the city. Phnom Penh has many modern and unusual things.”

A friend helped Peou secure a job as a sewer in a large garment factory on the outskirts of the city. Peou reports that “the work was hard at first—my back hurt very much—but I got used to it and now I can make many clothes. I also have some close friends whom I live with. They help me when I am feeling lonely or unwell. In our free time, we go to the park and to the restaurants. Sometimes we go to sing karaoke!”

Away from the social confines of the village, Peou is able to do things that would normally be closely monitored at home. Figuring prominently among them is dating. “I have a sweetheart named Somcheat,” she shyly admits. “He is a cutter at the factory. We would like to get married one day.”

While Peou expresses her hopes for the future, she also worries that Somcheat will leave her for another woman if she does not have sex with him. “Maybe he will fall in love with someone else—there are many pretty girls at the factory and he is a handsome man,” she states. “But if a woman has sex with her boyfriend he might abandon her because he knows her body. She will also be a ‘broken’ woman and no one will want her.”

In an environment so different from her village, Peou is confounded by the choices and decisions open to her. She also feels isolated and confused. “I must have honor so I cannot talk to my friends about this problem,” Peou claims. “I don’t know what to do.”
Peou is just one of the estimated 180,000 workers employed in garment factories in Phnom Penh. Enticed by the promise of unrestricted access to foreign markets, investors from Taiwan, Hong Kong, China, and elsewhere have established more than 300 factories in the capital alone.¹ Cambodia’s economic growth has been correspondingly sharp: garment exports rose from US $20 million in 1995 to more than US $1.1 billion in 2001, accounting for 90 percent of the country’s export earnings. The garment sector is recognized as a key component of Cambodia’s greater macroeconomic stability and an important factor contributing to the country’s continued socioeconomic development.

While garment factories have galvanized the expansion of industry, growth remains somewhat uneven and urban-based. A lack of employment opportunities in rural areas—where the majority of the 12 million strong populace² lives—has resulted in a constant stream of job seekers to the capital. Female labor migration has become such a noticeable feature of these movements that some have spoken of the “feminization” of migration.³ Approximately 90 percent of garment factory employees are women, many of them recent immigrants from the Cambodian countryside. Factory work is seen as a way to break the bonds of poverty and, while taxing, the work is believed to be more stable and less strenuous than other common jobs, like rice farming. Factory work offers opportunities for young rural women to develop skills deemed important in other employment pursuits. In the absence of educational opportunities—a staggering 70 percent of rural women have not completed even a primary level of education—employment in the garment factories allows a woman to make valuable contributions to her family’s welfare. “People who know how to work well save money and send it to their parents in the countryside,” explains one GFW. “If you stay in the village, there is nothing that you can do.”⁴

Young and predominantly single female migrants often break free of established Cambodian social structures by moving to the city. Ready access to cash incomes, increased independence, exposure to new behaviors, peer influence, and lack of parental supervision has precipitated the stirrings of a social and sexual revolution among this population. Local research⁵ suggests that GFWs—most of whom are in their late teens and early or mid-twenties—are at an age when sexual desires and discovery are becoming increasingly significant and the wish to belong is important for identity development. Many explore and develop emotional and physical relationships. Some take advantage of their newfound independence by going out at night with friends and taking a sweetheart—something that would be frowned upon and moderated by adults in rural villages. While a few of these sweetheart relationships lead to marriage, cases of broken relationships and abandonment are high. Unwanted pregnancy is also a problem, although the degree to which this occurs is unknown.

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¹ In 1997, the U.S. Congress granted Cambodia ‘Generalized System of Access’ (GSP) status which allows products to be exported without tariffs and quotas as long as they are labeled ‘Made in Cambodia.’

² July 2001 figures estimate Cambodia’s total population at 12,491,051 persons. The majority of the population is below 24 years of age, with 18% between the ages of 15 and 24 years.


In a society where girls typically reside with their families until they marry, female GFWs can be considered “loose” or “bad” women because they live away from home. Men may see them as desirable sexual partners, but judge them unsuitable for marriage. A growing body of research suggests that young women who are removed from a two-parent household, or who do not feel a sense of connection to a parent or adult, are more vulnerable to sexual coercion and exchange. Factory workers report fears of being tricked by men, or of entry into the commercial sex industry because of their damaged reputations. Others articulate a general sense of insecurity or vulnerability in relation to their sexual and physical well-being.

Male factory workers—although they constitute the minority—play an important role in the factory setting. They have sweetheart relationships with other factory employees, some confidently asserting that they have “a new sweetheart every day.” Others engage in commercial sex encounters at nearby brothels or indirect sex establishments. Sex is described as a “life need” for Cambodian men, and it is expected that men will seek a variety of sexual experiences. Discussions with male factory workers, however, suggest that condom use is inconsistent and that a significant proportion of them have suffered from STIs.

Recent studies of sexual risk behaviors and knowledge among both male and female garment workers show limited understanding of, and myths about, reproductive anatomy and sexuality. Incomplete knowledge about STIs, fecundity, and contraception leave factory workers unprepared to safeguard their sexual health. Young women typically lack the negotiation and assertiveness skills to make empowered choices in the area of sexuality. Young men may not consistently use condoms with trusted partners who are deemed “safe” or free from infection. Perhaps most disturbingly, young people are often reluctant, or unable, to discuss their sexual concerns, questions, and relationships with others. Such isolation compounds their vulnerability and leaves them at risk for various reproductive and sexual health problems, including STIs and HIV/AIDS.

Cambodia currently has one of the highest HIV prevalence rates in Southeast Asia. Although the country has responded forcefully to curtail the epidemic, approximately 2.6 percent of the population is infected with the virus. Young people ages 15-29 years have the highest rates of infection; women, in particular, are the largest vulnerable group. The loss of persons in their most economically productive years is expected to have drastic effects on Cambodia’s economy in the new millennium. Accordingly, the Cambodian government stresses the need for education, provision of skills, and access to condoms and STI treatment for young people as priority actions to stem and control the epidemic in the coming years.

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A number of barriers, however, make it difficult for young people to access services and make safer sexual and reproductive health decisions. Young men and women are not encouraged to discuss or inquire about sexual matters, nor are they informed about how their bodies function. They may not know what services are available or where to seek support, information, or care. This is especially true of migrants who are often unfamiliar with health services, information, and systems in the new area. Insufficient resources further hamper a young person’s ability to avail him- or herself of services and to purchase commodities such as contraceptives. Cost includes not only the price of the health service, but the time required to travel to health facilities and to receive treatment. Factories may be located in areas some distance from health services. Factory employees also may have little free time in which to seek treatment for reproductive or sexual health problems.

Cambodia’s fragmented and poorly equipped health system further compounds young people’s access to services. While health-sector reform is currently underway, the rehabilitation of the system is limited by a low national health budget. As a result, the health needs of the populace have largely been met by the private health sector, comprising clinics, pharmacies, and traditional healers. These private health facilities are typically the first—and often the only—point of access for health services because they offer what the GFW values: privacy and anonymity. The higher costs associated with some private treatment services also connote higher quality and greater professionalism of staff. Unfortunately, assessments of pharmacists and drug sellers indicate limited knowledge and capacity to provide effective primary preventive and curative services to young people. The availability of drugs and contraceptives belie weak systems of delivery and inconsistent or inappropriate sales of contraceptives. While many young people rely on pharmacists and drug sellers for advice, those providing contraceptives and STI treatment are themselves inadequately informed.

Perhaps even more important, the existence of friendly, non-judgmental and supportive environments is sadly lacking in both private and public health facilities. Young people, particularly unmarried women, report that health providers often “talk down to them” when they seek reproductive and sexual health services. Busy hospital and clinic waiting rooms offer little privacy for those who want discrete consultation and treatment. Confidential services are often non-existent, as is STI and HIV/AIDS counseling. Specialized, “youth-friendly” approaches are needed to attract, and more importantly keep, young people as RH clients. The question is, “how can this best be done?”

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Factors Affecting the Health Seeking Behaviors of Factory Workers

- Knowledge of reproductive health issues.
- Familiarity with services.
- Cost of services.
- Accessibility in terms of transport costs and opening hours.
- Perceived efficacy of treatment.
- Privacy and confidentiality.
- Professionalism (e.g., non-judgmental and friendly attitudes) of health providers.

—List compiled by Sewing a Healthy Future Peer Health Volunteers, October 2002
YSRH Issues in Cambodia: How are People and Communities Responding?

The Sewing a Healthy Future Initiative

Background

PATH and the Private Sector
From 1995 onwards, PATH has been working in partnership with private and public health providers to improve the health of Cambodian women, children, and their families. Its activities focus on four main areas:

- The prevention and control of communicable diseases, such as STIs and HIV/AIDS.
- Integrated management of childhood illnesses.
- Adolescent reproductive and sexual health needs.
- Behavior change communication.

PATH emphasizes improving the capacities of private sector health providers, so these persons can provide higher quality health services and facilitate greater access of services for women, adolescents, and children. Work with the proprietors of pharmacies and community drugstores is especially important: a National Health Demand Survey conducted in 2000 showed that 68 percent of Cambodians sought treatment at pharmacies and drugstores for general illnesses, and were inclined to visit these places for sensitive health issues like STIs and contraception. PATH has collaborated with UNICEF, the Pharmacy Association of Cambodia (PAC), and the Phnom Penh Municipal Health Department (MHD) to help pharmacists and people who work in pharmacies to improve their skills to deliver RH information and services related to unprotected intercourse, STIs, and contraceptive methods, with an emphasis on youth-friendly services. In 1999, a joint initiative by PATH and UNICEF established a technical capacity-building program for approximately 300 Phnom Penh-based pharmacists and also facilitated referral linkages between these pharmacies and the public health system. More recently, PATH, PAC, and the MHD trained over 164 pharmacists and 327 drug sellers as part of the three year Reproductive Health Access Project funded by the Hewlett Foundation.\(^\text{13}\) Current evaluation data show

\(^{13}\) This initiative began in 2000 and is scheduled to end in 2003.
a greater willingness of pharmacy frontline staff to serve youth in a sensitive manner, as well as the enhanced abilities of these persons to correctly promote contraception to their clients.

**European Commission (EC)/UNFPA Asian Initiative for Reproductive Health**

CARE International in Cambodia first began working with GFWs in 1998, as a member of the EC/UNFPA’s global initiative to respond to the urgent RH needs of young people. Over a three-year period, CARE partnered with three LNGOs\(^\text{14}\) to deliver comprehensive sexual and reproductive health services to more than 8000 employees of five factories. The pilot project’s goals were threefold:

- To increase knowledge and awareness of RH among approximately 10,000 non-school youth and to train 50 health providers in RH.
- To increase the availability and use of clinical reproductive services.
- To build national capacity in at least two LNGOs.

Recognizing that real improvements in YSRH needed to address not only the quality of RH care but also the barriers that prevent young people from making safer sexual decisions, emphasis was placed on participatory approaches in capacity-building and experiential learning to empower individuals and facilitate change. Capacity-building here was defined broadly as the enhanced understanding of YSRH and/or delivery of quality services by LNGO staff, CARE employees, factory health providers, factory workers, and factory management through intensive training and education sessions, workshops, technical assistance, and advocacy efforts.\(^\text{15}\) The use of participatory tools, such as Participatory Learning and Action (PLA), was a critical component of all capacity-building measures. By establishing trusting relationships, creating a supportive environment, and encouraging members to be active participants in the learning process, CARE and its partners strove to build the confidence and skills of project members. In so doing, these persons could better challenge the social and attitudinal norms that create inequalities in access to YSRH services and knowledge.

Over the life of the project, a number of significant outputs were realized. CARE and LNGO project staff became increasingly comfortable with using PLA tools and more skilled at carrying out project activities. Health clinics in the five participating factories were renovated and equipped with proper medicines and equipment. Factory health staff received training in STI syndromic management, contraception, and counseling and communication skills. Managers attended a one-day workshop—at their request—to learn more about the project and to better understand the education activities. And a participatory health promotion curriculum on reproductive and sexual health was developed and piloted for use with GFWs.

Although the project demonstrated that the RH needs of factory workers were immense, lessons learned from the pilot initiative indicated that existing activities were limited in scope and impact. Scaling up and improving project interventions, however, required

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\(^\text{14}\) CARE’s LNGO partners in the EC/UNFPA Asian Initiative for Reproductive Health were Cambodian Health Education Development (CHED); the Reproductive Health Association of Cambodia (RHAC); and the Women’s Development Association (WDA).

substantive changes in the way services were articulated and delivered. No longer would a loose partnership of four NGOs and five factories suffice; the expansion of the initiative demanded an expansion of the network. Creating formal, enduring, and innovative partnerships with other NGOs and sectors—including the government, factory management, the private health establishment, and the garment workers themselves—was heralded as the best way to enhance the quality of YSRH services and to contribute substantially to improvements in GFWs’ health.

**Project Overview**

In 2001, CARE International and PATH consolidated their respective strengths and developed the *Sewing a Healthy Future* initiative. Under the auspices of NGO Networks for Health, Family Planning+ Initiative, the *Sewing a Healthy Future* project seeks to improve the quality of YSRH programs and empower factory workers to safeguard their health by conducting health promotion within factories and forging linkages to services beyond. Emphasis has been placed on the development of a multisectoral network of public and private stakeholders to promote reproductive and sexual health among factory workers and other community members in three factory “zones.” Project interventions comprise the following main areas:

- **Training and capacity-building of formal and informal sector health providers, particularly pharmacists, drug sellers, health center staff, and factory clinic employees.** The program aims to build the capacity of health professionals to provide quality services to young people, and to strengthen referral networks among service providers and between providers and youth.
- **Delivering intensive health education and life-skills training to GFWs in their places of employment.** The creation of informal peer networks to support factory-based activities (e.g., library, health promotion events) and to facilitate a peer-based health referral system is another important project component.
- **Promoting advocacy and network-building activities among NGOs, the private sector, and government agencies to influence the institutional and policy environment and modify social norms that put young people at risk for RH problems.**

CARE and PATH provide managerial, technical, and financial oversight to NGO and private sector counterparts who then implement separate, but complementary, project activities. CARE and its three NGO partners—Cambodian Health Education Development (CHED); Cooperation for a Sustainable Cambodian Society (CSCS); and the Women’s Development Association (WDA)—are responsible for the factory-based activities, including the development of partnerships with factory management, business associations, and relevant Ministries, and the delivery of a health promotion program for factory workers. PATH and the MHD focus on establishing youth-friendly health provider networks in areas...
surrounding the target factories, and providing capacity-building measures and ongoing technical support to participating health professionals, including health staff employed by the factories. Linkages between the CARE/PATH project components are reinforced via referral systems that establish connections among service providers and between these providers and youth. Networking and advocacy efforts further serve to integrate the project components by focusing on changes in the broader social and institutional environments. Through a synergistic approach, the partners aim to create a comprehensive program that makes a real and substantive impact on YSRH.

The following sections chronicle the experiences of the program, from building partnerships, to developing innovative interventions, and distilling lessons learned. Despite linguistic, cultural, and programmatic differences, it is anticipated that many of the themes articulated here can inform the development of other initiatives in Southeast Asia and beyond.

Networking for Improved Adolescent Sexual and Reproductive Health

Building Partnerships and Mobilizing Networks

Best practices in Cambodia and around the world recognize that adolescent sexual and reproductive health can be safeguarded by fostering strong political and local commitment; working in partnership with communities, government, civil society, and vulnerable groups; adopting innovative and multisectoral approaches; and making the most effective use of available resources. Partnerships, in particular, are central to a project’s success, since no single organization can, in the words of one Cambodian health provider, “attain real results on its own. We need to work together to achieve greater impact.”

Partnerships bring about change in a number of ways. By working collectively to realize a common aim, partners can scale up effective program strategies to reach greater numbers of people. Linkages between different organizations, groups, and institutions can facilitate access to hard-to-reach people and places, and address sensitive issues. Financial stability and the sustainability of interventions are made possible when partners draw upon diverse resources and encourage “buy-in” from various stakeholders. Partnerships can also bring about policy improvements or create more supportive environments for youth through enhanced advocacy efforts. Mobilizing “networks”—or informal connections between organizations or individuals—plays a critical role in facilitating change in the broader environment. Such collective efforts may ultimately protect young people from sexual and reproductive health risks and support the development of

Elements of Successful Partnerships

• Have a good relationship.
• Share information, experience, and resources.
• Set up work plans together.
• Involve each other in activities.
• Respect each other.
• Be committed.
• Understand the project objectives and constraints.

—List compiled by Sewing a Health Future Project Staff, October 2002

Elements of Unsuccessful Partnerships

• Lack a strong relationship.
• Have competition between partners.
• Do not share information.
• Cooperate poorly.
• Lack involvement.
• Have language difficulties.
• Have time constraints.
• Have different capacity levels.

—List compiled by Sewing a Health Future Project Staff, October 2002

healthy lifestyles.17 Building successful partnerships, however, does not occur without significant effort. In building our understanding of effective partnerships, we must ask a few critical questions:

• How are partners identified and effective partnerships established?
• How do organizations, institutions, and groups work together in a way that has real impact?
• To what extent do organizational networks meet the needs of young people and how can they be strengthened?

Establishing Partnerships with Factory Management

When Sewing a Healthy Future first began, very few NGOs had worked with garment factories, and those that had were primarily concerned with documenting human rights abuses and improving factory workplace and labor conditions. Not surprisingly, factory management was reluctant—and in some cases downright hostile—to overtures of collaboration for improved YSRH of their employees. Some NGOs responded to these difficulties by meeting with factory workers and conducting health education sessions after working hours and outside factory grounds. However, CARE and its NGO partners believed that securing formal support for the initiative was the only way to legitimize, scale up, and enhance the quality of project activities. Factory management approval was also paramount for NGOs who sought to access the factory worker population in a systematic and substantive manner.

Accordingly, CARE and its partners spent the initial months of the project developing and implementing a garment factory advocacy plan. Certain elements have since emerged as key factors for soliciting factory management support for YSRH initiatives. The following are some of the recurrent themes and avoidable mistakes.

A seemingly obvious but crucial factor in the development of sound partnerships is the development of mutual understanding and respect. For CARE and its partners, this involved gaining an understanding of the garment factory industry, and learning what motivated factory management to undertake social action.

As a first step to establishing ties with garment factory businesses, CARE and its partners developed a comprehensive understanding of the garment factory industry, including knowledge of the business environment and culture. It soon became clear that while the protection of profits was an overriding concern of all factories, so too was the preservation of their reputations, particularly in light of recent media reports highlighting charges of human rights and labor law violations. Portraying a positive corporate image has also been encouraged by overseas garment buyers who are increasingly seeking out factories that demonstrate corporate social responsibility. As one factory manager explained:

“At the moment the buyers are concerned with reproductive health. We need to keep our workers in good health to gain their support.”

CARE learned that while a few factory owners or managers are motivated to engage in social action from a purely philanthropic standpoint, others are more likely to become involved in issues that are close to their business interests or from which they can directly benefit. Still others lack information and may need encouragement to better understand the threat that issues like HIV/AIDS pose to their businesses.

Differences in language and culture—particularly as the majority of factory managers or owners hail from Taiwan, Hong Kong, and China—proved a significant factor impeding even the most cursory overtures into factories. The project team contracted a Chinese interpreter to translate all relevant documents and to facilitate interactions with Chinese-speaking factory management. Though not all of these factories agreed to participate in the project, Chinese factory managers were more likely to read materials or listen to advocacy presentations when these were presented in their native language.

**Breaking down barriers between the public and private sectors is possible when both partners understand the reasons for initiating and maintaining collaborative action. “Selling” the project to the private sector, however, requires that NGO staff learns to present health concerns in business terms.**

CARE and its partners put together a Sewing a Healthy Future promotional package in an attempt to elicit support and participation of up to 15 factories in four geographical districts. The promotional package was designed to be a “baited hook” which encouraged factory management to not only become interested in YSRH, but to actually take action in their factories. The package included colorful brochures about CARE, outlining the organization’s experience and highlighting its status as a worldwide leader in health and development programs. A one-page handout stressed the apolitical nature of the organization and its unique understanding of the garment industry, including CARE’s public endorsement of garment factories as important employment venues for young Cambodian women.18

A professionally-made video—in English and Chinese —explained the issues faced by GFWs and the steps CARE and its NGO partners were taking to improve their health. A crucial component of the video was a series of public endorsements of Sewing a Healthy Future by the chairman of the Garment Manufacturers’ Association of Cambodia, the Minister of Women’s and Veteran’s Affairs, a key official of the Ministry of Commerce (see box), and factory managers associated with the EC/UNFPA health project. Written letters of support from these institutions accompanied the video and served as key advocacy materials for factory managers, some of whom later admitted that they became interested in the project only after discovering that these respected organizations backed it.

**Promoting the added value of collaborative efforts and developing a common agenda can ensure an equitable public-private relationship.**

The comparative advantages associated with partnering for enhanced YSRH also were included in the Sewing a Healthy Future promotional package. CARE put forth a number

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18 Asia Week magazine, December 2000.
of benefits it believed the project could offer potential factory partners. They include:

- An enhanced reputation as a result of association with the initiative.
- Health training and supervision of factory clinic staff.
- Improved health services for factory workers in and around the factory.
- Improved knowledge and better health practices of the factory workforce.
- A healthier, stronger workforce with less absenteeism.

To ensure that partnerships were equitable, CARE and its partners established some non-negotiable demands. The team drew up a list of ten criteria that they deemed essential for ensuring “perfect” access to GFWs. Paramount among them was the full support of factory management for project activities, and the unhindered access of the project team to the factory. Also crucial was the willingness of factory management to allow 60 peer health volunteers and two factory clinic medical staff time off—with pay—to attend capacity-building sessions. Factory management was also asked to identify a contact person to coordinate project activities in the factory and to serve as a conduit between management and NGO implementers.

Factories that fulfilled all ten criteria got help developing an implementation plan that outlined the scope, location, and timing of project activities. CARE and each participating factory then signed a formal agreement to guarantee full understanding of, and commitment to, the initiative. In the end, 15 factories from a total of 44 agreed to participate in the project. Each factory was assigned to work with one of the three LNGO partners (five factories per LNGO) and project activities finally began in earnest.

Don’t give up! Be persistent when making contacts with factory management.

Establishing collaborative relationships with factory management was slow, deliberate, and often demoralizing work. Managers frequently hung up on project employees when they tried to make telephone contact. Others were overwhelmed with garment work orders and refused to meet with the team. CARE and its partner staff developed “thick skin” during this process, and banded together for moral support. They also learned to present the project simply, clearly, and most important, quickly, in terms factory managers understood. Recognizing that establishing partnerships is a time-consuming process was particularly crucial; in some cases, negotiations could take several weeks before managers agreed (or refused) to participate. The persistence paid off though, and many of these partnerships are now flourishing. As word of the project spreads and benefits are being increasingly realized, CARE reports that factories that initially rejected the project are now calling up to be part of the initiative.

Building a Network of Health Providers

Almost 200 formal and informal health facilities can be found in a one-kilometer radius surrounding the 15 target factories. They include pharmacies, drugstores or depon, cabi-
New Generation Models for Asia’s Youth: Strengthening Networks and Building Capacity

nets,19 public health centers, private clinics, and factory health clinics mandated by the Cambodian Government. At the onset of the project, PATH and its partners carried out a mapping exercise to learn more about these establishments and the RH services and products they offer. Not surprisingly, they discovered that the quality of these services varies widely, ranging from competent to dangerous. While providers spoke of serving young people, they had little understanding of “youth-friendly” concepts and practices. A few of these practitioners maintained that they required further training and support to better serve their clientele, especially youth. “Young people nowadays are so brave,” said one pharmacist. “They knew about emergency contraception long before we did. I’m still learning and I’m feeling a little foolish.”

First Steps

Developing close relationships with relevant government departments and influential business associations is a crucial first step for legitimizing the program and establishing a health provider network.

Identifying appropriate health providers to include in the network was no easy task. While some practitioners stated outright that they were willing to participate in the project, PATH knew from experience that it needed the support of government and private agencies to legitimize the initiative and encourage widespread participation. Key stakeholders in the undertaking were the Ministry of Health (MOH), the MHD, and the PAC. Over the years, PATH has developed close working relationships with these bodies and these strong links proved vital for identifying health establishments and providing firm endorsements for participation in the activities.

Prior to completing the mapping exercise, PATH approached PAC and the MOH for a copy of their registration records. These listings allowed the team to determine which facilities were registered (and hence, legal) and which pharmacies and depos were members of the existing PAC network.

With employees of the MHD—ten of whom were assigned to work on Sewing a Healthy Future as members of the project support and technical teams20 —visits were made to eligible health facilities. Providers were told about the project, provided with letters of endorsement from the MHD and PAC, and invited to an orientation workshop where the project objectives and activities were to be explained in more detail.

19 A “cabinet” is a doctor’s office which operates on irregular hours, usually in the evenings when other medical support is unavailable.

20 The project support team consists of eight persons divided into four teams (two persons for each team) and designated to one of four geographical districts. Two MHD employees make up the project technical team charged with providing training and technical assistance to the factory clinic staff. The MHD Deputy Director acts as the coordinator and works closely with PATH counterparts to coordinate the project.
Bringing the health providers together saves time and also facilitates the development of personal relationships and referral linkages.

Nearly all the health providers initially contacted by the project teams attended a half-day meeting to learn more about the project and to get to know one another. At this meeting, the PATH and MHD Deputy Director told participants about the initiative and highlighted the benefits of participation for health providers and their community at large (see box). Over coffee and refreshments, the facilitators spelled out the kinds of capacity-building measures and support PATH and the MHD could provide them and the roles and responsibilities of health provider “partners.” Those who became involved in the initiative would be identified as promoters of youth-friendly services and appropriate sources of YSRH-related information and products. More specifically, partners would be responsible for providing advice and services to young people on three critical health needs arising from unprotected sex—STIs, pregnancy prevention, and the need for ongoing contraceptive care and counseling. They would also be charged with referring cases they could not handle within an appropriate “peer” network and keeping records of referrals, both coming and going, in their establishments.

Following animated discussions, interested attendees were asked to sign a Memorandum of Understanding (MOU) signifying their formal participation in the project. Out of the 63 health service outlets represented, a total of 58 MOUs were signed. The beginnings of friendships were also established at the meeting, with much handshaking and name card exchanges taking place throughout the day’s event.

Developing Capacities for Improved YSRH

Identifying partners and establishing partnerships was a critical component of the Sewing a Healthy Future initiative. Yet, it was just the beginning of the development and implementation of responses to improve the lives of GFWs. The following section describes the kinds of education and training that are crucial for building the capacities of LNGOs, health providers, and factory peer volunteers to promote and enhance YSRH. It also presents some of the lessons learned along the way.

Supporting LNGOs to “Talk About Sex”

Good capacity building in YSRH should provide opportunities for participants to improve their skills and knowledge and to examine their personal attitudes, assumptions, and biases. This requires a long-term and intensive commitment.

Capacity building of CARE’s NGO partners has been an ongoing process since the beginning of the EC/UNFPA pilot project in 1998. Realizing that the success of the project relied heavily on the skills of the implementing staff, a significant proportion of the pilot project was devoted to capacity development. Training was broad-based and iterative. It included measures to strengthen partners’ project management skills, to improve their
understanding of PLA and to enhance their RH knowledge. Much emphasis was placed on challenging participants to recognize and examine their beliefs, attitudes, assumptions, and prejudices. Staff members took part in thought-provoking exercises about sexuality and gender roles in an attempt to deconstruct cultural stereotypes and challenge social and attitudinal norms. They also learned sensitive facilitation techniques and became increasingly self-aware about the effects of their verbal and non-verbal language. As partner staff grew more confident, they realized the positive role they could play in promoting YSRH.

Getting to this realization was a complex process, however, and required long-term, ongoing support and commitment—a fact not initially budgeted or planned for by the project implementers.

In Sewing a Healthy Future, the capacity-building measures introduced and implemented in the pilot phase have continued, although now the more experienced LNGO partner staff can support and coach less confident colleagues. Partners have received comprehensive refresher training in project planning and monitoring, PLA techniques, and RH concepts. All instruction includes practice to reinforce and enhance the learning process. Particularly important are opportunities to practice facilitating the 18-hour behavior change curriculum developed by CARE for factory workers. In this realm, participants spent 11 days at the beginning of the project followed, four months later, by another ten-day workshop to review, adapt, and update their health promotion strategies. Other capacity-building measures are planned in the coming months, as the project matures and enters its final days.

The transfer of capacities is best realized in collaborative partnerships that involve a good deal of independence and a great amount of support.

Of the three original partners in the EC/UNFPA project, CHED and WDA have remained to implement Sewing a Healthy Future, while the staff at the Reproductive Health Association of Cambodia (RHAC) realized that they now have enough skills to launch factory-based RH programs on their own. A new partner has thus been added to the mix: CSCS. The partners work in a spirit of collaboration, rather than in a hierarchical fashion. At the onset of project activities, individual organizations identified four of their staff members to work on the initiative on either a full- or part-time basis. Together, they make up a larger project team consisting of 12 LNGO staff and six CARE employees. Each LNGO is responsible for implementing all project activities in five target factories. This includes the delivery of the behavior change/life-skills education curriculum, supervising and supporting youth peer volunteers, planning small and large promotional events, organizing youth corners (libraries), and overseeing management issues in their project components.
LNGOs are equal partners and play a significant role in determining the direction of the project. Every month the partners and CARE support staff meet to review technical and program management issues. In this venue, adjustments and adaptations to the program can be made, based on the inputs received by individual members and the team.

Emphasis is placed on providing intensive support to the LNGOs, and gradually reducing the amount of assistance as the staff’s capacity and confidence increase. CARE’s role is to act as an older, more experienced “sibling” who provides encouragement, supportive supervision, and aid. By doing so, capacities can be more easily transferred from management to the partners themselves. The following comments from LNGO staff illustrate their satisfaction:

“My organization has gained a lot of skills and experience in management, monitoring and evaluation, report writing, work plans, and collaboration.”

“I have learned a lot about participatory approaches for understanding young people’s problems and participating with workers to help them express themselves.”

Perhaps, however, the strongest endorsement of capacity transfer is the fact that LNGOs “are doing it by themselves.” Recently, RHAC began implementing a factory-based program targeting seven factories in Phnom Penh and Kampong Som province. And WDA—using the model developed in Sewing a Healthy Future—will reach another three factories beginning in December 2002.

Creating Youth-friendly Services: Capacity-building of Health Providers

Over the past one and a half years of project implementation, some 300 personnel from formal and informal health establishments have been trained on YSRH issues. Participants described these sessions as not only informative, but in many cases profoundly life-changing:

“This is the best training I have ever come to . . . I will send both of my children to attend. This is all about young people—it’s a real eye opener!”

“I look at young people in a different way. I have learned so much and I understand more.”

Recognizing that private and public health providers—especially pharmacists—can be an invaluable reproductive resource for young people, PATH set out to create a comprehensive training curriculum which could best develop health providers’ capabilities and respond to existing gaps in knowledge and behavior. Incorporating lessons learned from other projects, the curriculum focuses on three main areas:

Youth-friendly Services Mean:

- Providing quality services
- Having a friendly attitude
- Making youth trust us
- Promoting privacy and keeping secrets
- Being sincere
- Providing good explanations

—List compiled by Sewing a Healthy Future Health Providers, October 2002

- Understanding the meaning of adolescence and the importance of promoting YSRH.
- Developing technical knowledge of oral contraceptive pills, STI prevention and care, and ongoing contraception management.
- Creating “youth-friendly” services by enhancing communication skills and supportive behaviors.

The use of participatory teaching methods provides opportunities for participants to think about YSRH issues in a more comprehensive way, and to take an active role in the learning process. Some may be a little shy, but most appreciate the chance to explore the topics in a safe and stimulating environment.

Over a period of approximately five days (or 20-22 hours), health provider participants attended the YSRH training courses, generally in cohorts of about 18 to 25 people. Participatory exercises, such as role-plays, group discussions, games, and small group work, constituted the main teaching methods and offered participants plenty of opportunities to critically think about issues and to take a more active role in the learning process. The health providers—most previously unfamiliar with such teaching methods—responded favorably to the approaches, remarking that they were fun and allowed them the chance to sit and “talk together.”

While much emphasis was placed on imparting technical knowledge about STIs, contraception and emergency contraception (EC)—the latter being a new concept in Cambodia and sparking great interest among the participants—attempts were also made to improve providers’ provision of “youth-friendly” services. Participants were asked to think about what youth-friendly services meant to them (see box) and to try to empathize with young people by identifying their own risk factors for STIs and HIV. The groups discussed the broader socioeconomic and cultural issues that affect the vulnerability of youth, such as poverty, migration, gender equity, and limited services. Animated discussions ensued about the role of health providers in making services better so that young people “want to come talk to us when they have a problem.”

Exercises—particularly role-plays—underscored the importance of proper consultation and advice, especially the “4Cs” approach of counseling and education, compliance to treatment, condom use, and contacting partners for treatment. Participants were asked to pretend that they were a young woman or man with a problem; for instance, they had sex and the condom broke, or they were raped and suspected they were pregnant. By taking turns being the client and the provider, participants were better able to practice applying some very important concepts, and to put themselves in the young person’s “shoes.” This process was illuminating for some. “A higher dose of oral contraceptives,” exclaimed one man, “That’s the only thing it takes to make the difference in some young girl’s life.”

While all participants challenged their notions about youth and sexuality in the training sessions, many were unable to fully endorse the issues. “Young people have reproductive rights, yes,” replied one, “but they also have responsibilities to their families to take care of themselves and not get into trouble.” Older participants had an especially hard time reconciling Cambodian traditions and mores with a rapidly changing societal context. In

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23 Factory clinic personnel were trained separately but used the same curriculum.
these cases, it was better to emphasize the practical benefits of youth-friendly services, namely more clients, more business, and ultimately, better profits. Money was a matter that everyone understood.

Providing resource materials and regular technical follow-up allows for ongoing capacity building to occur and makes partners feel valued.

At the end of the training sessions, participants were provided with resource materials for further consultation and study. They included an oral contraceptive information package, a mini-booklet on important RH technical concepts, and a longer guide detailing the information covered in the workshop. Moderators asked the participants to place these materials in their workplace so that the information would be easily available if needed. Subsequent discussions with health providers and visits to the project sites suggested that these materials are indeed important references and are put in convenient drawers and prominent places in their pharmacies and clinics.

While the resource materials do respond to the needs of many health providers, others are lax to read through mounds of documents to answer their queries, or may not feel comfortable enough with the subject matter to articulate their questions. Talking with experts on a regular basis allows these persons to feel supported while they continue to learn and develop their skills.

Accordingly, two MHD staff per district (four districts in total) travel to every health establishment on a monthly basis. They answer outstanding questions of the health providers, provide them with additional information, education, and communication materials for their clients, monitor the number of referrals made or received, and determine any unresolved training needs. Participants often look forward to these visits, and have lists of questions ready for discussion. Others have established close relationships with the MHD teams and can contact them any time. More important, the visits reinforce the fact that health providers are active partners in the initiative and that their needs are important.

Building the Skills of Factory Peer Health Volunteers

One of the most significant outputs of the EC/UNFPA-funded YSRH program was the development of an 18-hour life-skills and RH education curriculum for factory workers. The curriculum was positively received and generated enormous excitement when it was first unveiled in 1999. One factory worker told the project team that:

“Now my mum and sisters ask me about reproductive health. I have to tell my mother—she thinks it is very good. Before you found out on your wedding night.”

The contents of the curriculum focus on issues of concern identified by factory workers themselves. Topics include the following:

- An overview of RH issues, such as reproductive anatomy, menstruation, pregnancy, and contraception.
- STI/HIV/AIDS education, prevention, and care.

24 A project technical team of two persons makes monthly visits to the all factory clinics.
• Gender roles and stereotypes.
• Development of sexual negotiation skills.
• Safe health services identification.

Like the other kinds of capacity-building measures mentioned here, participatory tools form the basis by which the topics are delivered. Factory workers are encouraged to talk together, discuss and even debate YSRH issues in a non-judgmental, supportive environment. Through body mapping, role-plays, and other interactive games and exercises, they gain improved knowledge and skills, and leave the sessions in a better position to protect their health and well-being. Evaluations of the curriculum’s impact during the EC/UNFPA pilot found changes in knowledge and attitudes, including increased spontaneous knowledge of STIs and HIV, among a random sample of 1072 workers. However, the reviews suggested that the effects of the education were not being realized beyond a relatively small group of participating workers. Implementers therefore looked for ways to spread the word to greater numbers of employees in the target factories.

When Sewing a Healthy Future began, it was decided that the curriculum would be modified to include a communication component, so that participants would be more adept at discussing RH with their colleagues. CARE and its partners also realized that the careful identification of the trainees—or “peer health volunteers” (PHVs) as they came to be called—and the provision of intensive peer support activities would facilitate the development of a peer-driven service referral system for YSRH.

Peer volunteers need to be carefully selected and trained, but this is not always possible in difficult settings. Extensive supervision and backup is therefore vitally important and must be an integral part of a peer volunteer program.

Because the role of the PHV was so important, CARE and its partners identified characteristics of prospective candidates. Being open-minded and non-judgmental were critical, as was the ability to listen and respect others. It was important that PHVs be confident and friendly, and above all, not feel embarrassed to talk about sex. They should also be well liked by their colleagues and eager to participate in the project.

While CARE tried to formalize the selection process so that the best people became PHVs, this was not always possible. Factory management played a significant role in choosing the PHVs. Often this was done on the basis of who was least busy or least essential to the business operations. Conversely, the manager’s “favorite” might also be chosen, and the PHV position offered as a reward for good service. While competition to become PHVs was strong in some factories, much of it stemmed from the small per diem attached to the role (US $2 per month, plus snacks at meetings). Another more likely reason concerned
the status associated with a PHV. Increased knowledge meant increased power, which could be demonstrated by giving advice to one’s peers, or used to find other kinds of gainful employment, such as NGO work.

Sixty PHVs were eventually identified per factory per intake (two intakes per year). Following training, they are charged with cascading RH information to at least ten peers, serving as a PHV for a three month period, helping the project teams with YSRH promotional events in the factory, and supervising the comic book library in the youth corner. They are also responsible for recording all peer interactions in a peer contact book and, in some factories, for dispensing referral coupons to youth-friendly health facilities. All PHVs are easily identifiable—wearing T-shirts and carrying resource materials (e.g., peer handbooks) that show them to be a source of YSRH information and support.

Two times every month, PHVs and LNGO staff meet during the factory lunch break to go over the peer contact books and discuss questions or issues arising from PHVs’ interactions with colleagues. The meetings generate animated discussions as the attendees jointly respond to questions that arise and give inputs, as in “when the same thing happened to me, I did this or said that.” The meetings provide useful opportunities for the LNGO partners to support and monitor the PHVs and to increase their potential for further learning. They also give the PHVs the chance to develop and deepen interpersonal ties.

In these regular feedback sessions, PHVs report that they commonly talk to their friends about RH issues, especially menstruation problems and pregnancy issues, which are considered extremely important in the factory workers’ lives. Although discussions of STIs and HIV/AIDS are more rare, male workers sometimes approach them for advice on how to put on a condom, as they are now seen as the resident experts. Peer health volunteers maintain that they feel confident in providing information to their fellow workers because of the high quality of the training and ongoing support provided by the LNGO partner staff. Responses from a minority of PHVs, however, suggest that they are too eager to dispense medical advice in the place of health providers, especially if such services are considered an unnecessary or wasteful allocation of resources. Their assertions underscore the necessity of continued close supervision of PHVs to ensure that they do not abuse their power and/or spread misinformation to their peers. It further reinforces the need for the project implementers to set limits about the kinds of situations PHVs can handle and those they must refer to either the LNGOs or to health providers. The development of referral systems, in particular, constitutes an essential part of improved YSRH services for factory workers. Those developed in Sewing a Healthy Future are described in more detail in the following section.

26 See next section for more information on the referral system.


Developing Innovative Approaches

Creating Demand for Services through Peer and Health Provider Referral Networks

An effective YSRH education program generates demand for other services. Project implementers deemed the creation of youth-friendly health referral systems necessary in the EC/UNFPA pilot project when it became clear that workers were reluctant to seek RH medical services because of poor treatment. Others were availing the services of health providers, but tended to look for help outside the factory walls. Still others maintained that they were uncertain where to find these services, particularly those in which the health providers were friendly and provided quality assistance.

The development and operation of referral systems lies at the heart of the Sewing a Healthy Future program. Two referral networks have been developed over the course of the initiative to respond to two different scenarios.

• In the first scenario, a factory worker approaches a health provider—whether a factory clinic doctor or a pharmacist—for assistance with a RH problem. She asks for a service the health provider cannot provide. Instead of refusing to help the young person, or worse, providing inappropriate or ineffective service, the health provider completes a referral form and directs the youth to another more specialized health facility.

• In the second scenario, a factory worker talks to a PHV about a concern. Knowing that her friend needs professional assistance but is unwilling to go to the factory clinic, the PHV provides her with a referral slip and tells her to go to one of the health establishments in the PATH/MHD-supported network. The PHV either identifies a particular place by name or refers to the network more broadly. In the latter case, she might tell her friend to go to a designated area, say some place around the factory, and then look for those places with the recognizable “youth-friendly” logos displayed on their storefronts.

In both cases, factory workers are asked to present their referral coupons (or slips) to the attending health provider. The coupons are collected monthly by MHD staff and the slips are compared with the number of referrals initiated by factory clinic personnel and pharmacists, or made by the PHVs.

The development of referral systems should be an iterative process, arising from, and responding to, the needs and capacities of beneficiaries and implementers.

Originally, a peer-initiated referral system was the focus of Sewing a Healthy Future. However, many PHVs did not have the capacity or confidence to initiate such referrals, and required more extensive training before they were able to do so. So CARE and its partners introduced the peer-initiated referral system in three of the 15 factories as a pilot initiative to ascertain the effectiveness of the activity. Another more broadly based referral network focused on developing links among health providers, with factory clinic staff and pharmacists directing referrals to other health facilities in their districts.
As key steps for preparing activities, PATH led a two-day referral strategy meeting with CARE, its NGO partners, and all health provider partners. During this meeting the group explored the rationale behind referrals, namely why they were important and under what circumstances they should be done. Together they designed a referral coupon to be used in the project. The coupon contained information on the referring institution (including the name and type of services offered); the symptoms of the client; the place to which the client was referred; and the course of treatment. In the weeks that followed the meeting, partners were trained to learn how to complete the form correctly and what to do with the forms they received.

The peer referral system, on the other hand, was not instituted until later in the project. Knowing that factory workers were important sources of health information, CARE and its partners chose three factories where the RH education program was most established. The PHVs were provided with color-coded referral slips to denote each factory. The slips contained no information—PHVs were merely told to give them to peers who requested health assistance and to ask these persons to present them to the referred establishment. Like the health providers, PHVs were also given extensive support to learn how, when and where to refer, and to make a record of the generated referrals.

The fact that the peer and health service referral systems were not introduced simultaneously caused some confusion among health providers, who initially did not understand why a peer-generated referral slip was being used in the project. The MHD teams needed to make a number of personal visits—outside their usual rounds—to provide an orientation to providers on what to do with the slips once they were presented.

Having more than one referral system allows GFWs the opportunity to use the services of a variety of health establishments. It may be necessary, however, to expand original networks to include other facilities and services, depending on the needs of the clients.

Preliminary data suggest that, with two referral systems in place, more and more coupons and slips are being collected from health establishments every month. Garment factory workers have the choice to seek treatment from a variety of health care facilities—from youth-friendly pharmacies, public and private health centers, and factory clinics. Pharmacies and clinics report increasing willingness to forgo profits and to refer clients to places that offer more comprehensive services. The problem is that, in many cases, referrals are not being made to providers within the network, but to other well-recognized RH facilities, such as RHAC and the CWC (see box). The reasons for this are many.

It is unlikely that factory clinic staff would refer clients to other health providers, particularly pharmacists. Because they are doctors, midwives or medical assistants themselves, they know how to perform consultations and assessments to determine a client’s problem. They are able to conduct examinations and some tests in the relatively well-equipped factory premises. Condoms and oral contraceptives are available in the clinics, via a partnership with Population Services International. Referrals then are primarily done in cases of vaginal discharge or bleeding, pregnancy complications, and vaginitis. In these instances, referrals may be made to nearby clinics, cabinets, public health centers, or to

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27 At the time of the documentation, data on the number of referrals generated remains inadequate to make comprehensive conclusions.
RHAC and the CWC. Cases are rarely referred to pharmacies—clinic staff admitted that they only do so when they lack particular medicines or contraceptives.

Referrals are also affected by the PHVs’ training. When capacity-building measures were first initiated on the referral system, PHVs were sent to RHAC and CWC to learn more about available services. Their familiarity with these places makes it easier for them to refer factory workers there. PHVs also state that they have difficulty directing their peers to other places because they simply do not know where they are located. In these cases, it may be sensible for LNGO partners to provide a thorough orientation of the area, with personal visits to health providers in their immediate vicinity. This, however, is difficult to do because of busy work schedules.

Perhaps the most compelling reason for the large number of referrals generated to RHAC and CWC is because they are well-established and well-recognized youth-friendly establishments. Factory workers appreciate the high-quality service and the professionalism of the staff. Treatment and consultation are offered in discrete areas and confidentiality is strictly observed. Both places provide a variety of services, making “one-stop shopping” an option. And the business hours normally extend longer than those of other establishments, particularly public health centers.

It should be noted that RHAC and CWC have built their reputations from the intensive capacity-building efforts of management and outside sources. This does not happen over night. As more and more young people learn about the youth-friendly services at health facilities in the Sewing a Healthy Future network, the numbers of clients will most certainly increase. In fact, discussions with health providers suggest that this is already happening, but it requires long-term and intensive efforts.

**Protecting Youth Through Advocacy**

Experience from around the world has found that the most profound changes in YSRH occur when attempts are made to influence the broader social and policy environments. Sewing a Healthy Future incorporated various advocacy efforts in the original program design, but because of funding shortfalls was unable to address these issues without additional resources.

Among the most important of these efforts is the improvement of occupational health standards in garment factories. This involves greater buy-in of factory management to support the sustainability of programs, and strong endorsement of governmental bodies to advocate for change. In the coming months, CARE and its partners plan to facilitate a
working group of key stakeholders—including factory management, workers, government ministries, the GMAC, and NGOs—to advocate for improved health conditions within garment factories. The working group will conduct policy mapping exercises and in-depth analyses in an attempt to better articulate policy and programmatic issues. It will also liaise more closely with factories in order to improve manager-worker relationships.

Advocacy efforts seek to sensitize and educate factory management on issues of health within the context of the Cambodian labor law, and also work towards a shared understanding of the law and the development of minimum standards for the implementation of health regulations. Like other activities implemented in Sewing a Healthy Future, these efforts require strong multisectoral partnerships to succeed and flourish. We believe that the activities described here have allowed us to develop an important base from which to build and strengthen these relationships. In so doing, GFWs will be in a better position to attain real improvements in their sexual and reproductive health.

Improving the Quality of YSRH Programming Through the Networks Approach

Achievements of the Program

Over the past one and a half years of project implementation, CARE, PATH, and their partners can count the following achievements:

- The development of a strong consortium of private- and public-sector actors committed to YSRH issues.
- The establishment of health provider and peer-driven health referral networks for increased access to quality YSRH services.
- The development and implementation of a health provider curriculum, which has reached more than 300 health providers in four geographical areas in Phnom Penh and neighboring Kandal province.
- The implementation of a multi-faceted RH education program in 15 factories, in which more than 40,000 factory workers have attended large and small health promotion events, 1142 workers have been trained as PHVs, and 14,572 peer contacts have been made.
- The development of related initiatives for factory workers, based on the successes and lessons learned in Sewing a Healthy Future. Two prime examples are the advocacy program mentioned in the last section and a RH radio program for GFWs and other young people initiated by CARE and Health Unlimited.

Preliminary outcome data suggest that more substantive behavior change has also occurred. This includes findings that health providers in the Sewing a Healthy Future network are applying youth-friendly principles in their interactions with clients, particularly with regard to comprehensive consultation and the delivery of more discrete services.28

Referral data from the project reports that the numbers of young people going to providers both within and outside (e.g., RHAC, CWC) the network is increasing every month. While not all clients are presenting coupons and slips, providers’ increasing caseloads do imply

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that GFWs are becoming more aware of RH issues and more inclined to seek services when these are provided in a sensitive and friendly fashion. This conclusion is supported by the PHVs themselves, who maintain that their peers are becoming more interested and proactive in learning about and safeguarding their health, and that they want to know more.

Perhaps the most demonstrable outcome thus far concerns the developing capacities of the project partners. The MHD now has experienced staff on board to deliver comprehensive YSRH training packages and to support private and public health providers as they apply their new knowledge and skills. Factories involved in the initiative have resource persons (PHVs) and factory clinic staff who are able to provide YSRH information and services to their employees. And LNGOs supported by CARE are now able to “go it alone” and establish factory-based RH programs, based on the models and lessons learned from Sewing a Healthy Future.

Behind these successes, however, lie continual challenges. Working in multisectoral partnership is difficult. It requires flexibility, compromise, good faith, and a great deal of perseverance. When the beneficiary population is a hard-to-reach one, such as GFWs, and many of the partners are in the private sector, these challenges are compounded. Factory management may suddenly decide that they are unwilling to support RH activities on their premises. Private health facilities may close their doors or relocate to other areas. Outside influences, such as war and changes in World Trade Organization principles, may influence garment factory business and affect the implementation of the project. On a more local level, broad organizational differences in approaching and responding to problems may make it difficult, or even impossible, to put together an effective and comprehensive YSRH action plan.

Ideas about youth sexuality (in general) and about the provision of youth-friendly services (in particular) further require that programs challenge cultural attitudes, values, and norms which are deeply ingrained in Cambodian society. This involves extensive capacity-building and ongoing support of key stakeholders, including government agency personnel, health providers, NGO staff, and young people themselves. Programmers and donors need to realize this and allocate a great deal of time, and financial and human resources to these tasks. By doing so, they can increase the knowledge and skills of key stakeholders, change behaviors, and ultimately contribute to improvements in the health and well-being of young people in their areas.

The Sewing a Healthy Future initiative implemented by CARE, PATH, and their partners is nearing its final days and new program offshoots are being planned. As the project matures, we hope that others planning similar initiatives in the region and elsewhere will be able to benefit from what has been learned to date. Many of the themes are general ones and will be applicable, we believe, in a variety of cultural, linguistic, and programmatic contexts.

Despite the challenges, Sewing a Healthy Future strongly advocates for the development of multisectoral networks of public and private stakeholders to promote reproductive and sexual health. By continuing the activities espoused here and implementing other more far-reaching efforts in the future, we are confident that young women in Cambodia will soon be Sewing a Healthy Future for themselves.
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