What Makes for a Sustainable Sexual and Reproductive Health Education Initiative?

An appraisal of two reproductive health programmes; the *Reproductive Health Initiative for Youth in Asia* (RHIYA) in Vientiane, Laos and the work of *Siem Reap Citizens for Health, Educational and Social Issues* (SiRCHESI) in Cambodia.

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ABSTRACT

Sustainability is a vital concept in health programme design, delivery and evaluation, yet it is not always given the attention it deserves. This study examines how sustainability has been approached in two sexual and reproductive heath (SRH) education programmes targeting vulnerable youth in Southeast Asia: the Reproductive Health Initiative for Youth in Asia (RHIYA) project in Laos and the Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI) initiative in Cambodia. As hundreds of thousands of Laotian and Cambodian youth prepare to enter their prime reproductive years with a burgeoning HIV/AIDS epidemic looming on their countries' doorsteps, the question of what makes for a sustainable SRH education initiative assumes great significance. Despite sharing some common programme goals and methods (e.g. peer education), RHIYA and SiRCHESI differed in their overall approach to ensuring sustainability. One primarily sought to embed the programme in national organizations and government institutions (a 'top-down' approach), while the other prioritised embedding the programme in the local community (a 'bottom-up' approach). This thesis critically reflects on the merits and weaknesses of these respective strategies, and assesses whether or not RHIYA and SiRCHESI are likely to prove effective in achieving their sustainability goals in the medium to longer term.

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And finally to the sex workers of Laos and Cambodia, I hope that this study contributes, if even just a little, so that you may get the chance to live healthy and happy lives to your full potential.

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GLOSSARY

AIDS	Acquired Immunodeficiency Virus
ASEAN	Association of Southeast Asian Nations
EU	European Union
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
MMR	Maternal Mortality Ratio
NGO	Non Government Organization
PAO	Provincial AIDs Office (Siem Reap, Cambodia)
PAR	Participatory Action Research
PE	Peer Educators
PWT	Project Working Team (RHIYA, Laos)
RHIYA	Reproductive Health Initiative for Youth in Asia
SiRCHESI	Siem Reap Citizens for Health, Educational and Social Issues
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
VYC	Vientiane Youth Centre
WHO	World Health Organization

What Makes for a Sustainable Sexual and Reproductive Health Education Initiative?

CHAPTER 1
BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The issues surrounding reproductive health, especially for adolescents and young people, are of pressing concern in Laos and Cambodia where over half the population is under the age of 20. With hundreds of thousands of young Laotians and Cambodians about to enter their prime reproductive years, how prepared are they to face the ensuing challenges? What realistic prospects do they have for a long and healthy life when – equipped with minimal reproductive health knowledge and limited access to health services and information – they confront a burgeoning HIV/AIDS epidemic on their countries' doorsteps? HIV knows no boundaries and recognises no borders; it has the potential to cut a swathe through a generation. How will the sexual and reproductive health (SRH) needs of these vulnerable youth be met in resource-stretched developing countries with demonstrably inadequate health funding and infrastructure? What additional problems will need to be confronted in these culturally conservative countries as they experience all the political, economic and social turmoil associated with rapid transition from traditional rural cultures to modern urban and industrial ones?

This thesis is a comparative appraisal of two SRH education programmes that were designed to start addressing (at least in part) some of these needs and challenges: the *Reproductive Health Initiative for Youth in Asia* (RHIYA) project in Laos[1] and the work of *Siem Reap Citizens for Health, Educational and Social Issues* (SiRCHESI) in Cambodia. My assessment of these two programmes is particularly focused on how each of them has approached the issue of sustainability; that is, the extent to and means by which they have sought to ensure that their interventions and achievements

[1] The Peoples Democratic Republic of Lao, or Lao PDR, is more commonly referred to as Laos, and the latter term will be used throughout this thesis.

in the area of SRH have a lasting impact on the communities they were designed to serve. I hope that, in doing so, my study will shed light on the bigger picture question of 'what makes for a sustainable SRH education initiative'?

Both RHIYA and SiRCHESI shared a similar goal: to make sustainable improvements in the SRH of vulnerable youth with a particular focus on sex workers. In addition, both programmes utilised the peer education model to achieve this goal. Yet in terms of their approach to ensuring sustainability, RHIYA and SiRCHESI pursued somewhat different strategies. RHIYA aimed to 'build the capacity of the Lao Government, local NGOs and civil society as a whole to recognise and meet the sexual and reproductive health needs of adolescents and youth, using sustainable approaches, where possible' (RHIYA(a) 2003). In particular, RHIYA sought sustainability by way of embedding its programme in national organizations and government institutions, which in turn was seen as a method of sustaining and strengthening the Lao Government's commitment to SRH (RHIYA(a) 2003). SiRCHESI, by contrast, used Participatory Action Research (PAR) as its *modus operandi*, giving higher priority to embedding its programme in the local community. This study aims to critically reflect on what successes and challenges these two SRH education programmes faced in trying to achieve their goals of sustainability, and to assess whether or not they are likely to prove effective in doing so in the medium to longer term.

This chapter provides an introduction to the study, discusses how I became interested in the topic, and outlines my key research questions. The operations of RHIYA and SiRCHESI are then outlined, followed by a brief overview of the geographical region in which these two programmes have operated. A brief survey of some key political, demographic, socioeconomic and health indicators of both Laos and Cambodia follows, along with a discussion of the challenges faced by their local health systems. The chapter also contains an outline of the structure of the remaining chapters of the thesis.

1.2 RATIONALE FOR THE STUDY AND RESEARCH QUESTIONS

I first became interested in this topic when, in May 2006, I worked on the monitoring and evaluation of the RHIYA peer education programme in Vientiane, the capital city of Laos. The RHIYA programme was then coming to the end of its funding period, and I met with and interviewed sex workers (SWs), peer educators (PEs), and Lao Government officials who, together with staff of the Laos branch of CARE International, made up the Project Working Team (PWT) that had carried out the peer education programme and training. I asked this wide range of participants what they thought of the programme, what were the lessons they had learned? The overall response was that the programme had been a resounding success and had 'gone direct' and reached the target group of vulnerable youth. This in itself was quite an achievement, given the difficulties in contacting SWs, a highly mobile group whose work is illegal in Laos. As one of the participants in the RHIYA peer education programme put it, they wanted to see 'the programme keep going, not only for this generation, but also for future generations'(Kirkwood 2006); they hoped that it would not only be very successful, but also truly sustainable. This led me to question what happens to programmes such as RHIYA when the funding stops? As Shediac-Rizkallah and Bone have observed, successful programme implementation is no guarantee of sustainability (Shediac-Rizkallah and Bone 1998). What, if anything, would be the residual achievements from the finitely-funded RHIYA peer education programme for the generations of vulnerable Laotian youth to come?

The following year I became aware of the work of SiRCHESI in Cambodia, and this led me to consider whether this organization's somewhat different approach to SRH education amongst vulnerable youth presented a more sustainable alternative to that pursued by RHIYA. In 2007 I attended a talk by Professor Ian Lubek at Sydney University entitled 'Research, Intervention, Advocacy, Activism and Policy Change in Siem Reap Cambodia: Making a Difference for Women's and Children's Health in HIV/AIDS Prevention'. Inspired by Lubek's passion and commitment and interested in SiRCHESI's approach, I volunteered to help out at SiRCHESI in Siem Reap for three weeks in April/May 2008. During that time I experienced many aspects of

SiRCHESI's peer education and outreach work, and attended the graduation of the second cohort from their Hotel Apprenticeship Programme, a vocational retraining programme targeting indirect SWs in the beer promotion trade. To hear stories from the graduates, firsthand, and hear what a difference the programme had made to their lives was truly moving. I became interested in looking at the different methods, approaches and strategies that RHIYA and SiRCHESI had pursued to address essentially the same problems. I wondered how each programme strove for sustainability and what success they had in doing so. This led me to ask the question, what makes for a sustainable SRH education programme?

Sustainability, in common usage, means to keep something going, as an action or process; it also encompasses the idea of (an institution or the like) enabling something to continue by furnishing means or funds (dictionary.reference.com). As we will see in Chapter 2, while much has been written about the concept of sustainability – be it sustainable development, sustainable health programmes, sustainable health outcomes, or sustainable communities – this ubiquitous term is not always clearly defined and, as a result, there is little consensus as to what sustainability really means. Notwithstanding this, the mantra of sustainability is freely used in the vision statements of government and Non Government Organization (NGO) programmes alike, and it is almost always found in the documented plans of health promotion projects (St Leger 2005). But is the use of 'sustainability' in health programmes just paying lip service to funding bodies? Is sustainability something that just occurs, or it is something that needs to be carefully planned for and incorporated into health programmes from day one? This in turn begs other questions: What *is it* about a health programme that is actually worth sustaining? Is it the programme itself, or aspects thereof? Is it the institution or organization implementing the programme, and/or its infrastructure of programme delivery? Is it, instead, the health outcomes for participants and/or the broader community? Or is it, more likely, some combination or all of the above? What are the key factors that can help us shed light on what makes for a truly sustainable health initiative?

These experiences and thoughts, and my initial engagement with the sustainability literature, led me to define the following key research questions for my study:

- **What is sustainability in a SRH programme and what benchmarks should be used to measure it?**
- **How can sustainability be planned for and achieved in SRH programmes?**
- **What were the key characteristics of the different strategies used by RHIYA Laos and SiRCHESI to achieve sustainability? Is one preferable to the other, or do they both have a role?**
- **Using the benchmarks mentioned above, how did RHIYA Laos and SiRCHESI 'measure up' on the sustainability front? Did their different approaches make for disparate outcomes in terms of sustainability?**
- **What challenges and opportunities did RHIYA and SiRCHESI face in pursuing their sustainability goals?**
- **What are the implications of all this for future programme and policy development?**

The following chapters of this thesis document my attempts to answer these research questions. The next section of this chapter provides a brief overview of the RHIYA and SiRCHESI programmes, followed by a discussion of the key political, demographic, socioeconomic and health context in which these two programmes have operated. In Chapter 2 I explore the literature on the concept of sustainability in relation to SRH education initiatives, with a particular focus on planning for sustainability, defining benchmarks to measure it by, and identifying the different approaches that have been used to achieve it and the common barriers that have been encountered in doing so. In Chapter 3 I outline the methods used to conduct my study, fieldwork for which was undertaken in Cambodia and Laos in early 2009. This comprised interviews with management and staff from RHIYA and SiRCHESI who were asked about the approaches and strategies they adopted to ensure their respective SRH education programmes were sustained beyond the initial funding period. In Chapters 4 and 5 I present the findings of this fieldwork. Chapter 6 concludes my study with a summary of its key findings, and an assessment of its implications for future policy, practice and research.

1.3 BACKGROUND ON THE PROGRAMMES

RHIYA Laos

The Reproductive Health Initiative for Youth in Asia (RHIYA) was a European Union (EU) and United Nations Population Fund (UNFPA) funded collaboration. Seven countries participated: Laos, Vietnam, Cambodia, Nepal, Pakistan, Sri Lanka and Bangladesh. The RHIYA initiative was a partnership between the EU, UNFPA, local and foreign NGOs and national government counterparts (UNFPA(b) 2007). The RHIYA programme in Laos ran from April 2003 until Jan 2007.

The overall goal of the programme was to improve the sexual and reproductive health (SRH) of young people and adolescents (men and women aged 15-24) with a focus on vulnerable, disadvantaged people such as sex workers (SWs). Under this overarching goal, RHIYA Laos had four main objectives: to improve the political and community support for adolescent and SRH interventions; to increase and improve SRH knowledge and behaviour among the target group; to improve access to quality youth-oriented SRH services; and to enhance managerial capacity and technical planning among government partners to provide information and clinical services that are adolescent-friendly (UNFPA(b) 2007). A range of approaches were used to achieve these ends including capacity building and training in adolescent and SRH, peer education, the provision of youth-friendly SRH services, and advocacy (UNFPA(b) 2007).

The RHIYA Laos programme comprised three key components: the Vientiane Youth Centre (VYC), the Peer Education for Vulnerable Youth programme in Vientiane, and an outreach programme in southern Laos. This study concentrates on the first two of these: the VYC and the peer education programme in Vientiane, the latter of which was a collaboration with the Lao branch of CARE International. These two programme components are discussed in more detail in Chapter 4.

SiRCHESI

Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI) is a Cambodian NGO that focuses on HIV and related illnesses in Siem Reap. It was formed in 2000, following a visit by Professor Ian Lubek from the University of Guelph, Canada, to the World Heritage Listed temples of Angkor Wat. While there, Lubek was shocked to learn of the high prevalence of HIV in Siem Reap, the town closest to the temples which attract well over a million tourists each year. With this boom in tourism had come not only the cultural tourist but also human traffickers, sexual tourists and paedophiles (SiRCHESI(a) 2008). When challenged by a local tour guide as to what he, as a professor, could do about the situation, he took up the challenge and SiRCHESI was formed.

SiRCHESI is a non-profit, community-based organization that utilises participatory action research (PAR) as its *modus operandi*. Such an approach focuses on getting the target groups and local community to participate and give feedback on the goals and directions of the research and thus help shape its next steps, methods and interventions. The organization also adopts what it calls a 'hybrid model of capacity building', working with other NGOs, hospitals, agencies and government organizations to strengthen the public health sector, especially through its partnership with the Provincial AIDS Office and the Provincial Department of Health (SiRCHESI 2008). SiRCHESI's hybrid model aims to build the capacity of local health workers and achieves this without 'stealing' them away from their regular jobs.

SiRCHESI runs two main programmes aimed at improving the SRH of sex workers in Siem Reap, particularly targeting those who work for beer companies and at entertainment venues[2]. The two programmes are the Peer Education/Outreach programme and the vocationally-oriented Hotel Apprenticeship Programme. These programmes have been funded by grants from the Elton John AIDS Foundation,

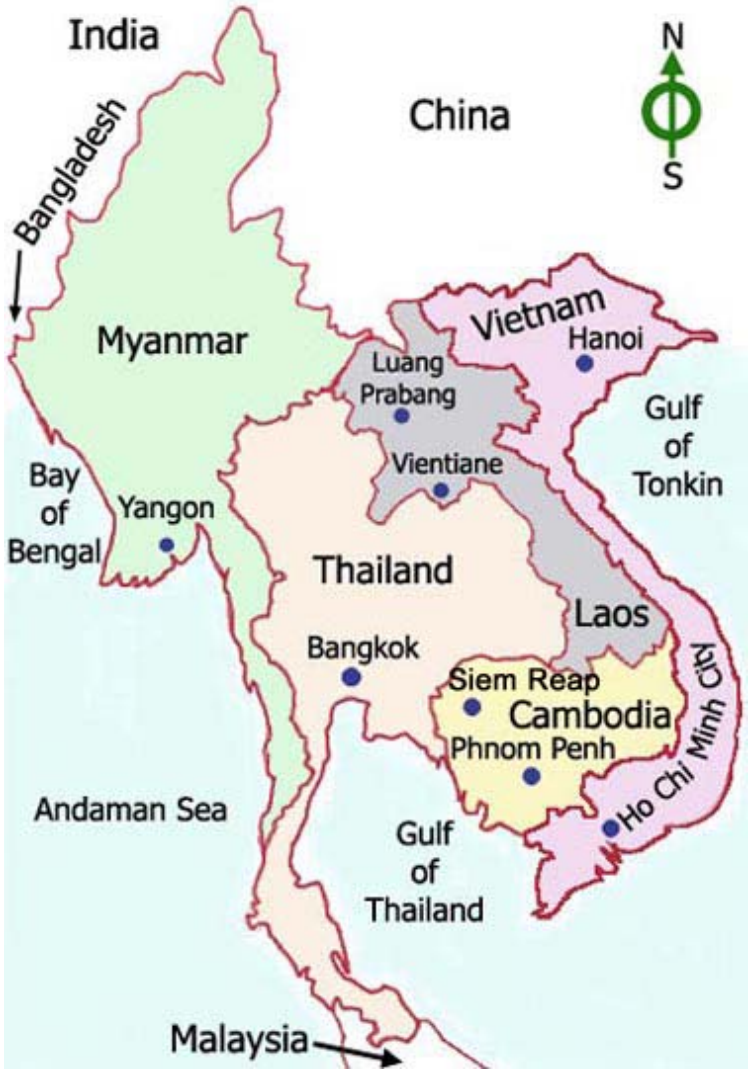
[2] Women who have sex in exchange for money can be referred to by a number of terms. Brothel workers are often referred to as commercial sex workers or direct sex workers. Women who sell beer or work in karaoke bars and have sex for money can be referred to as indirect sex workers (IDSWs). 'Beer bar girls' are IDSWs who sell beer and often drink with the clients in order to sell more beer. They may then have sex for money as a result of too much alcohol and being very poorly paid. For this study we shall only use the term sex worker (SW) of which the majority are in fact IDSWs.

M.A.C. AIDS Fund, Rotary International, as well as from revenue gained from the NGO's own fundraising activities. A discussion of these programmes, and an evaluation of SiRCHESI's effectiveness and sustainability, is found in Chapter 5.

1.4 BACKGROUND ON THE COUNTRIES

Laos and Cambodia are neighbouring countries situated in Southeast Asia. They share borders with Thailand and Vietnam, with Laos also having borders with Myanmar and China. The majority of the populations in Laos and Cambodia are Theravada Buddhists. Both countries have approximately two-thirds or more of their population living in rural areas.

Figure 1.4.1 Southeast Asia, showing the location of Laos and Cambodia



(http://www.ourweb.info/01/maps/ 2007)

Political Background

Laos and Cambodia have both endured much civil and internal conflict. Laos has been a one-party communist state since 1975, when the Peoples Democratic Republic of Laos was established (Stuart-Fox 1997). In more recent years, Laos instituted 're-education' camps and imprisoned many citizens for political crimes. According to an Austrade briefing on Laos, 'the ruling Lao People's Revolutionary Party exerts control over most aspects of civil society', with 'constitutionally-guaranteed freedom of assembly, religion and speech … not always evident' (Austrade-Laos 2009). Compounding this is the fact that Laos is also facing major challenges in addressing transparency and corruption issues (WHO(a) 2008).

For Cambodia, 1975 was 'Year Zero', marking the start of a genocide like no other, with millions dying at the hands of the Khmer Rouge. With the educated and professionals being singled out and killed, and many survivors having emigrated, Cambodia now faces a shortage of skilled labour. After thirty years of war and severe internal conflict, the economic infrastructure of the country has been ruined and Cambodia has been left severely impoverished (WHO(b) 2008). Whilst the Cambodian Government is attempting to undertake economic reform, many challenges lie ahead such as potential political instability, corruption and transparency issues.

The effects of bloodshed, political instability, widespread corruption and heavy reliance on foreign aid, combined with often grinding poverty, have presented major obstacles and put the Cambodian and Laotian peoples' health and wellbeing at risk, as the indicators discussed below substantiate.

Demographic Indicators

The issues surrounding reproductive health, especially for adolescents and young people, are of pressing concern in Laos and Cambodia with both countries having such young populations. In Laos almost two-thirds of the country is under 25 years of age and a vast 54% of the population is under the age of 20 (UNFPA(b) 2007). Likewise, half of the population of Cambodia is under the age of 20 (WHO(b) 2008).

Therefore adequately addressing the health needs of this large sector of the population, as they enter their reproductive years, is of major consequence.

Socioeconomic and Health Indicators

Macfarlane and Racelis et al. (2000 p841) provide a bleak list of the factors that have an impact on the livelihood and welfare of the poor in many developing countries, many of which have had a dramatic impact in Laos and Cambodia:

> political unrest, environmental disaster, declining economic performance, the introduction of structural adjustment programmes, unresponsive governance, weak public infrastructure, changing population dynamics, the advent of HIV/AIDS and the onset of globalisation.

Laos ranks among the least-developed countries in the world, with around 70% of the population living on less then $US 0.40 per day (WHO(a) 2008). Laos is heavily reliant on donor funding and agriculture as its main sources of income. Despite a steadily increasing GDP, growth is still slow and serious inequalities remain. At a national level, health indicators in Laos have been improving steadily over the past three decades, but despite the efforts of the national authorities (and others), they remain below international standards, being some of the lowest in the region.

Cambodia has some of the worst human development indicators in Southeast Asia. In 2006, per capita GDP was $US 419, with 35% of the total population still living below the official rural and urban poverty lines of $US 0.46 and $US 0.63 per day (WHO(b) 2008). Cambodia is heavily reliant on external aid to meet the needs of its people. ‘The emerging Cambodian economy is heavily reliant on imported goods and services, given its very weak infrastructure and low industrial base’ (Austrade-Cambodia 2009). Poverty, poor sanitation and disease are rife posing obstacles to basic health.

Gender Issues

Women have lower literacy rates than men, and girls have lower school completion rates than boys in Laos and Cambodia. These gaps are accentuated in the rural and highland areas of Laos, where poverty is highest (WHO(a) 2008). Women in both Laos and Cambodia have less access to education and employment opportunities than

their male counterparts. ‘Women have not achieved equal rights with men as provided in the Cambodian Constitution. Gender gaps continue in education, women in decision-making positions are rare and gender-based violence, including trafficking, is a growing concern’ (RHIYA(c) 2009).

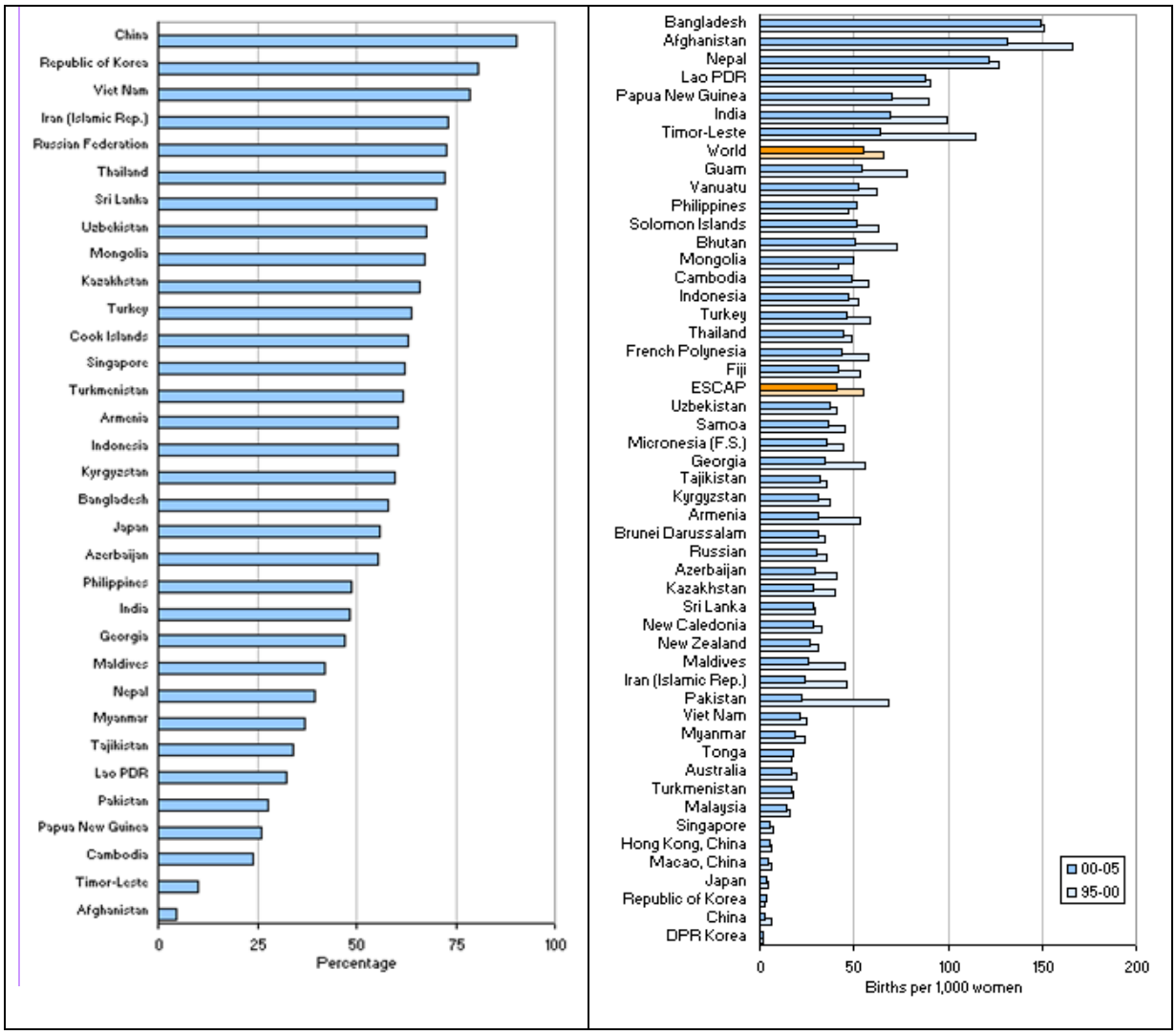
Sexual and Reproductive Health Knowledge of Youth

As we have seen, both Laos and Cambodia have very young populations that face issues of poverty, lack of education, unemployment and many other socioeconomic concerns. All these factors directly contribute to the health status of young people. There are many serious SRH risks and problems facing youth in Laos and Cambodia, including the risk of dying prematurely, be it from infectious disease such as HIV/AIDS, violence or maternal mortality. What, then, is their knowledge of SRH issues like?

Laos had the lowest level of SRH knowledge of all seven countries that participated in the EU/UNFPA-funded RHIYA programme (UNFPA(b) 2007). According to Satia (2001) adolescent awareness and information about sexually transmitted infections in Laos was generally inadequate with limited understanding and knowledge about HIV/AIDS prevention or transmission modes. This was corroborated by the RHIYA baseline studies (discussed in Chapter 4). Cambodian youth show a similar lack of knowledge and information in regards to SRH, with limited awareness and insufficient access to youth-friendly services (RHIYA(c) 2009).

In terms of contraceptive use amongst adolescents, Cambodia ranks third last and Laos sixth last out of 33 countries in the Asia-Pacific region (Figure 1.4.2a LHS chart). Low rates of contraceptive use are the forerunner to high rates of fertility. This is particularly evident amongst adolescents in Laos, as shown in Figure 1.4.2b RHS chart. Cambodia’s Maternal Mortality Ratio (MMR, per 100,000 live births) is 450, while in Laos it is 650. The ASEAN region, in contrast, averages an MMR of 208. In 2006 Australia had an MMR of 6 (ESCAP 2007). These disparities speak for themselves. They highlight the urgent need for sustainable SRH programmes to ensure that the youth of Laos and Cambodia have the opportunity to live long and healthy lives.

Figure 1.4.2 Asia and the Pacific: (a) Contraceptive prevalence 1996-2004 (LHS)[3] and (b) Fertility rates in 1995-2000 and 2000-2005 (RHS)[4]



(UNESCAP(a) 2007; UNESCAP(b) 2007)

HIV and other STIs

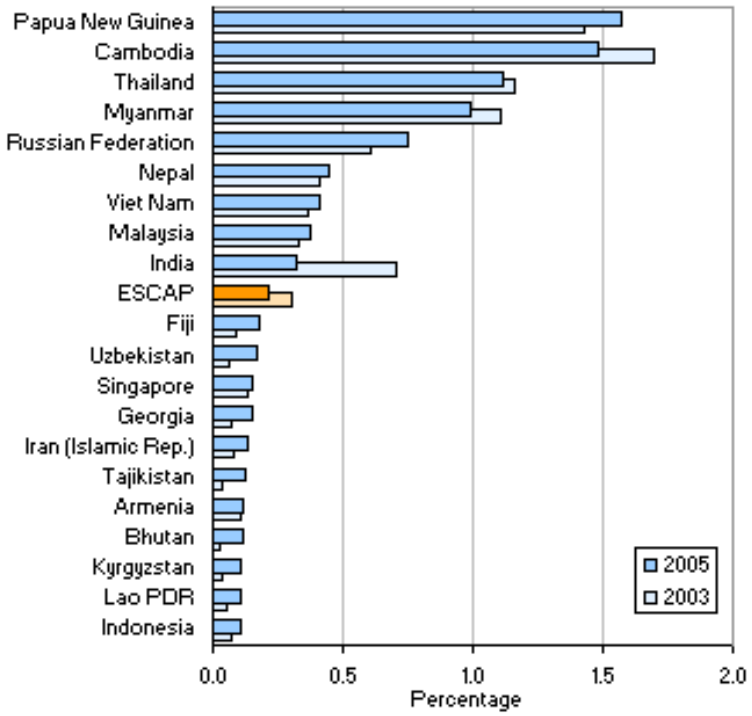
As seen in Figure 1.4.3 below, Laos has comparatively low HIV/AIDS rates at the present time. Also evident is the fact that Laos' neighbours, Cambodia, Thailand and Myanmar, have some of the highest rates of HIV prevalence in the Asia-Pacific region. According to the World Health Organization, Laos is facing major challenges on this front as the country opens up to external influences. With the recent trend in

[3] Contraceptive prevalence among women aged 15-49 in Asia and the Pacific, latest year from 1996-2004

[4] Fertility rate among adolescents aged 15-19 in Asia and the Pacific, 1995-2000 and 2000-2005

opening of offshore trade zones with China and Vietnam, the investment in casinos throughout the country, and the easing of migration formalities, Laos faces important challenges with regards to spread of HIV/AIDS and other communicable diseases (WHO(a) 2008).

Figure 1.4.3 Asian and Pacific countries/areas with highest proportion of adults 15 years and above living with HIV/AIDS, 2003 and 2005.



(ESCAP 2007)

The majority of Laotians currently living with HIV/AIDS are between 20 to 39 years old, and the main method of transmission of the disease is heterosexual sex (85%) (WHO(a) 2008). The WHO also states that HIV rates in sex workers in Laos have increased from 0.9% in 2001 to 2% in 2005. Access to testing facilities and anti retroviral medication is limited with only one listed treatment site. In Laos sex workers also have high rates of STIs (such as Chlamydia and Gonorrhoea), with an estimated combined infection rate of 37.6% (WHO(a) 2008). Whilst Laos is technically a low HIV prevalence country it is important to note that the data available from routine health information systems is neither ‘robust or universal’ (WHO(a) 2008). With such high rates of HIV on its doorstep, sustainable SRH programmes will play a decisive role in keeping HIV rates to a minimum.

Cambodia has experienced a generalized AIDS epidemic, according to RHIYA (2009), with HIV prevalence being amongst the highest in Asia (Figure 1.4.3). Yet according to ESCAP (2007), the HIV epidemic seems to be stabilising in Cambodia, with HIV prevalence rates among adults falling between 2003 and 2005 (Figure 1.4.3). It is, however, important to keep in mind that neighbouring countries such as Vietnam are seeing an increase in the number of people with HIV/AIDS and that the virus does not recognise geographical borders.

Whilst overall HIV rates may be stabilising in Cambodia, there has been a rapid increase in HIV for those who do not identify themselves as sex workers. Beer promotion women, according to SiRCHESI, have shown HIV rates as high as 20.5%, with Siem Reap having the highest HIV rates in Cambodia, especially amongst young persons (15-19 years) (SiRCHESI(a) 2008). This is due in part to the sexual tourists, paedophiles and men who come to be 'cured of AIDS by sleeping with virgins'(SiRCHESI(a) 2008). Underpaid, poverty-stricken women resort to exchanging money for sex and thus 'infections are "bridged" to local men earning income from tourism then to wives, partners and newborns' (SiRCHESI(a) 2008). The increase in non-brothel-based sex work in bars, massage parlours and beer halls will present a challenge to these indirect sex workers and their clients, according to UNAIDS (2008), especially as their clients are less likely to use condoms in such situations. Changing forms of sexual networking mean that these problems will spread more widely amongst the population as UNAIDS (2008) points out. The latter's 2005 STI Sentinel survey reports showed that almost half of new infections were among married women.

Challenges Facing the Local Health Systems

The lack of adequate financing of the health systems in Laos and Cambodia makes policy and programme implementation extremely difficult. As Figure 1.4.4 indicates, both countries are highly dependent on donor funding, 'which has often led to competing and overlapping donor demands' (WHO(a) 2008). For example, Cambodia's health sector has been described as a 'crowded field where the Ministry of Health is joined by some 20 bilateral and multilateral donors, development

agencies and global health partnerships, as well as 100+ international and national NGOs' (WHO(b) 2008).

In Laos current estimated per capita health expenditure is around $US 19, about 80% of which comes from households, 10% from donors, and 10% from the Government (WHO(a) 2008). Inadequate financing of health programmes, as well as poor allocation and management of funds, are also issues in Cambodia (WHO(b) 2008) where total per capita expenditure on health was $US 34 in 2006 (Figure 1.4.4).

Figure 1.4.4 Health Expenditure in Laos and Cambodia

	Laos	**Cambodia**
Population	5,600,000 (2005)	14,331,000 (forecast from 2004 sentinel for end of 2007)
Facilities with HIV testing and counselling	36 (2007)	197 (2007)
Total health expenditure		
- amount in millions ($US)	106.01 (2006)	488.65 (2006)
- total expenditure as % GDP	3.9% (2006)	6.8% (2006)
- per capita total expenditure on health ($US)	18.86 (2006)	34 (2006)
Government expenditure on health		
- amount in millions ($US)	21.17 (2006)	111.17 (2006)
- general govt expenditure on health as a % of total expenditure on health	20.20% (2006)	22.80% (2006)
- general govt expenditure on health as a % of total govt expenditure	3.3% (2006)	10.7% (2006)
External source of government health expenditure		
- external resources spent on health as a % of general government expenditure on health (usually from donor funding or NGOs)	52.0% (2006)	19.5% (2006)

(WHO(a) 2008; WHO(b) 2008)

Many developing and low income countries also face staff shortages in the field of health. There are many reasons for this including a limited number of, and misdistribution of, qualified health care practitioners, and, as the WHO(a) (2008) points out, 'low staff productivity'. Health supplies and equipment are also lacking; this can lead to low morale and poor attendance in the workplace.

Laos faces a 'general shortage of qualified health workers' (WHO(a) 2008; WHO(b) 2008) as does Cambodia where a generation of educated professionals was wiped out

during the genocide and subsequent civil unrest. Low wages have also contributed to this problem. In 2005, the average annual salary for health workers in Laos was estimated to be $US 405 (or $US 33.75 per month) (WHO(a) 2008). When staff are paid such low wages they will often compensate with secondary occupations. It is reported in Cambodia that 'many public health civil servants have initiated private activities to complement their official government salaries to earn a living wage' (WHO(b) 2008).

Both RHIYA and SiRCHESI utilised government staff working two jobs. This increased workload for health care workers can impair the growth of the countries' health systems if they are diverted from their primary jobs and thus stand in the way of truly sustainable health outcomes. Yet in many ways this is a double-edged sword as doing two jobs is necessary, both to build capacity and skills in community-based health initiatives as well as to earn a living wage. In sum, the pressures on local health infrastructure combined with a lack of funding, resources and staff make the need for sustainable SRH programmes in Laos and Cambodia all the more critical.

The above survey of the political, demographic, socioeconomic and health context of Laos and Cambodia highlights the importance of addressing the needs of young and vulnerable youth through sustainable SRH programmes. The unregulated and informal nature of sex work, along with the discrimination and stigma SWs often face, combine to make the SRH of this particularly susceptible group of the utmost importance (Ireson 1994). Faced with little education, high unemployment and few opportunities to break out of the cycle of poverty, the youth of Laos and Cambodia have a right to obtain accurate SRH information, to have choice and to have appropriate, adequate and accessible SRH services. With the responsibility for providing this largely falling to NGOs, who themselves often have limited time and funding, the question as to what makes for a sustainable SRH initiative seems even more imperative.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter explores the literature on the concept of sustainability in relation to sexual and reproductive health (SRH) education initiatives. First, I briefly discuss the literature about sustainability in general and why it is significant. Sustainability is then explored more specifically in relation to population health outcomes and health programmes (Sections 2.2 and 2.3). In section 2.4 I investigate what the literature suggests sustainability looks like 'on the ground' in terms of health programmes, and what benchmarks can be used to measure it. Then, in section 2.5, the need to *plan* for sustainability is considered. The emerging literature on this topic suggests that active planning must be done in the early phases of programme design if sustainability is to be achieved in the longer term. Sections 2.6 and 2.7 identify and discuss some of the different approaches that have been used to achieve sustainability in health programmes, and some of the common barriers that have been faced in working towards this goal, while section 2.8 concludes.

2.2 WHAT IS SUSTAINABILITY?

Much has been written about sustainability: sustainable development, sustainable health programmes, sustainable health outcomes, sustainable communities. Yet what does this ubiquitous term really mean and why is sustainability so critical? The literature contains many references to the concept of sustainability and its multiplicity of meanings, but a clear, concise and universally agreed upon definition is yet to be established and is often the subject of much debate (Shediac-Rizkallah and Bone 1998; Morgan 2001; Johnson, Hays et al. 2004; Pluye, Potvin et al. 2004; St Leger 2005).

Perhaps the most frequently encountered use of the word 'sustainability' is in the sustainable development literature. Used in this context, sustainability may be broadly

defined as a concern to ensure that short-term economic growth objectives are not pursued *at the expense* of longer-term environmental, social and economic goals, but instead that such development 'meets the needs of the present without compromising the ability of future generations to meet their own needs' (WCED 1987). Such a definition emphasises the multifactorial nature of sustainability – in this case, a concern that development be viewed from social, economic and environmental perspectives – as well as an emphasis on durability: the capacity of such development to deliver beneficial outcomes over the long, not just the short, term.

Indeed, pursuing sustainable development is a fundamental factor in ensuring sustainable population health outcomes, particularly in developing countries such as Laos and Cambodia. The pursuit of sustainable development is often interlinked with poverty reduction which in turn may address some of the structural determinants of health and ill-health in these societies. This is vital as socioeconomic factors play a critical role in determining the health of the individual and of the broader communities in which they live (Wilkinson and Marmot 2003). For example, many of the young women that participated in the SRH programmes considered in this study were effectively forced into sex work due to poverty, lack of education, illiteracy and unemployment. This in turn led to further social exclusion and stigmatisation, giving them few opportunities to break free from the vicious cycle. The consequences for their physiological, mental and social health were severe. As Wilkinson and Marmot (2003) point out, such social disadvantage is one of the key drivers of health inequality. These authors highlight the need for policies to tackle the underlying issues – poverty reduction and the promotion of social inclusion – if population health is to be improved and health inequalities redressed.

We may conclude from the above that if a health programme is to be truly effective and sustainable, it needs to be part of a broader strategy to address these underlying structural determinants of health and ill-health. In addition, achieving sustainable health outcomes, particularly in developing countries, requires an increase in financial resources and investment in public health infrastructure as well as the development of adequate local capacity to truly utilise these resources in an effective way (LaFond, Brown et al. 2002).

A strong government and political leadership, including public policy and effective advocacy, are also important for achieving sustainable health outcomes, as is effective collaboration between NGOs, donors and the government (Hecht and Shah 2006). At an individual level, participants in health programmes need to have access to information and affordable services, education, and a supportive community environment if sustainable health outcomes are to be achieved.

Adopting such a comprehensive approach to the design of health programmes is particularly important in the area of adolescent SRH. It is simply not feasible, let alone sustainable, to focus on isolated behaviours of the individual without looking at the surrounding influences that affect their SRH 'choices' and behaviours. Blum (2004 p3) emphasises the need to pay attention to 'the contextual factors associated with [adolescent] SRH – whether it is government policy, the economic climate, family functioning, school climate and relationships, peer or community', rather than just focusing on the individual's knowledge, attitudes and beliefs. Within this broader framework, Blum found that SRH programmes that have been most effective were those that tended to increase protective behaviours as opposed to merely reducing risk (Blum 2004). These are some of the core issues directly influencing the sustainability of SRH programmes that form the context of this study.

2.3 WHY SUSTAINABILITY IS CRITICAL TO HEALTH PROGRAMMES

Although, as noted earlier, sustainability is not always clearly defined, it is a concept nonetheless mentioned in the documented plans of most health promotion projects and programmes (St Leger 2005). Failing to ensure programme continuity – one key aspect of sustainability – can have very significant negative effects. Shediac-Rizkallah and Bone (1998) point out that termination of a health programme is counterproductive when the disease or health concern which the programme was established to address remains or returns. Not only is the underlying health problem not solved, but as Pluye, Potvin et al. (2004) observe, the community can become disillusioned by discontinued programmes, making subsequent community mobilization and programme development more difficult.

The high start-up costs of health programmes – including human, fiscal and technical resources – also make sustainability a pressing concern, particularly when there is uncertainty about the availability of *ongoing* funding for the programme (Shediac-Rizkallah and Bone 1998). This issue was highlighted in a study by Altman (1991), which looked at nine different foundation-funded community health programmes in the United States. Six out of the nine programmes identified the issue of sustainability as a concern, and specifically the lack of diversified, reliable long term funding, which was seen as leading to an inability to integrate the programme into the community to ensure ongoing health promotion once the initial programme funding came to an end. With sustainability such a critical issue, this study will explore some of the different sorts of strategies that have been used to achieve it, and to what effect.

2.4 BENCHMARKS FOR IDENTIFYING SUSTAINABLE HEALTH PROGRAMMES

As the above discussion has indicated, sustainability is a multi-faceted and multi-dimensional concept that is unable to be captured in a singular all-encompassing definition. It is, however, fairly universally agreed that it is a vital concept in health programme design, delivery and evaluation. How, then, does one go about identifying and measuring such an elusive, yet important, concept? What exactly does sustainability look like 'on the ground'? This in turn begs other questions: within a given health programme, exactly what *is* it that is actually worth sustaining? The programme itself, or aspects thereof? The institution or organization implementing the programme, and/or the infrastructure of programme delivery? The health outcomes for participants and/or for the broader community? Or is it, more likely, some combination, or all of the above?

One useful approach to measuring health programme sustainability is the multi-dimensional conceptual framework developed by Shediac-Rizkallah and Bone (1998). This framework arose from the authors' several years of cumulative knowledge and experience in the community health field, as well as their review of the relevant literature, both of which were drawn on to formulate a 'coherent and systematic knowledge base

about programme sustainability' (Shediac-Rizkallah and Bone 1998). These authors see the latter term as encompassing much more than programme efficacy: it also includes the notion of continuity. Their resulting framework identifies three categories of indicators for evaluating the sustainability of community-based health programmes:

1) *The maintenance of individual health benefits as achieved through the programme*. The success of each programme in achieving its intended health goals is covered here as well as how this has been measured and the ongoing health benefits that have accrued to individual programme participants.
2) *The level of institutionalisation of a programme within an organization*. This includes programme design and implementation as well as factors within an organizational setting.
3) *Capacity building in the recipient community*. This incorporates sustainability as community 'capacity building': building the problem-solving abilities of individuals and the community at large.

Similarly, Scheirer identifies the continuation of programme activities, the continuation of measured benefits or outcomes, and the maintenance of community capacity as three key defining points of sustainability (Scheirer 2005). In Figure 2.4.1 below, I show how Shediac-Rizkallah and Bone's framework might be applied to assessing the sustainability of the SRH education programmes of RHIYA Laos and SiRCHESI.

Figure 2.4.1 Shediac-Rizkallah and Bone's (1998) Sustainability Benchmarks, as they can be Applied to Evaluating RHIYA Laos and SiRCHESI's SRH programmes

BENCHMARK	APPLICATION TO RHIYA Laos AND SiRCHESI

Individual Health Benefits	• Improved health status[5] of
	  ➢ Programme participants
	  ➢ Broader community
	• Lifestyle/Behavioural change for participants

Level of Institutionalisation of a Programme within an Organization	• Programme design and implementation • Assess factors within the implementing organization's organizational setting • Success in institutionalizing the programme in the community and/or the government
Capacity Building in the Recipient Community	• Assess how the implementing organization actually built capacity in the recipient community • Determine what role community participation played

2.5 PLANNING FOR SUSTAINABILITY

The importance of actually planning for sustainability – and not just hoping that it will occur as a by-product of successful programme implementation – is an emerging topic of discussion in the literature. Johnson, Hays et al. (2004) point out that the question of how to ensure sustainability is often not thought about until the end of a programme, when in fact sustainability activities need to commence much earlier. Arguably sustainability is something that needs to be planned for and incorporated into health programme design from day one (Shediac-Rizkallah and Bone 1998). This is the view of the World Health Organization (WHO 2007 p3), whose Strategic Approach to Strengthening SRH Programmes emphasises the importance of 'start[ing] with the end in mind'.

Sustainability, according to Goodman and Steckler (1987) and Shediac-Rizkallah and Bone (1998), needs to go from a latent goal to a planned approach. Shediac-Rizkallah and Bone (1998) state that from their experience on many health projects, sustainability is

[5] As discussed in Chapters 4 and 5 assessing the extent to which the health status of participants has improved can be problematic given the mobility of the target group (SWs) and a range of problems in data collection, reliability and availability.

often *stated* as a goal, but not necessarily actively planned for. For example, an otherwise successful five-year community-based breast and cervical cancer control project in Baltimore, Maryland devoted too few resources and too little time to building adequate mechanisms to successfully transfer various activities to another organization when the funding ceased. As Shediac-Rizkallah and Bone observe: despite best intentions, 'the absence of early and active planning [meant that] the conditions that would enhance the prospects for sustainability in the long term [were] not created and sustainability [did not] occur' (Shediac-Rizkallah and Bone 1998 p89). Merely aspiring for programme continuation does not mean this goal will be achieved. Planning for sustainability must be thorough with well-thought-out health programmes designed to fit each community specifically with local capacity and affordability (including time and technical resources) being taken into account (Shediac-Rizkallah and Bone 1998).

2.6 BARRIERS TO ACHIEVING SUSTAINABILITY

There are many different approaches to achieving sustainability in the design and delivery of health programmes. Before discussing some of the tools and strategies that have been used to strive for sustainability in section 2.7, in this section I identify some of the barriers that are commonly faced in working towards this goal.

a) Short Term Project v. Long Term Programme Approach

There is considerable literature on the impact of programme length on sustainability, much of which makes the point that short term projects, which are common in the field of community health, can actually hamper sustainability with their stop-start approach. Communities may start to feel that there is a revolving door of aid workers and health programmes, which in turn can diminish the community's trust and dampen their support and enthusiasm for new initiatives (Goodman and Steckler 1987; Shediac-Rizkallah and Bone 1998). Moreover, if health projects are terminated and evidence of them disappears, there can be no opportunity for follow up or continuity, further jeopardising the communities' confidence, expectation and trust.

By contrast, longer term health programmes that become embedded in the community enhance both programme effectiveness and sustainability. One of the significant factors contributing to the success of a behavioural intervention on hypertension in Baltimore, Maryland, for example, was the continuity over a 20-year period of key programme-related positions (Shediac-Rizkallah and Bone 1998). Active programme involvement by people who also play key roles in the community fosters community trust; the community perceives that its own members are playing an active and skilled role and building capacity using local knowledge (see Section 2.7 below). The importance of such an approach is particularly apparent in developing countries, where often the programme 'experts' are flown in on a relatively short-term basis from foreign shores. As Stewart (2008 p163) observes:

> an external person may be managing a project, and may have leadership responsibilities, but the goal of ensuring sustainability will not come from the person who is an external consultant and is often in a region or country for a relatively short period of time.

A further potential downside of short-term projects is their exacerbation of staff turnover problems in the implementing organizations, which in turn detracts from the sustainability of health programmes. Relationships built on trust and mutual understanding are vital for sustainable health initiatives, yet when a project finishes, staff disband and resources are wound up, and continuity is lost. Bradley, Mayfield et al. (2002) note that this is a particular problem in resource-poor settings, such as developing countries, where many NGOs and institutions 'experience constant staff turnover at all levels, resulting in the loss of established approaches, systems and support' (Bradley, Mayfield et al. 2002 p280). One way to address this problem is to invest in community-based long term programmes that have more permanent levels of staff, but the funds to do this are not always available. It should also be remembered that, despite their potential drawbacks, benefits can still be gained from shorter projects and programmes by utilising the technical support available and building capacity in the local community.

b) Funding

One of the biggest barriers to ensuring sustainability of a health programme is that of securing ongoing financing to support the programme once the initial funding comes to an end (Shediac-Rizkallah and Bone 1998). Having long term diversified funding sources is essential for delivering sustainable and successful health programmes. Johnson, Hays et al. (2004) argue that sustainability in regard to financing needs to be planned for and factored in from the beginning rather than being an afterthought when the funding has already ceased. While vital, this can be particularly challenging in the case of health programmes targeting sex workers, the available funding for which has been described as 'miniscule' (Dorf 2006). The securing of adequate, long term funding for such programmes has also become more difficult, according to Bradley, Mayfield et al. (2002), with the rise in performance or results-based management. It can be particularly difficult to document results when implementing SRH programmes for highly mobile target groups such as SWs whose work is often illegal. This in turn makes it harder to obtain ongoing financial support, because the evidence of success is difficult to procure. All these problems are further compounded in developing countries where, as Shediac-Rizkallah and Bone (1998) point out, 'Third world government capacity to fund even the most basic health services is often too limited for short term financial self sufficiency to be a real goal' (Shediac-Rizkallah and Bone 1998 p94).

As this thesis will document, both RHIYA and SIRCHESI faced a number of difficult issues around funding. RHIYA was a finite programme and the programme implementers knew from the start that the funding would end in three years. But, given this context, did they pay sufficient attention to planning for sustainability at the outset and, if so, what success was had in achieving this objective? SIRCHESI, meanwhile, was established with a longer-term horizon in mind, but it was also reliant on obtaining external funding – usually through short-term project grants. To date no long term donor or funding source has been located to carry its activities beyond 2009. There is an obvious connection between ongoing funding and the sustainability of an SRH programme: an issue which will be explored in depth in this study.

2.7 APPROACHES TO ACHIEVING SUSTAINABILITY

This section discusses the literature on two key strategies for accomplishing sustainability. First the role of community participation, empowerment and capacity building will be examined, followed by a consideration of the strategy of embedding the programme in government.

a) Community Participation, Empowerment and Capacity Building as a Tool for Sustainability

The notion of community participation – of the community playing an active role in the design and implementation of health programmes – has gained prominence in recent decades. The WHO's Declaration of 'Health for All' at Alma Ata in 1978 depicted community participation as a cornerstone of primary health care (Morgan 2001; Jacobs and Price 2003). The Ottawa Charter for Health Promotion (WHO 1986) built upon the Alma Ata Declaration and strove for 'effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health' (WHO 1986). By 2007 this emphasis on community participation had been comprehensively incorporated into the WHO's Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes (WHO 2007). This strategy highlights the importance of a participatory approach and the incorporation of a wide range of stakeholders (including community members) into the process of SRH programme planning, design and implementation.

Such an emphasis on community participation has the potential to significantly enhance the sustainability of health programmes. Indeed, many authors have argued that participatory techniques are *fundamental* to achieving sustainable health programmes (Altman 1991; Shediac-Rizkallah and Bone 1998; Bradley, Mayfield et al. 2002; Stewart, Taukei et al. 2008). Bradley, Mayfield et al. (2002) draw our attention to the importance of participatory techniques in achieving sustainability via issue identification and resolution, programme design and evaluation procedures, leading to mounting evidence of positive results. Altman (1991 p300) stresses the significance of active participation of

community members and various organizational constituencies, noting that they are ‘a critical factor in improving community health promotion services offered, the health status of community members, and the long term viability of institutionalisation of programmes and organizations’(Altman 1991). The WHO’s Strategic Approach to SRH also explicitly links participation to sustainability, noting that such an approach:

> fosters consideration of the views and needs of community members and [other key stakeholders] – and helps to build consensus among them, thereby increasing the likelihood of sustainable policies and programmes (WHO 2007).

Community participation, moreover, is intrinsically linked with community empowerment and community capacity building; these, in turn, further contribute to sustainability and the long term viability of health programmes. The Ottawa Charter describes community empowerment as occurring when communities have ‘ownership and control of their own endeavours and destinies’ (WHO 1986 p3). Commitment to a health programme is more likely when communities feel a strong sense of ownership of it, particularly, as Laverack (2008 p199) points out, if the programme has been designed to address a problem ‘identified by the community concerned rather than an outside agent’. Stewart, Taukei et al. (2008 p164) agree, noting that ‘having interested and knowledgeable local people who have “ownership” of a project is the key to sustainability from a human resource perspective’ and that ‘real success is concerned with the empowerment of local people and the long term sustainability of project outcomes’.

Community capacity building, a concept closely related to community empowerment, may be defined as developing the ‘assets and attributes of a community through improvements in skills, knowledge and competencies’ (Laverack 2008 p201). Many authors have stressed the vital role that capacity building plays in ensuring the long-term sustainability of a health programme (Shediac-Rizkallah and Bone 1998; Macfarlane, Racelis et al. 2000; Laverack 2008; Stewart, Taukei et al. 2008). Capacity building builds on *existing* community resources and fosters *existing* networks, thus developing within the community itself a sense of achievement, empowerment and an ability to address

their own health issues in a culturally appropriate way. According to Laverack (2008 p207), 'outside agents' can be important facilitators of this process, but their ultimate aim should be to 'transfer responsibility to the community through a systematic process of capacity building', so as to reduce the latter's reliance on external assistance (see also LaFond, Brown et al. 2002). Capacity building is thus seen as a vital tool for achieving sustainability via the transfer and development of resources and skills.

Whilst there is a considerable literature discussing the importance of the participation, empowerment and capacity building of the community at large in health programmes, there is, by comparison, little that discusses the role of the vulnerable and marginalised, such as sex workers (SWs), people whose voices are so often not heard. Encouraging participation as well as building the capacity of this frequently stigmatised, socially isolated and often highly mobile group can prove easier said than done. Yet Dorf (2006) argues that enabling the participation of SWs in the design and implementation of SRH programmes, laws and policies is essential, both ethically and pragmatically, if these measures are to achieve their ultimate goal of protecting the SWs' health and civil rights.

Tsey (2008) agrees, citing the WHO Health Evidence Report which found that when socially excluded populations worked with participatory empowerment interventions, this led to empowerment on many levels – psychological, organizational and community – as well as to improved health outcomes and quality of life. Parker, Easton et al.'s (2000 p5) 'participatory and collaborative forms of action research' with vulnerable women from a Hmong hill tribe from Northern Thailand, also sought to 'redefine the gendered social roles and socioeconomic conditions that contribute to the spread of HIV'. They have demonstrated that having SWs actively participating in SRH programmes can potentially move toward addressing some of the structural determinants of their (ill) health.

As these authors have documented, working with marginalised groups can lead to improved, potentially sustainable, health and other life outcomes for the groups concerned. That is not to downplay, however, the practical difficulties of involving what are often highly mobile groups in such initiatives. This has proved difficult for both

RHIYA in Laos and SiRCHESI in Cambodia as this study will show. Nonetheless, the importance of working *with* marginalised groups, not just *for* them, cannot be overstated.

As indicated above, community participation, community empowerment and capacity building are crucial operating principles in achieving sustainable health outcomes from health programmes, yet they may not hold all the answers to the problems at hand. Morgan (2001 p227) rightly contends that many other factors, such as the political, economic and social context contribute to successful, sustainable health programmes. Laverack (2008 p206) warns that 'in many developing countries the resource opportunities are minimal and political and economic constraints many'. In such circumstances, community members, especially those from marginalised and disenfranchised communities, do not necessarily have the time or resources to become fully involved in health programme design and delivery.

This is particularly the case given the time-consuming and 'long haul' nature of participation and participatory techniques, as documented by Bradley, Mayfield et al. (2002) and Jacobs and Price (2003). These authors argue that sustaining the involvement of local people is not only time consuming for all involved, but may also require external support for a period of time 'before concrete results are realised' (Bradley, Mayfield et al. 2002). However, gaining such support from external donor organizations, the most likely funders of such initiatives in resource-stretched developing countries, can be problematic. The short-term, results-driven funding horizons of many such organizations mean that they are not always willing to invest when the returns are only evident in the longer term.

The goal for any health programme, however, should be that community stakeholders, the people who *really* own the activities, have the resources, knowledge and skills for sustained continuation of the work (Stewart, Taukei et al. 2008). One important goal of this research is to explore whether this has been the case with the SRH education initiatives undertaken by RHIYA and SiRCHESI in Laos and Cambodia.

b) Embedding the Programme within the Government as a Tool for Sustainability

The above discussion has emphasised the vital role of community participation but, as Midgley (1986 p vii) points out:

> …you cannot ignore the activities of the state in social development. It is naïve to argue that state involvement in social development is superfluous and that local communities in the Third World can solve the serious problems of poverty and deprivation wholly through their own efforts (Midgley 1986 p vii).

Despite the fact that community participation may be the desirable goal, it is imperative to also build the capacity of the state and to encourage the state and the community to work together in key areas of social development such as improved SRH.

This argument echoes the Ottawa Charter's emphasis on the vital role that governments play in ensuring the sustainability of health programmes by constructing healthy public policy that can maintain such programmes or aspects thereof (WHO 1986). According to Pluye, Potvin et al. (2004), healthy public policy, which they define as 'relatively broad patterns of action that are recommended or enforced by public authorities in relation to a problem set by the public agenda' are, like institutions, comparatively durable (Pluye, Potvin et al. 2004 p125). These authors talk of the potential to achieve sustainability via such policy. When a programme introduces a new policy or becomes integrated into organizational routines it is thereby more resistant to change. Thus government policy can potentially increase the likelihood of sustainability of an SRH initiative via the institutionalisation of policy.

The latter argument, however, assumes that institutions are stable (Pluye, Potvin et al. 2004), but in developing countries such as Laos and Cambodia this is not always the case. There is much political, economic and social instability which can present obstacles to achieving sustainability via government policy. Healthy public policy can enhance sustainability of programmes, their health benefits, and help make good practice into policy, but the necessity of developing the capacity of the deficient public health infrastructure in developing countries needs to come first. This makes it all the more important to not only build the capacity of the government and/or of the community, but

to actively encourage a working relationship between both. This is the principle adopted in the WHO's Strategic Approach to Strengthening SRH Policies and Programmes, which is based on collaboration between the public health sector, NGOs, international agencies and the local community. The overall context of each country's health system as well as the broader political and sociocultural environment are all taken into account which clearly influences the feasibility, effectiveness and sustainability of SRH programmes.

As noted earlier, there is a need to build the capacity of the deficient public health infrastructure in developing countries such as Laos and Cambodia. But when funding is inadequate, what will often be found is overstretched and underpaid local staff trying to balance huge workloads in vastly under-resourced public health systems. By doing their own often poorly paid government jobs, while trying to balance contributions to community-based programmes (the wearing of 'two hats'), a stretching of the capabilities of the staff may occur. Jobs can be compromised due to conflicting and overlapping schedules. This potential downside of a 'government embeddedness' sustainability strategy will be considered for both RHIYA Laos (Chapter 4) and SIRCESI (Chapter 5).

2.8 CONCLUSION

This review of the sustainability literature has identified the importance on this concept in health programme planning, design and implementation and some of the main approaches (and barriers) to achieving it. It has also identified a set of sustainability benchmarks which will be used to assess the sustainability of RHIYA Laos' and SiRCHESI's SRH programmes in the chapters that follow. Perhaps what is most clear from this survey of the literature is that there is not one simple or magic solution, no one factor that will ensure the sustainability of a successful SRH initiative. The factors that contribute to the sustainability of health and specifically SRH programmes are many and complex. The need to develop sustainable SRH programmes, however, is critical and urgent, especially as many SRH problems such as HIV/AIDs have far-reaching and dire consequences. It is of the utmost importance that successful health programmes do become sustainable to

give the young people of Laos and Cambodia the opportunity to live full and healthy lives.

CHAPTER 3
METHODOLOGY

3.1 INTRODUCTION

Evaluation, using qualitative and quantitative research methodologies, is essential to determine what makes for a sustainable SRH education initiative. In this chapter I briefly outline the main methods I used to conduct my evaluation of the sustainability of the RHIYA Laos and SiRCHESI programmes in order to answer the key research questions outlined in Chapter 1. As highlighted there, one of my main goals in conducting this research was to gather evidence that could potentially contribute to the way SRH programmes are run, with further emphasis being placed on post-programme continuity and the various ways to achieve sustainability.

A combination of qualitative and quantitative research methods was used in my attempt to answer the research questions both 'fully and ethically' (Monk and Bedford 2005). A range of quantitative data were collected and analysed in order to establish the 'macro' context in which the SRH programmes operated (geographical, political, socioeconomic, operational, etc). Qualitative methods of research, including fieldwork, made it possible to look at the 'micro' level and give voice to the people involved in running the actual programmes. This was done by means of interviews with senior project staff from RHIYA Laos and SiRCHESI's SRH programmes.

Formal ethics approval for the study was granted by the Macquarie University Ethics Committee (Human Research) on 5 September 2008. Some of the key ethical issues faced during the study included: informed consent; confidentiality and privacy; cultural and community sensitivity; and the provision of feedback to participants. Ethical considerations are discussed in more detail below.

3.2 FIELD TRIP

Fieldwork 'involves the negotiation of complex relations, interests, situations and logistics' (Scott, Miller et al. 2006) and this certainly proved to be the case during my two week field trip to Vientiane, Laos and Siem Reap, Cambodia in January 2009. (Two interviews with senior SiRCHESI staff were also conducted in Australia, as per the interviewee's availability.) The need for flexibility was fully anticipated whilst undertaking this fieldwork: as a lone researcher, I needed to be adaptable when situations change, as advised by Connor, Treloar et al. (2001). Trying to lock in interview schedules with, and gather data from, senior project staff at RHIYA and SiRCHESI proved challenging at times due to difficulties in organising transport and venues as well as the availability of interviewees.

Qualitative data was collected by means of a series of semi-structured individual interviews with four senior staff from RHIYA and three senior staff from SiRCHESI. The Director of the Vientiane Youth Centre was also interviewed (a list of those interviewed, and their job titles, is at Appendix 1). No interpreter was required as all interviewees spoke English. All interviewees signed an information and consent form prior to the interview taking place.

Following Connor, Treloar et al. (2001), the interviews can be characterised as 'semi-structured'. A pre-defined set of questions was used to guide and standardise the information gathered (see list of questions at Appendix 2). The overall aim of these questions was to explore what obstacles and challenges each interviewee had encountered when striving for sustainable SRH initiatives, as well as their views of which methods and practices were successful, and which were not. Less structured questions were then asked to further investigate the information ascertained. This latter technique enabled the participants to not be limited to only answering the set questions; informants were also able to express their own understanding and opinions on certain issues more conversationally. Detailed notes were taken during the interviews and transcripts from the

recorded data were made. Follow up questions or clarification post-interview was carried out via email.

There were a number of ethical considerations to take into account in the interview process. Scott, Miller et al.(2006) state that 'we all embark upon research with "maps of consciousness" which are influenced by our positionality and perspectives shaped by our own unique mix of class, gender, nationality and other identities'. The concepts of gender and foreignness were kept in mind whilst doing this research; they may have helped some people open up, whilst others may have seen it as a barrier, viewing the interviewer as an 'outsider'. Being an 'outsider' to the research participants has its positive and negative aspects. It can bring benefits to the research, as Dowling (2005) points out, as it can lead to research participants making 'more of an effort to clearly articulate events, circumstances and feelings to the researcher'. But it can also have its downsides, if 'insiders' do not feel sufficiently trustful of the 'outsider' to disclose important and/or sensitive information.

The importance of cultural sensitivity cannot be underestimated and was an important aspect in approaching this research. Being sensitive to the interviewees' needs and not being critical in any way of their behaviour, views or rationale was paramount. Connor, Treloar et al. (2001) emphasise that research on sensitive or illicit topics is likely to require the establishment of rapport between researcher and subject. It was important to be professional and remain mindful at all times and use direct questioning and observation techniques whilst not asking controversial, difficult or insensitive questions. It was particularly important to allow the space to discuss issues as sensitive as sexual and reproductive health. A range of other ethical issues were taken into consideration whilst undertaking the interviews; these are summarised in Appendix 3.

3.3 DATA ANALYSIS

As noted earlier, a range of quantitative data was collected and analysed in order to 'set the scene' in which the SRH programmes operated: geographically, politically, and socioeconomically. Statistical health data were also collected and analysed. Such data

were drawn from the Lao and Cambodian Governments (Ministry of Health), WHO and the UN. Surveys, statistical data, and programme materials containing information on health status were also examined. For example, CARE baseline and endline surveys directly related to the RHIYA Programme were used to gain insight into basic SRH knowledge before and after the peer education programme and thus provided a basis to assess what success was had by programme participants in regards to their health knowledge and practice post-programme. Anecdotal health statistics were also sourced from an interview with Prof Ian Lubek of SiRCHESI.

Whilst quantitative data such as these might be venerated as accurate and scientific, the validity of this assumption is wholly dependant on who collects it and the integrity of the methods used. Data collected from both 'official sources' and NGOs must be assessed on a case-by-case basis for its accuracy and reliability. As noted in Chapters 4 and 5, there were a number of concerns about statistical data integrity in this study, mirroring the experience of other researchers such as Scott, Miller et al. in Vietnam. As these authors observed: the 'difficulties and limitations related to the general lack of information and reliability of published materials, and the constraints faced by researchers accessing information from government institutions'. This was certainly my experience in Laos and Cambodia.

Other sources of data used as a part of the contextual analysis included a range of articles on vulnerable youth populations of Southeast Asia. Newspaper articles (for example from *Vientiane Times* or the *Phnom Penh Post*) on the RHIYA peer education programme and SiRCHESI activities and subsequent achievements were also used as a source of information, as were organizational newsletters and websites.

Qualitative data content from the interviews was coded and analysed whereby themes emerged and conclusions were drawn (see discussion in Chapters 4 and 5). In doing so I was guided by, and took into account, the information I gathered and evaluated during the Literature Review. Of particular importance in this regard were the sustainability benchmarks identified by Shediac-Rizkallah and Bone (1998): individual health benefits,

the level of institutionalisation of a programme within an organization, and capacity building in the recipient community.

The following two chapters discuss the key findings of my research.

CHAPTER 4
ACHIEVING SUSTAINABLE SEXUAL AND REPRODUCTIVE HEALTH EDUCATION IN LAOS: AN EVALUATION OF THE RHIYA PROGRAMME

4.1 INTRODUCTION

The following two chapters will present and discuss the findings from a fieldtrip to Laos and Cambodia carried out in January 2009 as well as two interviews that took place in Australia. Key informants interviewed were management and staff from RHIYA and SiRCHESI who were asked about the approaches and strategies they adopted to ensure their respective SRH education programmes were sustained beyond the initial funding period. In these two chapters I provide, for each programme, a discussion of the extent to which *planning* for sustainability was an explicit programme priority, the main methods or approaches they used to achieve sustainability in *practice*, informants' perceptions of the *barriers* to sustainability their programme encountered, and how they sought to address these challenges. I also assess how each programme measures up on the three key benchmarks for sustainability identified in Chapter 2: maintenance of individual health benefits; institutionalisation of the programme; and community capacity building. Chapter 4 addresses these questions in respect of RHIYA, while Chapter 5 does likewise for SiRCHESI. The latter chapter concludes with a brief assessment of the pros and cons of the two different approaches to achieving sustainability employed by RHIYA and SiRCHESI, laying the basis for a discussion of the implications and recommendations from my research which follows in Chapter 6.

4.2 RHIYA LAOS (VIENTIANE)

The Reproductive Health Initiative for Youth in Asia (RHIYA) was a three-year project funded by the EU/UNFPA. CARE Laos, a local NGO formed a partnership with the government-run Lao Youth Union to implement key components of the programme in the capital city of Laos, Vientiane. The Lao Women's Union was also involved in the

RHIYA programme through the establishment of the Vientiane Youth Centre (VVC). The overall goal of the RHIYA programme was to improve the SRH of the most vulnerable populations in the city, with a particular focus on sex workers (SWs). The multi-sectoral Project Working Team (PWT) responsible for implementing the programme utilised peer education as well as outreach activities as the main methods for achieving its goals. A brief overview of how the programme worked is found in Chapter 1 (Section 1.3), and further details of its operations are canvassed throughout this chapter.

4.3 PLANNING FOR SUSTAINABILITY

Shediac-Rizkallah and Bone (1998) highlight the importance of formulating specific sustainability goals, objectives and strategies if sustainability is to move from a 'latent goal' to a planned approach in health intervention programmes. There is little evidence, however, that RHIYA engaged in *explicit* sustainability planning in the initial phases of programme design. Sustainability appears to have been a somewhat lower-order priority, as the following quote from the RHIYA programme documentation indicates: '[RHIYA Laos aims to] build the capacity of the Lao Government, local NGOs and civil society as a whole to recognise and meet the sexual and reproductive health needs of adolescents and youth, using sustainable approaches, *where possible*' (RHIYA(a) 2003, emphasis added). Sustainable approaches were to be embraced in RHIYA, but apparently only 'where possible'.

Although planning for sustainability may not have been an explicitly-stated priority, the quote above mentions the key programme components and implementation strategies which RHIYA hoped would enable it to have an ongoing impact once the three-year project funding came to an end. Foremost amongst these was the strategy of embedding the programme in national organizations and institutions, such as the Lao Youth Union and Lao Women's Union, which in turn was seen as a method of strengthening and sustaining the Lao Government's commitment to SRH (RHIYA(a) 2003). Indeed, many RHIYA documents contain no further information as to how sustainability was actually going to be achieved, other than by building up national institutions and reinforcing the Lao Government's political commitment to SRH.

That said, the RHIYA documentation quoted above implies that a second key strategy was also seen as potentially enabling sustainability of programme outcomes beyond the three-year funding period. This strategy was to 'build the capacity of … civil society as a whole to recognise and meet the sexual and reproductive health needs of adolescents and youth' (RHIYA(a) 2003). As discussed below, one of the main means by which this was to be achieved in practice was through the use of the peer education model. Such a model not only enhanced the skills and knowledge of SRH issues amongst the programme's target group of vulnerable youth (especially SWs), but also those of the government workers involved in the RHIYA project. Beyond these specific groups, awareness of SRH issues amongst the community at large was also enhanced by RHIYA's use of a range of community participation and awareness-raising strategies.

Each of these *implicit* sustainability strategies – seeking to embed the programme in the Lao government, use of the peer education model, and adoption of a range measures to increase community participation – are discussed in more detail below.

4.4 ACHIEVING SUSTAINABILITY IN PRACTICE

a) Embedding the Programme in the Lao Government

The strategy of embedding RHIYA in the Lao Government was pursued in a variety of ways. RHIYA was carried out by a Project Working Team (PWT) made up of CARE staff, Lao Government staff (including from the Lao Youth Union, the Lao Women's Union and the Ministries of Health, Education, Information and Culture), as well as the Peer Educators (primarily drawn from the target groups of sex workers). The aim was to develop a direct working relationship with government staff, so as to maximise the chances of the programme being institutionalized in existing governmental structures, and hence capable of being sustained once the RHIYA project funding came to an end. Such an approach also enabled RHIYA to work toward its objective of '[enhancing] technical planning and managerial capacity among Government partners to provide appropriate, adolescent-friendly SRH information and services' (UNFPA(b) 2007).

RHIYA's approach in this regard was quite ground-breaking, as it was the first time that the Lao Youth Union had collaborated with an NGO such as CARE (CARE(Laos) 2006). It is also important to note that it was the first time that the Lao Youth Union led a team that focused on SWs, a particularly noteworthy achievement given that prostitution is illegal in Laos.

Another key means of implementing RHIYA's government-embedding strategy was through the establishment of the Vientiane Youth Centre (VYC). The VYC was set up and implemented by the Lao Women's Union under RHIYA and has since received technical assistance from many NGOs. The VYC was the first of its kind in Laos. The government-owned centre now employs three government staff; the rest of its total staff of 20 are employed on a project basis, with their salaries paid for by donor funding. The VYC has become a focal point for the youth in Vientiane. It acts as a drop-in centre, has a confidential clinic and counselling service, and operates peer education and outreach programmes in a youth-friendly environment. It is also home to a referral and counselling network that was created under RHIYA. The VYC has played a vital and ongoing role in increasing awareness and advocacy of SRH, as CARE Project Coordinator Suzie Albone explains:

> Having the Youth Centre, [with the] young people [involved]….and the CARE girls and all the sex workers just sort of hitting groups of young people and getting those key messages out…The Youth Centre was able to do that and is *still* able to do that and keep the messages [alive] (Albone 2009).

The PWT approach and the VYC were important steps in embedding the RHIYA programme in the Lao Government, but the implementation of this strategy was by no means problem-free. CARE's Albone (2009) points out that the structures of government in Laos are very top down and this can make it very difficult to get sufficient traction to achieve longer-term policy change. This is particularly the case on issues such as SRH, which are still considered marginal compared to the 'bigger picture' issues of poverty reduction and the like. An overall assessment of the extent to which RHIYA was successfully in embedding the programme in the Lao government is provided in Section 4.6 below.

b) Peer Education

RHIYA's Peer Education for Vulnerable Youth programme, overseen and implemented by the PWT, involved the running of SRH training sessions at various locations in Vientiane, the establishment of a number of drop-in centres, and a range of other outreach activities. SWs, bar girls and out-of-school youth were the main groups targeted by the programme. The Peer Educators (PEs) themselves were recruited from initial SRH training sessions run by the PWT. In total, over 700 PEs were trained during the life of the programme and they in turn made over 2,000 contacts with other young people (UNFPA(b) 2007). The PEs conducted training sessions at 132 bars and 24 nightclubs in Vientiane, distributed over 50,000 condoms and referred over 1,200 vulnerable youth to the SRH clinic at the VYC.

In addition to the PE training sessions, a key part of the Peer Education for Vulnerable Youth programme was the establishment of drop-in centres in each of the four districts in Vientiane. These centres were usually small rooms close to where the SWs and PEs lived. They created a space where SRH posters and information could be displayed and where free condoms were available. They were also a space where the vulnerable youth could feel safe and supported – a meeting point. A sense of belonging was fostered in the drop-in centres: SWs could gather there to 'hang out' and relax as well as gain information and advice, talk and share problems. The SWs related well to the PEs as they often worked together in the same beer shops, bars and nightclubs. This reinforced the importance of the drop-in centres as a focal point for the programme. They were viewed as happy and congenial places to gather and a supportive environment; one PE said that she 'felt warm' at the centre whereas before she had felt sad and lonely in the afternoons at home (Kirkwood 2006).

According to CARE Project Coordinator Suzie Albone, RHIYA's adoption of the Peer Education model described above was one of the most important means by which sustainability could potentially be accomplished in RHIYA. Peer education involves 'going direct' (Kirkwood 2006; Albone 2009) and, as Albone explains, this characteristic makes it a particularly valuable tool for achieving sustainability:

> The idea that you are going directly to young people …, and I hate that [phrase] "putting the knowledge", but you are developing the understanding and the information [about SRH] within that group of people, who can then share it - even through informal contact. And they carry on networking and you build a sort of critical mass of people with certain levels of knowledge and understanding, [as well as the] skills to be able to communicate it (Albone 2009).

Peer education allows a programme to form a critical mass of individuals with information and skills that will continue to spread the SRH message in the community, formally or informally, even after the funding for the specific project stops.

Tingthong Phetsavong, Senior Project Officer with CARE, agrees with his colleague about the effectiveness of peer education, emphasising that communicating the programme's objectives, especially around such sensitive issues as SRH, was easier for the RHIYA youth workers and PEs as opposed to other health professionals or members of the PWT (CARE or Government staff). Most of the PEs built on their existing relationships with the target group of SWs and the level of communication between them and the sex workers was thus more easily facilitated:

> The young people they feel confident and [found it] easy to talk with us [youth workers and PEs] to discuss [their concerns, as if they were speaking to] a brother or mentor (Phetsavong 2009).

Peer education allows SRH information to be shared in an informal way, in casual conversations, as the knowledge is there intrinsically within the group and is coming from their peers. As CARE's Albone points out, in a small town like Vientiane this 'does hold some sway' (Albone 2009).

Dalayvanh Keonakhone, the Managing Director of the Vientiane Youth Centre, agrees that peer education is a most effective method of ensuring sustainable health outcomes. She also emphasises the importance of using PEs with local links in getting the message across:

> You can ask a person to come out to a community [to deliver the SRH information], but when you have a PE that [grew] up [in] that community and [they are] talking with their own community, [it] is better ... The Peers working with[in] the area is the best, they understand each other, they know what happen[s] (Keonakhone 2009).

Use of local PEs, combined with their strong sense of commitment to their work – an attribute emphasised by Viengthong Manivone, now a Project Officer at UNFPA but who formerly worked at CARE on the RHIYA programme – made peer education an invaluable tool for bringing about more sustainable outcomes from the RHIYA programme (Albone 2009; Manivone 2009).

Becoming a PE did more than just enhance each participant's health knowledge: it empowered them, increased their status and potentially made them role models which in turn made them even more engaged and persuasive advocates for the programme. This in turn made it more likely that the programme would be both effective and sustainable. Albone elaborates on this point:

> Towards the end of the programme PEs had been given more responsibility, in their own villages, to plan and organise activities and even [manage] a little bit of budget at one point…These sorts of things meant that they were engaged, really in there perhaps, they had more responsibility and could make more decisions [and] they were [thus] more likely to sustain the project (Albone 2009).

But were there any downsides of using peer education to communicate SRH information in the RHIYA program? CARE's Albone acknowledges that:

> I have heard criticisms of peer education that it is very expensive for what you get: you train people up and they move on… I take the view that you are training people up and that in the long term it will be beneficial, [but] in the short term people want to see how much they *get* for their money. [And] they find peer education, because of the number of people who stop and drop out of it, means it is very expensive per head … (Albone 2009).

Albone firmly believes that the long term benefits from peer education can be substantial, although, as discussed below, measuring and demonstrating these (for example, to potential funders) can be problematic. This is especially so given the mobile nature of the target group. Having long term timeframes is essential in such programmes, as she explains:

> There is a lot of change that needs to happen. You need to work on change at the individual level – people's knowledge, understanding and attitude. [You also need to work on] change at community level [and] change at [the] national structure or level… And yes you can show them quick wings from the baseline on knowledge but if you want to go deeper there has to be longer time frames (Albone 2009).

An overall assessment of the extent to which RHIYA's peer education strategy was successful in enhancing the programme's sustainability, as measured against three key benchmarks, is provided in Section 4.6 below.

c) Community Participation

It is very important to get the local community involved in, and supportive of, SRH programmes, a point emphasised by CARE Project Officer Suzie Albone:

> What the RHIYA did with both CARE and the Youth Centre…was to build very strong community links, and keep it very low level (Albone 2009).

RHIYA involved the community in many ways: for example, by having stalls at the annual Rocket Festival and at World AIDS Day concerts. Advocacy and community involvement was also established, according to Viengthong Manivone, a former Project Officer with CARE, via the mass media:

> VYC also has a radio programme and a monthly magazine and they produce that and they have some activity like traditional music, vocational also and more activities in the community (Manivone 2009).

Links were also forged with local authorities to negotiate the entry of the RHIYA programme activities, such as peer education training, to their villages, thus laying the groundwork for enhanced community participation in the programme.

Informal community involvement in the programme also occurred when the neighbours of SWs started to approach them – something previously not done – with questions on SRH issues. Social norms can hinder health outcomes by way of discrimination and need to be addressed by the community as a whole. This is why maximising community participation in health interventions is such a vital component of ensuring their acceptability and ongoing sustainability.

There is some anecdotal evidence that the RHIYA programme helped improve the social standing of SWs by increasing awareness of the many challenges and discrimination that they faced. The Government staff on the PWT and the community as a whole learnt much

from participating in RHIYA. Viengthong Manivone points out that the Government counterparts look differently at the SWs now whereas previously the latter had been looked down upon and faced much prejudice:

> I think that also from the concern of the… government partner – the way they look[ed] at the sex worker[s]…they look[ed] down on them…[and] in terms of the RHIYA project when they work[ed] with them they [became] aware that the sex worker[s] also have to be support[ed] by society (Manivone 2009).

An overall assessment of the extent to which RHIYA's community participation strategy was successful in enhancing the programme's sustainability is provided in Section 4.6 below.

4.5 BARRIERS TO SUSTAINABILITY

As noted earlier, while up-front planning for sustainability may not have been a top-order priority in programme design, the RHIYA Laos (Vientiane) team responsible for implementing the programme on the ground were acutely aware of the barriers to achieving sustainability in practice. According to CARE's Suzie Albone, the whole nature of a short-term project approach to health interventions is, of itself, an obstacle to achieving sustainability:

> You get very intensive money coming in, [followed by] intensive working and training … and really, when the project finishes, even though capacity and skills might be built, I'm not always sure there is either the willingness or … the financial [capacity] … to keep it going or well monitored (Albone 2009).

Priorities change and/or another project comes along which, in a resource-scarce environment, inevitably takes the trained personnel, funds and impetus away from the 'old' project. Short term funding leads to short term projects, which in turn hinders making long term sustainable change.

Viengthong Manivone, who worked at CARE on the RHIYA programme, agrees that the short-term nature of one-off project funding is the most critical barrier to programme sustainability, especially in a country with limited financial capacity:

> Laos is a developing country … [with a government] reliant on budgets from [foreign] donors. If a project has no [on-going] money to support [it,] then the work does not continue (Manivone 2009).

If a project has been worthwhile, or at least some components of it, then alternative funding sources have to be identified and secured if the work (and good results) are to be sustained. This is what happened when the Vientiane Youth Centre (VYC) – which performed such a critical role in the RHIYA programme – was about to run out of funding and faced the very real prospect of having to close its doors.

With the Vientiane Youth Centre's (VYC) closure imminent, it became apparent that the only solution would be to seek further donor funding. Manivone (2009) talked of the UNDP stepping in and supporting the VYC until further funding could be secured:

> …if we stop at that moment then everything would stop so UNDP had to support them [VYC] even though it is not the mission of the UNDP (Manivone 2009).

According to CARE's Albone, Oxfam also stepped in to fill the breach: 'As they [Oxfam] were pulling out from [the peer education] sector in Laos', she reports, 'they decided to spend some money in the final year to support the sustainability of the VYC…to get funding for sustainability measures' (Albone 2009). This involved setting up a marketing department that was trained to put together proposals to send off to prospective donors, as well as making sure that the Centre's management was operating at a better standard, in order to satisfy prospective donors' quality assurance requirements.

This two-pronged strategy appears to have been successful, at least in the short to medium term. The VYC is currently supported by six donors ranging from UNESCAP to the Netherlands Embassy, according to the Centre's Managing Director, Dalayvanh Keonakhone (Keonakhone 2009). And, given that the VYC has put in place the marketing capacity and skills to apply for further grants, this in turn should provide sufficient support for maintaining such an integral part of SRH in Vientiane, at least for the foreseeable future. This is an important achievement, as Albone points out:

> So they [the VYC] have come through this very rocky road ... [and] weathered the storm... It's through the hard work of everyone to keep that centre going and then in turn that keeps peer education going, and that keeps reproductive health alive and that keeps a focal point also for the CARE PEs and sex workers as well (Albone 2009).

Another key barrier to sustainability identified by CARE's Albone derives from the nature of the programme's target group itself: vulnerable youth and in particular SWs. SWs in Laos are a socially marginalised and highly mobile group which makes monitoring them, their health needs, and health status difficult. 'The fact that the sex workers were very mobile was one of the biggest challenges CARE faced with sustainability,' she explains (Albone 2009). She points out that SWs are 'often not registered with the villages…and not well integrated into the community and so it is very hard to use the village and community structures to work with this group' (Albone 2009). This makes achieving sustainable change at a core village level challenging. In addition, and as discussed in more detail below, the mobility of the target group made documenting sustainable health outcomes from the RHIYA programme difficult. And if the benefits from health programmes cannot be measured and documented for donors, then acquiring ongoing or additional funding can be problematic. This lack of data also has ramifications for advocacy, as Albone explains:

> If you don't have your evidence for your impact then you can't advocate so easily, and then if you haven't got your enabling environment, then it's harder to get institutional change (Albone 2009).

Another barrier to sustainability identified by Albone ironically derives from the hard-working nature of the project staff implementing the RHIYA programme. She talks about how dedicated the staff at CARE were, how they worked on the project at weekends, and notes that, while that was great while it lasted, it is perhaps not the most sustainable approach to programme implementation in the longer term:

> That may not be the most sustainable way because when they are not there, there is a feeling that it would all just sort of slide… (Albone 2009).

Unless the programme activities can be resourced and institutionalised in such a way that would enable the very 'hands on' work to continue once CARE's involvement came to an end, the sustainability of the programme is put at risk.

4.6 ASSESSMENT OF RHIYA AGAINST KEY SUSTAINABILITY BENCHMARKS

In light of the previous discussion, this section assesses how the RHIYA programme measures up on the three key benchmarks for sustainability identified in Chapter 2: maintenance of individual health benefits; institutionalisation of the programme; and community capacity building.

a) Ongoing Individual Health Benefits to Participants

Even though the programme has not been rigorously evaluated (UNFPA(c) 2006), there is some quantitative evidence of the benefits that implementation of the RHIYA programme in Laos had for individual programme participants. The official RHIYA documentation states that 'comparisons of the RHIYA Lao Baseline and Endline surveys showed that the programme had strongly positive effects on young people's sexual and reproductive health knowledge and behaviour: almost all the indicators increased significantly'. The report goes on to note that:

> The changes were especially large among the most vulnerable groups (less-educated, poor and rural young people), confirming that RHIYA has contributed to greater equality across socio-economic groups in the project areas. Awareness of STIs increased by over 40% in rural areas and averaged 75% overall. Condom use also increased by 20%, mainly by young unmarried men. Among those who participated in RHIYA project activities, better knowledge and safer sexual behaviour was even more evident (RHIYA(b) 2007).

However, at a more disaggregated scale, measuring the benefits to the health of the individual programme participants has proved difficult for RHIYA in Vientiane. As noted earlier, RHIYA took place in Vientiane as well as in some of the rural southern provinces (in the latter provinces the RHIYA programme was implemented by an NGO called Health Unlimited). Baseline studies were carried out in Vientiane before the programme started and these showed SRH knowledge amongst vulnerable youth to be extremely low. The endline statistics provided above, however, are based on data from both regions. According to CARE's Albone, CARE's programme design of RHIYA in Vientiane did not take into account the very high mobility of the sex workers in that area. This meant

that the baseline surveys on SRH knowledge and attitudes were limited in usefulness, as endline surveys were not able to be carried out amongst programme participants in the capital city (Albone 2009). Albone speaks of the difficulty of capturing the impact of these SRH programmes for that very reason:

> It was the southern provinces and the youth centre that demonstrated a really good increase in knowledge and awareness of all the key [SRH] issues and even some behaviour change in the south - increased condom use, reduced pregnancies, unwanted pregnancies - and that was really great. But we couldn't capture that for CARE's [implementation of RHIYA in Vientiane] because of the nature of it, and we are having the same issues with [another] project as well … how do we measure impact? (Albone 2009).

It is likely that there were similar good outcomes in Vientiane, but Albone's comments highlight the problem of capturing these when the characteristics of the target group (especially mobility and marginalisation) make it hard to do 'before and after' surveys with them.

b) Institutionalisation of a Programme within an Organization

CARE's programme implementation of RHIYA in Vientiane involved working with (and within) the existing national structures of the Lao Government. In terms of the institutionalisation of RHIYA within the government, now that the project funding has ended, it has been the Vientiane Youth Centre (VYC) that has carried on many of the activities that RHIYA operated, as well as being the repository of the information, education and communication materials. It is interesting to note that while the Lao Government contributes the building itself, there are only three Government staff out of the 20 that currently work there. Other staff source their wage from foreign NGOs who fund various projects run through the VYC (Albone 2009; Keonakhone 2009).

As discussed earlier, the key focus at the end of RHIYA was to seek a sustainable funding source for the VYC as it was clear that the Lao Women's Union could not contribute financially to its ongoing operating costs. The strategy adopted was to build the marketing and management capacities of the VYC staff to enhance the Centre's appeal to foreign donors. This has been successful to date: having secured funding for the

short to medium term, the Centre has been able to continue to offer all its existing services (Albone 2009) and put itself on a more sustainable footing for the future.

A referral and counselling network for sex workers and vulnerable youth was set up by the VYC under RHIYA, and this has become 'strongly institutionalised' according to CARE's Albone (Albone 2009). It has now been incorporated into the Centre for HIV/AIDS/STI (CHAS), a formal part of the Lao Department of Public Health. The Lao Government, via the CHAS, has thus taken over the network and maintained it as a 'client orientated, SW friendly service - and that is brilliant and a great legacy from RHIYA' (Albone 2009). During the final year of RHIYA a hotline was also set up aimed at SWs and vulnerable youth to answer SRH questions and make referrals. Funding for the hotline has continued beyond the RHIYA project timeframe via the VYC, and private sector funding has enabled the hotline to become a free call which is a great advantage to those with little money, according to Tingthong Phetsavong, Senior Project Officer with CARE (Phetsavong 2009).

The initial RHIYA programme funders thus have some justification when they claim at least partial success in their sustainability strategy of embedding the project in the government:

> The project has made progress towards sustainability by developing strong ties with local government authorities and by diversifying its funding sources (RHIYA(b) 2007)

But while RHIYA helped to sustain and strengthen the Lao Government's commitment to SRH to a certain extent, in terms of policy, advocacy and health sector reform there is still a lot more work to do if SRH programmes in Laos are going to be put on a truly sustainable footing. These points are discussed in more detail at the end of Chapter 5 where the Pros and Cons of RHIYA's and SiRCHESI's approaches are considered.

c) Capacity Building

In terms of capacity building, RHIYA proved to be a significant learning experience for all involved, from the CARE staff who built on existing skills, through to the government

staff, PEs and SWs who had previously not worked together. Viengthong Manivone, who worked for CARE on the RHIYA programme, argues that one of the fundamental elements in achieving programme sustainability was to build the capacity of the Government staff that worked on RHIYA in the PWT.

> I think in term[s] of the [issue of] sustainability…we had [to] build capacity to the counterpart[s]...to the PWT (Manivone 2009).

This included the development of new managerial, clerical and organizational skills which led to an increase in the technical aptitude of those involved. Capacity was also built in the sense that the programme increased the government workers' knowledge about SRH issues and, as mentioned earlier, their appreciation of the SWs' plight. The skills learnt from RHIYA will be utilised by government participants on future programmes and thus contribute indirectly to successful and sustainable SRH programmes in Laos.

The PEs learnt vital SRH information and the methods of communicating this newfound knowledge to not only their peers but also the community at large. Their capacity was also built when their role was expanded to incorporate more responsibility. This included organising community events, doing more work locally, having a small budget to manage and increasing their advocacy role (Albone 2009). In sum, it is fair to conclude that RHIYA successfully built capacity of those involved whilst raising SRH awareness in the community at large.

CHAPTER 5
ACHIEVING SUSTAINABLE SEXUAL AND REPRODUCTIVE HEALTH EDUCATION IN CAMBODIA: AN EVALUATION OF THE SiRCHESI PROGRAMME

5.1 INTRODUCTION

In this chapter I provide, for the SiRCHESI programme, a discussion of the extent to which *planning* for sustainability was an explicit programme priority, the main methods or approaches used to achieve sustainability in *practice,* informants' perceptions of the *barriers* to sustainability the SiRCHESI programme has encountered, and how they sought to address these challenges. I also assess how SiRCHESI measures up on the three key benchmarks for sustainability identified in Chapter 2. The chapter concludes with a brief assessment of the pros and cons of the two different approaches to achieving sustainability employed by RHIYA and SiRCHESI, laying the basis for a discussion of the implications and recommendations from my research which follows in Chapter 6.

5.2 SiRCHESI

Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI) is a Cambodian NGO that focuses on HIV and related illnesses in Siem Reap. It utilises participatory action research (PAR) and adopts a 'hybrid model of capacity building' aimed at strengthening the public health sector rather than depleting its ranks (SiRCHESI 2008). SiRCHESI runs two main programmes aimed at improving the SRH and status of SWs in Siem Reap, particularly targeting those who work for beer companies and at entertainment venues: the Peer Education/Outreach programme and the vocationally-oriented Hotel Apprenticeship Programme. These programmes have been funded by grants from the Elton John AIDS Foundation, M.A.C. AIDS Fund, Rotary International, as well as from revenue gained from the NGO's own fundraising activities. A brief overview of how the programme works is found in Chapter One (Section 1.3), and further details of its operations are canvassed throughout this chapter.

5.3 PLANNING FOR SUSTAINABILITY

From its inception, SIRCHESI has operated within a participatory action research (PAR) framework, which has involved the development of multidisciplinary, multi-sectoral, ongoing health programmes embedded within the local community. Such an approach has sustainability as an implicit objective, yet Professor Ian Lubek, the founding member of SiRCHESI, is frank in his admission that up-front *planning* for sustainability (or at least financial sustainability) was not necessarily given the priority it deserved:

> For the first 3 or 4 years we didn't know what sustainability meant, it was only when our funding agencies said that "you can't keep coming back and renewing, you've got to make this self sustaining" that we began to think about [it] (Lubek 2009).

Lubek is quick to add, however, that SiRCHESI's emphasis on capacity building – an approach it has adopted from day one in its SRH Peer Education/Outreach programme – has formed a basis that sustainability could subsequently be built upon:

> [One] aspect of sustainability is what we would call capacity building; that is, leaving some skill behind us when we leave so that the work can go on, and I think we were always very much tuned to capacity building (Lubek 2009).

It is also the case that planning for sustainability has evolved as SiRCHESI's work has progressed. Over time the organization has seen the need to adopt new approaches and devise new programmes in order to address some of the *underlying* social and economic problems responsible for the high rates of HIV and other STIs in Siem Reap. Lubek talks of poverty, gender and low wages directly driving these health problems, hindering the achievement of sustainable health outcomes from Peer Education/Outreach programmes alone:

> What drives … all of these illnesses is poverty…We found that the women were selling sex because they couldn't afford not to …The beer girls or beer sellers who had 3 or 4 family members that they are supporting and no other bread winner in their household - that's where they ran out of options of what else could they do ... [They receive] $55 per month from a beer company, ... [but] they needed to make $110 dollars a month [to survive]. And when the beer companies are paying exactly half of what they needed, many found part time jobs in the marketplace, but about half ended up selling sex (Lubek 2009).

Dr Sarath Kros, Project Director of SiRCHESI and head of the Provincial Aids Office (PAO) in Siem Reap, agrees that it is the 'social and economic environment ..., the literacy rate, everything like that' that needs to be addressed if sustainable health outcomes are to result from SiRCHESI's activities (Kros 2009). He, too, emphasises that many girls have little or no other choice than to become sex workers to earn a living.

Recognition of this situation led SiRCHESI to shift its planning horizons to consider how socioeconomic factors – the underlying or structural determinants of ill-health, including high rates of HIV infection – could be addressed in its work. SiRCHESI decided it wanted to offer young, vulnerable women the chance to break out of the trap of poverty, illiteracy, lack of education and few opportunities of employment. It planned to do so via vocational retraining in the Hotel Apprenticeship Programme. This programme offers the beer girls the chance to work in a safe workplace away from the alcohol, violence and sex work that came with selling beer for little earnings. As Kros says:

> If we can move the girls from [an] unsafe workplace to the safe workplace they can work in a place that they don't have any risk with the HIV infection or another STI (Kros 2009).

The Hotel Apprenticeship Programme also represented a step towards planning for greater financial sustainability for SiRCHESI's work by attempting to get the local hotels to see the benefit of the programme with the hope they would take over the running and funding of the programme in the longer term. (See below for more details of the Hotel Apprenticeship Programme.)

5.4 ACHIEVING SUSTAINABILITY IN PRACTICE

a) Community Participation

SiRCHESI has placed much importance on community embeddedness and participation, especially by way of PAR, which has been the organization's defining characteristic. PAR is an approach 'based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health' (Baum, Macdougall et al. 2006 p854). PAR is about

working in partnership with communities whilst acknowledging history, culture and local context (Baum, Macdougall et al. 2006).

The potential effectiveness of a PAR approach has been enhanced as SiRCHESI's establishment has coincided with SRH issues coming to the fore in Cambodia due to the rise in HIV infection rates. SRH issues are now more open to community debate and community involvement in programmes addressing them (Kros 2009). One measure of PAR's successful implementation in SiRCHESI, as noted by Neela Griffiths, the organization's Assistant Programme Manager, is 'the fact that 95% of people involved in the project on the ground are Cambodian' (Griffiths 2008). This is important for sustainability, she explains, as it means that if and when the foreign advisors such as Lubek leave, the work can theoretically continue, as the expertise is resident in the locally-based staff of SiRCHESI.

By using a PAR model, SiRCHESI has involved many stakeholders in the community, from the PAO to local clinic staff and other NGOs operating in the community. This methodology has enabled a feedback loop directly from the community at a grassroots level as Lubek points out:

> We are a grass roots-directed organization; in other words we use the PAR model. And that means basically always using these feedback loops of the community at grassroots level: what questions do they need answered next or, from their own behaviour, what [interventions do] they need [to be] done next (Lubek 2009).

An example of how the feedback loop has worked in practice illustrates this point. SiRCHESI runs a community monitoring programme through Mondul Moi, the local clinic and confidential HIV testing centre. Health questionnaires are collected from 560 patients per year (of the 3,000 or so that attend the clinic), comprising four main groups: married women, men, sex workers (from brothels) and beer sellers (who are considered indirect sex workers). This data, according to Lubek:

> [enables] a longitudinal study of the changes in behaviour and, ... in a sort of feedback loop, that helps us direct what our educators are going to do in the coming year. So if we see a change in community behaviour like condom use, for example, we can alert our educators [and the education programmes can be tailored accordingly] (Lubek 2009).

For example, in 2002-03, the clinic data indicated that many men had stopped using condoms. Upon questioning, the men claimed that the condoms were being poisoned by the Vietnamese. The health education that was being carried out by SiRCHESI then addressed this misconception by assuring the men that the condoms were from Indonesia and not transported anywhere near Vietnam, thus allaying their concerns (Lubek 2009).

Another important form of enabling community participation, via community partnerships, has been the development of SiRCHESI's Hotel Apprenticeship Programme. This programme aims to provide young women with the opportunity to break out of the cycle of low paid work selling beer in restaurants and bars. The beer bar girls' meagre incomes, too little to survive on, are often supplemented via indirect sex work, usually whilst under the influence of alcohol in potentially harmful amounts. But their options for alternative employment are limited as they generally have minimal education, little English, and poor Khmer literacy. The Hotel Apprenticeship Programme was designed to address these problems by enabling the beer promotion women to upgrade their skills and gain valuable work experience in the hotel industry, the main source of income for the town of Siem Reap.

From its inception, the Hotel Apprenticeship Programme was developed as a community partnership. The programme involves participants learning English, Khmer reading, health education, social and life skills in SiRCHESI's school and undertaking an eight month apprenticeship with various participating hotels in the town. The hotels pay part of the participant's wages while they are in training and SiRCHESI supplements this amount to provide them with a 'fair wage' they can live on. The hotels also provide mentoring for the participants and their apprenticeship is followed by a 16 month permanent contract with the hotel. To date the Hotel Apprenticeship Programme has had two cohorts graduate, involving about 26 participants in total. Although, as discussed later, this Programme has faced a number of difficulties in its implementation, it, along with PAR, is another example of SiRCHESI's commitment to working *with* the local community in order to enhance the sustainability of its health-related interventions.

b) Peer Education

SiRCHESI's Peer Education/Outreach programme has been operating since 2002. Working closely with the PAO, the outreach programme runs health promotion activities and workshops that target beer promoters, married women and men and the young vendors around Angkor Wat. Topics include SRH, HIV and other STIs as well as alcohol-related harm reduction. There are currently 22 outreach workers who reached almost 8,000 people in and around Siem Reap in 2008. Lubek believes that, of all SiRCHESI's activities, the Peer Education/Outreach programme has probably made the biggest contribution to achieving sustainable health outcomes in the community:

> I think [peer education has] been one of our best programmes … The education programme was dear to my heart: as an educator to create a school out of nothing and see women's lives transformed was really quite excellent ...(Lubek 2009).

The peer education model builds capacity within communities by implanting knowledge and skills, as Sarath Kros, SiRCHESI's Project Director explains:

> Peer education is the most effective [method]…they can speak…they have the same career, they are friends…it is the most effective approach to [SRH] (Kros 2009).

Records have been kept as to where the PEs have done the training and biographical and behavioural information on participants has been sourced from questionnaires. Through the peer education methodology, 'we have trained local people to use all the questionnaires, [they] are bilingual and they are now completely self sustaining in using that methodology' (Lubek 2009). As a result, these skills can be utilised both now and in the future.

c) Embedding the Programme in the Cambodian Government

SiRCHESI has consciously adopted the strategy of employing staff who also work for the Cambodian Government. In particular, SiRCHESI works closely with the PAO in Siem Reap. The head of the PAO, Dr Sarath Kros, is also the acting Project Director for SiRCHESI. Many other staff at SiRCHESI also 'wear two hats': they work for the government (PAO, Department of Health or Department of Women's Affairs) as well as

SiRCHESI. They do so, in fact, on the *proviso* that they maintain their government jobs, this is to ensure that the good workers are not poached away from the public sector, as Lubek explains:

> If you come in with money you will destroy the public health service…Every other NGO came in and grabbed the best doctors out of the hospitals or from each other…We decided not to do poaching right from the very beginning... [Instead,] it would be [the] hybrid model of capacity building…All the staff we took from the public health sector would keep their jobs in the public health [system] …and because we took [Sarath Kros] as the director of the NGO, because he was the head of the PAO, he was able to jointly programme his staff [and hence minimise conflicting work schedules] (Lubek 2009)

There are other ways in which SiRCHESI's work has been embedded in the local government. During the first six years of operation (2001-2007), SiRCHESI held an annual conference which brought together many stakeholders in Siem Reap: other NGOs, beer sellers, children that sell goods around Angkor Wat. This created 'synergies between stakeholders' (Lubek 2009) and proved a valuable forum for the exchange of information. The local government then started running similar meetings every two months; SiRCHESI's annual meeting were no longer necessary as this job was now being done elsewhere. This is a good example of how SiRCHESI has helped to ensure sustainability by (de facto) institutionalising parts of its programme within the government.

In sum, for SiRCHESI, the idea of embedding the programme in the government *or* embedding it in the community has not been an either-or choice. As Lubek (2009) comments: 'we were lucky because we could play both'. Kros (2009) refers to this association as 'partners for development': when an NGO (local or international) works together with the government on programmes for mutual benefit. It is interesting to note that in Siem Reap alone, the PAO works with 35 NGOs. It is clear that local government support is essential if health programmes in Cambodia are to be sustainable and successful. SiRCHESI has recognised and incorporated this principle through its hybrid model of capacity building.

5.5 BARRIERS TO SUSTAINABILITY

SiRCHESI was formed in 2000 and has been in operation for 9 years. In terms of the life span of community-based health programmes in the developing world, this is considered a long time. According to Lubek (2009), it is rare to find a researcher who wants to do a project for more than one or two years, and even rarer to find a funding agency that will fund for more than one year, let alone more than two. Yet embracing a long term approach to ever-present problems such as HIV is crucial if sustainable gains are to be made in community health. Persistence has directly contributed to SiRCHESI's relatively long run (Lubek 2009). SiRCHESI's initial funding, in the form of small, short-term grants, came from the Elton John Foundation and M.A.C. AIDS. This funding allowed a local structure of staff to be recruited to run the community surveys, workshops and Peer Education/Outreach programmes. The grants generally had a one-year time frame, but SiRCHESI was habitually successful in 'stretching these to two' (Lubek 2009).

The difficulty in obtaining longer-term financial support for SiRCHESI's activities is identified by the organization as one of the most critical barriers to its ongoing success and sustainability. Lubek says SiRCHESI 'tried everywhere' to get 8 or 10 year funding, but to no avail (Lubek 2009). As Lubek argues, it is hard to see how short term projects can create truly sustainable change in the community when it can take an organization many years to get the required infrastructure in place:

> You can't just abandon people in the middle of a programme because you have one year funding … And that's the sustainability of implanting structure: … you need enough funding to plant those seeds to let it grow. In our case that took almost 10 years (Lubek 2009).

Acknowledging the inherent problems in relying on short-term grant funding to ensure on-going financial sustainability, SiRCHESI decided to try a new tack when it set up its Hotel Apprenticeship Programme in late 2005. In aiming for sustainability SiRCHESI intended to share the costs of running this programme with the hotel partners, achieving 'sustainability through community partnerships' (Lubek 2009). The hotels pay part of the participant's wages while they are in training and SiRCHESI supplements this to provide

participants with a ‘fair wage’ they can live on. SiRCHESI’s aim from inception of the programme was to transfer the entire costs to the hotels in 2-3 years time, once the programme’s benefits to industry had been established. Yet, according to Lubek:

> We found out that a partnership between a humanitarian NGO that saves women’s lives and a business such as hotels that are trying to make money for the owners of the hotels don’t always mesh… The world of public health and the world of business are not the same - they speak different languages. They [the business sector] speak a language of profitability and shareholders and dollars, and we are talking about women at risk in the workplace (Lubek 2009).

Regrettably, a number of the hotels seemed to view the Hotel Apprenticeship Programme as a short term supply of relatively cheap labour which they would no longer require once the training (and wage supplementation) had come to an end. They were unwilling to pay the women more money at the end of their contract, and, with an abundant supply of cheaper labour on their doorstep, there was little incentive to keep them on. Nor did the hotels always let the women use the new skills they had acquired: despite the intention of the programme for this to occur, some of the hotels were reluctant to promote the trainees as they acquired new skills. Lubek acknowledges these problems with the programme’s implementation, reflecting that ‘we were naïve about making it sustainable in the community’ (Lubek 2009)**.** To date no further funding has been acquired for the Hotel Apprenticeship Programme, which will see the programme come to an end in 2009 (Griffiths 2008; Kros 2009; Lubek 2009).

In sum, the key barriers to sustainability for SiRCHESI have been the difficulties in securing ongoing, longer-term funding for its programmes, and in particular a lack of willing participation and support from the hotels for the Hotel Apprenticeship Programme.

5.6 ASSESSMENT OF SIRCHESI AGAINST KEY SUSTAINABILITY BENCHMARKS

In light of the previous discussion, this section will assess how the SiRCHESI programme measures up on the three key benchmarks for sustainability identified in Chapter 2: maintenance of individual health benefits; institutionalisation of the programme; and community capacity building.

a) Ongoing Individual Health Benefits

There are problematic issues with official data collection, data reliability and data availability on HIV prevalence rates in Cambodia. The Cambodian Government publish the data several years after they are collected, and, since 2002, the HIV rates have been published not by individual provinces, but by grouping provinces together. This practice may mask the actual extent of HIV in particular provinces: 'they might mix two high instance provinces with two low instance ones', SiRCHESI's Lubek observes. 'This is the politics of AIDS: … there is a whole politics about how the national AIDS prevalence rate is calculated' (Lubek 2009).

It is thus not possible to access or present official data on HIV prevalence for the Siem Reap area for the purposes of this research. Nonetheless, Lubek cites some impressive quantitative evidence of apparent improvement in the health status of one of SiRCHESI's key target groups in Siem Reap, the beer sellers:

> When we were starting up [in 2000], the average [HIV] prevalence rate was about 20% for the beer girls and higher [42%] for the sex workers [in the brothels] … Then the rates really started dropping for the sex workers in brothels after about 2004 [as a result of government-funded and other interventions targeting this group]... Literally [the HIV prevalence rate for the brothel workers] is 1.4% [now]: there are hardly any cases in the brothel workers. Same thing for the beer girls: it was 20% in 2000 [and] it is close to zero now (Lubek 2009).

Whilst it may be difficult to determine the exact role that SiRCHESI has played in directly contributing to this impressive decline in HIV prevalence, there is little doubt

that SiRCHESI's efforts would have made some contribution. That said, it is important to acknowledge that there are many other stakeholders that have also played a role, including the local Government and the 35-plus NGOs operating in Siem Reap.

It is also worth noting that, while the Hotel Apprenticeship Programme has had its share of problems, the outcomes for some individual participants have been substantial. For those beer promotion women who have participated in the programme and gained new skills, improved English and Khmer literacy, SRH education and new opportunities for employment, the change in their lives has been remarkable.

b) Institutionalisation of a Programme within an Organization

As noted earlier, many of the SiRCHESI staff 'wear two hats': they work for the government as well as for the NGO itself. This has been an explicit strategy of SiRCHESI designed to strengthen (rather than deplete) the ranks of the Cambodian public sector. However, it has also had the additional benefit of potentially providing a means by which SiRCHESI's programmes can be put on a more sustainable footing. For example, the Peer Education/Outreach programme that SiRCHESI has been running will, at least in theory, be sustained if SiRCHESI ceases to operate, because the government staff are able to take over and continue running the programme, according to SiRCHESI Project Director Sarath Kros (Kros 2009). The Peer Education/Outreach programme has been successful in becoming institutionalised within an existing structure: the PAO.

Thus, by working with the local Government, SiRCHESI has built capacity and enhanced their skills base, whilst not removing staff from the under-resourced public sector. However, the question remains as to whether the government will have sufficient funds to keep these activities going in the longer term – and the initiative to utilise these newfound skills, as Lubek explains:

> [An] area where we were naïve [is that] most of our staff are civil servants who are used to behaving in a civil service manner. There is a hierarchy with bosses, the government, [etc] - there is a politics there and you don't say certain things or you get fired. And so they are somewhat timid about doing new things ... (Lubek 2009).

This unwillingness to take initiative has meant that opportunities to expand SiRCHESI's activities have to some extent been missed:

> We never developed a local group who could go forward, knock on the door of a hotel and say "we do these wonderful workshops, your staff need to know [about] SRH, we can do a whole day for all your staff for $200 dollars" … They've got the skills ... but they don't sell the skills or market them (Lubek 2009).

While it should also be acknowledged that there are many structural barriers such as working in a top-down, anti-private-enterprise system that work against taking initiative, the lack of marketing ability may represent a threat to the longer term sustainability of the Hotel Apprenticeship Programme in particular. It is a very real possibility that SiRCHESI (at least in its current form) might not be around in Siem Reap for much longer if sustainable longer-term funding cannot be sourced. As Lubek declares, 'the goal of all NGOs is to make themselves disappear after they have transferred all their skills to the public health sector' (Lubek 2009). However, it would be a great pity if, through lack of adequate resources in the public sector to keep the programmes going, the transferred skills cannot be deployed in the future.

c) Capacity Building

SiRCHESI's hybrid model has enabled capacity to be built with international advisors and local government members working together on SRH programmes to benefit the local community. Cambodian capacity has been built as a result, by bringing in people with skills to help the government. Yet capacity building is always a *two-way* process, with learning happening on both sides of the equation. The international advisers, like Lubek, have also learnt about what works, and what does not work, in SRH programme design, which potentially builds their capacity to do a better job in the future.

The Peer Education/Outreach programme has also contributed to capacity building by instilling knowledge and skills amongst the target communities. The wider community has also benefited from capacity building by its inclusion in many aspects of SiRCHESI's programming by way of PAR and taking an active role and responsibility for the health of its citizens. That said, there are aspects of the way that PAR has worked in SiRCHESI

that could be improved. As SiRCHESI's Neela Griffiths observes, for PAR to lead to any kind of sustainable outcomes the research itself needs to be valid and reliable, and problems in some areas of data collection and reliability have meant that has not always been the case (Griffiths 2008). For example, in the Peer Education/Outreach programme, good quality evaluative data on exactly what material has been presented during each training session has not been collated. Lubek agrees, stating that:

> We don't have a real double check on every single session…We don't have good evaluation data on exactly what happens…That would be the one thing that we would want to do in the end before we write it up as best practice…we would want to go back and see what an average teaching session looks like now compared to what we trained them to do maybe five years ago (Lubek 2009)

With that proviso acknowledged, SiRCHESI's mode of operation via PAR and its various programme components appear to have made a substantial contribution to capacity building over the organization's lifespan.

5.7 PROS AND CONS OF DIFFERENT APPROACHES

This chapter and its predecessor have discussed the different approaches and strategies that RHIYA (Laos) and SiRCHESI (Cambodia) have adopted to ensure their respective SRH education programmes were sustained beyond the initial funding period. In this final section of the chapter I identify some common problems both organizations have faced, and provide a brief assessment of the pros and cons of the two different approaches, thus laying the basis for a discussion of the implications and recommendations from my research which follows in Chapter 6.

a) Short-term Project-Based Approach

As the experience and comments of staff from both RHIYA and SiRCHESI make clear, the whole short-term project-based approach to SRH can be a real obstacle to sustainability. Unless properly managed, short-term project work can take government staff away from their 'real' jobs, at a time when the government sector needs to be developed and strengthened and capacity built, especially in developing countries such as Laos and Cambodia. SiRCHESI's Lubek goes so far as to say that an NGO pursuing a short-term project-based approach can 'destroy the public health sector' if it poaches the

latter's best staff. He emphasises the importance of using a hybrid model instead, where public servants keep their jobs and work part time for NGOs:

> If you are working in a country which has no money or budget for health then one thing that we really learnt from this is "don't rob the public health sector". The hybrid model really works and has worked well for us and we recommend it to any other NGO. Borrow people part time, elevate their salary so they can feed their family, teach them all that you can teach them to do, so when the money runs out they can still continue doing that and try to find a way in the community to sustain them (Lubek 2009).

Yet the wearing of 'two hats', maintaining two jobs, also has its downside, as SiRCHESI's Griffiths (2008) points out. She observes that community- and government-embedded programmes can substantially increase the workload for local staff, which in turn can lead to conflicting schedules and a precarious balancing act. The hybrid model, if not monitored and managed carefully, may not be sustainable if the workload simply becomes untenable. This is particularly the case with resource-intensive programmes such as peer education, which require substantial time and emotional commitment by staff. As CARE's Albone observed, 'the CARE RHIYA staff [working on the peer education programme] were very, very hands on and dedicated, yet this may not be the most sustainable way' (Albone 2009).

There are also many problems, as SiRCHESI's Lubek has observed, associated with obtaining longer-term funding for SRH programmes. Training local staff in marketing techniques (as RHIYA did at the Vientiane Youth Centre), can enable these staff to continue the work of searching for new donors once a particular short-term project comes to an end. But there is the fundamental problem of these staff then having to spend time out from their 'core business' in order to search for these funds, rather than delivering the health programmes that their resource-stretched developing countries so desperately need.

The experience of RHIYA and SiRCHESI highlight some of the difficulties in turning short-term programmes into sustainable community health outcomes. CARE's Albone states:

> My experience has generally been that once the project and associated impetus of people and money stops, then only the most basic monitoring will take place, if that…(Albone 2009)

If there is no ongoing monitoring, then there is no evidence of a programme's effectiveness, and hence no evidence base for advocacy or further funding bids. This in turn makes it difficult to achieve an 'enabling environment', and without one, there is little likelihood of achieving wider institutional change. The end result is a lack of *sustainable* health outcomes from the programme. That said, it should be remembered that, despite their potential drawbacks, benefits can still be gained from the short-term projects and programmes by utilising the technical support available and building capacity in the local community, especially if the project is piloting a new approach. Although short-term projects undeniably have drawbacks, the alternative of *not* having a project at all is rarely a preferable alternative.

b) Community-Embedding versus Government-Embedding as Strategies for Sustainability

As Chapters 4 and 5 have documented, both RHIYA and SiRCHESI shared a similar goal: to make sustainable improvements in the SRH of vulnerable youth with a particular focus on sex workers. In addition, both programmes utilised the peer education model to achieve this goal. Yet in terms of their overall approach to ensuring sustainability, RHIYA and SiRCHESI have prioritised somewhat different strategies. While RHIYA primarily sought sustainability by way of embedding its programme in Lao's national organizations and government institutions (a 'top-down' approach), SiRCHESI, by contrast, gave higher priority to embedding its programme in the local Cambodian community (a 'bottom-up' approach). That is not to imply that RHIYA ignored the community and SiRCHESI ignored the government. As we have seen, both organizations adopted a range of strategies and worked with a variety of stakeholders to achieve their sustainability goals. The difference between them is more one of which strategy and stakeholder groups were *prioritised*. This concluding section of the chapter presents and assesses the inteviewees' thoughts on which approach they have primarily adopted (top-down versus bottom-up), and the pros and cons of each.

When it comes to top-down or bottom-up approaches to achieving sustainability in SRH programmes, CARE's Albone (2009) believes that you 'have got to have [it] both ways…and you want them to meet in the middle'. Former CARE project officer Manivone (2009) agrees that the best approach can be *both* top-down and bottom-up, depending on what you want to achieve. Albone's experience with RHIYA was, somewhat ironically, that strong community links were built, but making change at higher policy levels was not as evident, due in part to problematic aspects of the Lao political system:

> [In Laos] to make any real institutional change – because everything here *is* very top-down – you have to go right to the top and start with policy, and adolescent SRH is not a high priority (Albone 2009).

RHIYA did, however, create a 'good community enabling environment' through the VYC, and many public outreach events such as World AIDS day concerts (Albone 2009). In Albone's opinion, the main obstacle to making sustainable policy change was the fact that RHIYA only ran for three years. She believes that if RHIYA had run for longer, then more could have been achieved on the policy advocacy front. But she is also well aware of the difficulties in doing so in Laos:

> [If SRH is] not appearing as [the government's] priority, then you have to work at the grass roots to get it up there…RHIYA did a really nice job of getting it sort of there (in terms of policy) but perhaps couldn't make the final leap and I think it was to do with time (Albone 2009).

However, Keonakhone from the VYC has a somewhat different view. She believes that the Lao Government *is* starting to understand the importance of adolescent SRH, citing as evidence the government supports for the Centre and the lack of opposition to their proposals (Keonakhone 2009).

SiRCHESI's Lubek emphasises that, when it come to top-down versus the bottom-up approach, the choice is not always clear cut, nor does one always have the *option* to choose. Sometimes it is a matter of 'taking what you can get', utilising whatever is available. He maintains that SiRCHESI is not rigid in its methodology and stresses the importance of a multi-sectoral approach. Both Lubek and Kros feel the most effective

way to achieve sustainable SRH programmes is to combine government embeddedness *with* community embeddedness. As Kros (2009) observes:

> You know, all the programmes that the government take[s] into account, I think the sustain[ability] of these will be better than [those of] the NGO… I know many NGOs already…[are]…just [in Cambodia for] 1, 2, 3 or 5 years and they leave…But we [i.e. the government] have no choice. If we don't receive, if we don't accept [funds from] the NGO, then how can we get it? (Kros 2009).

In other words, countries such as Cambodia (and Laos) have little choice when it comes to relying on aid from NGOs and external donors as otherwise the important health programmes they need to implement will simply not get run at all. SiRCHESI's embrace of the hybrid model of capacity building is perhaps the best model for addressing this dilemma, combining, as it does, a top-down and bottom-up approach in one. Ideally this should be complemented by having available more diversified sources of longer term funding for project work and government programmes and public health infrastructure, which are ongoing challenges especially in resource-poor countries.

5.8 CONCLUSION

One important lesson emerging from the experience of RHIYA and SiRCHESI is that unless sustainability is planned for, it will not occur. Sustainability needs to have specific objectives, as Shediac-Rizkallah and Bone (1998) have emphasised. SiRCHESI's Griffiths (2008) believes that you have to plan for sustainability very carefully and that this should be done at the beginning when you set up a programme. But as RHIYA's Albone points out, sustainability can be hard to plan for – at least in concrete, practical terms – at the beginning of a project. She argues, however, that it is something that can usefully be done someway down the track:

> If you want something mainstreamed or you want a policy, or whatever level you are working on, some sustainability outcomes - and I know it is hard to see those things at the beginning of a project…because we don't know how its going to go, we can't say what the exit strategy is going to be. [That is why] the mid term review is a good point for [doing] that (Albone 2009).

In sum, a combination of up-front planning, flexibility and mid-term review are integral to achieving sustainability in SRH interventions.

It is also the case that there is a lot of change that needs to take place in Laos and Cambodia if the groundwork is to be laid for achievement of sustainable SRH outcomes. CARE's Albone (2009) points out that change needs to occur on an individual level with people's attitudes knowledge and understanding, but change also needs to take place at the community level and at national structural levels as well (Albone 2009). The key to this change, to embedding it more deeply, is to have longer time frames. And of course for this you need more funding and donors committed for the long haul (Lubek 2009). For now, it seems clear that until the health systems in Laos and Cambodia undergo significant restructuring there is a definite need to combine the project approach in conjunction with community and government embedding and health sector reform.

CHAPTER 6
CONCLUSION

The following chapter provides a summary of the key findings, implications and limitations of this research, and discusses recommendations for policy, practice and future research.

6.1 INTRODUCTION

This thesis has argued that is of the utmost importance to strive for sustainable SRH programmes, especially when there are such large numbers of young and vulnerable youth in Laos and Cambodia about to enter their reproductive years. There is no doubt that the issues involved are complex, not only in terms of SRH programmes, but also for the target group of SWs and other marginalised youth whose voices are often left unheard. Laos and Cambodia both face the imminent threat of increased rates of HIV and other STIs, a key underlying cause of which is poverty: women selling sex because they cannot afford not to. The sustainability of SRH programmes is therefore imperative, especially when the public health systems in both countries are struggling and under-resourced. This underlines the importance of looking at any health programme in its broader socioeconomic, cultural and political context, taking into account both opportunities and constraints.

6.2 SUMMARY OF KEY FINDINGS

This thesis presented case studies from two SRH programmes: RHIYA and SiRCHESI whose approaches have been similar and yet different. What works in terms of sustainability within each programme and context has been assessed. A discussion of the key findings and lessons learned follows.

Sustainability is referred to in many health programmes and is critical to SRH programmes. The start-up costs, in terms of human, fiscal and technical resources, are

high and the health problems they are designed to address are ongoing. Sustainability may be difficult to define precisely, but we know it encompasses more than just the success of a programme. It can be measured through long term benefits to individual health, the continuation of programme activities, and the building of capacity within the community itself, which in turn leads to truly sustainable change.

The importance of making sustainability part of the initial and mid-term **planning** of a programme – taking it 'from latent goal to planned approach' (Shediac-Rizkallah and Bone 1998) – cannot be overestimated. The scarce resources dedicated to SRH programmes must be made to have long-lasting effects. Planning for sustainability is essential, as is taking into account the nature of the target group and the challenges they themselves may bring. In the case of SWs this includes mobility and the desire to remain anonymous as they face discrimination and stigmatisation due to the illegal nature of their work.

Building SRH education and knowledge in vulnerable youth is imperative but this needs to be supported with **improved access to appropriate and adequate SRH services**. Improving access to youth-friendly, confidential services that are affordable helps to enable people to make informed decisions about SRH and to be less likely to engage in risk-taking behaviour. This directly contributes to sustainable health outcomes.

Furthermore, if a health programme is to be truly effective and sustainable it needs to be part of a broader strategy to address the underlying **structural determinants of health and ill-health**. Socioeconomic factors play a critical role in determining the health of the individual and of the broader communities in which they live, with social disadvantage being one of the key drivers of health inequalities (Wilkinson and Marmot 2003). It is not only the SWs, but the populations at large in Laos and Cambodia, that are deeply affected by problems such as low levels of education, illiteracy, high unemployment and few opportunities to break out of the cycle of poverty. Policies and programmes need to tackle these underlying issues – through poverty reduction and the promotion of social inclusion – if population health is to be improved and health inequalities redressed.

The collection of and access to accurate and reliable **data** remains a dilemma for the sustainability of SRH programmes. It is imperative to obtain good quality data, not only to enable **vigilant monitoring and evaluation** of the success (or otherwise) of a programme, but also to provide evidence of programme outcomes to funding bodies and other interested parties. The mobile nature of the target groups in Laos and Cambodia made it difficult to document the outcomes of RHIYA and SiRCHESI's programmes. Without strong evidence of the programmes' impact, it proved difficult to demonstrate their achievements and secure further funding. Thoroughly documenting health programmes and their outcomes also lays the basis for enhanced advocacy, another key means of enhancing sustainability.

Securing adequate and ongoing **funding** for SRH programmes will no doubt prove to be an issue for many years to come. The only option is to keep striving for longer funding periods and to improve and build on the marketing and other skills needed to make successful applications for donor funding. A move away from what Lubek describes as the 'civil service attitude' should also be encouraged to support initiative and promote the generation of funding sources with the aim of self sufficiency.

Hybrid models of capacity building and PAR encourage all stakeholders to work together, in coordination, toward common goals to make effective and lasting change. The utilisation of the PAR model, which by its nature embeds itself within the local community, has proven to be very beneficial. Having government staff wear 'two hats', working for RHIYA and SiRCHESI, gave an added advantage in that they could capitalize on existing health infrastructure whilst building capacity and the momentum to have the programmes, or aspects thereof, continue. The concern with this approach is that the 'double' workload becomes too much and therefore in itself a problem for sustainability.

Embedding the programme in the government can contribute to healthy public policy which can have ongoing and wider effects long after a particular health programme has

ceased. Yet having advocacy and policies in place is one thing, having sufficient resources to carry them out is another. The interdependence and reliance of the public sector on NGOs and external funding sources in developing countries cannot be overlooked. That said, the embedding of a health programme within the government, by way of **policy**, can facilitate longer term change. The experience of RHIYA Laos and SiRCHESI suggests that if advocacy of SRH is not a priority at government policy level, then making it one at a grass roots level can in turn help to bring it to the fore. Advocacy for marginalised groups such as SWs is relatively minimal; there is still much that could be done to make adolescent SRH a higher priority in terms of government policy.

Community participation provides a direct link between a health programme and the community itself. Community participation enables an important and direct feedback loop from the ground level and can help address urgent health problems as they arise. The connection to the community itself can potentiate an immediate response, especially when dealing with SRH issues such as HIV, and can thus save lives. Strong community links foster an enabling environment which can further draw attention to SRH issues, empower the local community to take action to define and address its own health needs, and build its capacity to do so effectively.

SRH programmes should continue to encourage community participation which fosters a sense of **ownership**. This is especially important when addressing such marginalised groups as SWs: by participating as PEs they can reaps benefits beyond biomedical health programmes and build self esteem, self worth and self empowerment.

In terms of methodology, **peer education** proved to be central to achieving sustainable change in RHIYA Laos and SiRCHESI. PEs keep the knowledge *within* the target group: even if the funding stops the knowledge is there as the programme has ‘gone direct’(Kirkwood 2006). Peer education is a long term strategy and so can seem costly to funding bodies, but its enduring benefits arguably far outweigh the costs.

Altman (2009) states that we have much to learn when it comes to sustainability and that it remains a key challenge in public health. There is still much debate as to the definition of sustainability and what it truly means and this may be something that is never agreed upon. In attempting to enhance sustainability, however, it will be important to strive for **flexible, adaptable frameworks** and guidelines that can be used in a variety of settings. At the same time there is a sense of urgency in encouraging constructive debate and consensus in this field, as young lives are at risk.

This research has highlighted the apparent need for **both top-down and bottom-up** approaches. Pursuing strategies to embed SRH programmes both in the government and in the community means finding a middle path for achieving sustainability. As the WHO's Strategic Approach to Strengthening SRH Policies and Programmes points out, an integrated and multisectoral approach is essential; to collaborate and have an ongoing sharing of results and a constant dialogue between the many stakeholders, funding bodies, government departments, communities and NGOs, all running SRH programmes is essential. It is also imperative to have a coordinated response so as reduce duplication and minimise gaps in coverage. Monitoring just how successful these guidelines prove, when implemented in the wider community, will be of much interest to future researchers as they have the potential to address some of the challenges that this study has identified and encountered.

6.3 LIMITATIONS OF THE STUDY

Truly sustainable change can only be achieved by incorporating a multitude of factors. This study has been limited due to time and resource constraints and has only looked at two SRH programmes. Whilst evaluation of these programmes has proven invaluable in shedding light on my research questions, it is important to acknowledge that the small sample size limits the extent to which more general conclusions can be drawn. Further study in this area would benefit from assessing a greater number of SRH programmes from more than one geographical region, allowing more comprehensive information to be obtained. Longer time frames would also enable a more comprehensive and nuanced analysis of what makes for a sustainable SRH education programme.

The lack of adequate, accurate data on participants' health status and health outcomes was a substantial impediment to monitoring the effectiveness of both programmes during the conduct of this study. Further examination of how to measure SRH programme outcomes more successfully, whilst taking into account the special circumstances of the target group, would be of enormous benefit to future researchers, the SRH programmes, their funding bodies, relevant government departments and the programme participants themselves. Having accurate data is imperative for assessing what has been successful and what has not.

These comments on data limitations apply not only to quantitative data on indicators such as health outcomes, but more broadly as well. With time and resources permitting, it would be of most interest/benefit to do a comprehensive *qualitative* study of the SWs themselves, to document *their* lives, *their* needs and experiences, and what *they* require in terms of SRH education, programmes and services. This study has acknowledged the importance of meeting in the middle, of embracing top-down and bottom-up approaches to SRH initiatives. Yet in countries such as Laos and Cambodia where SRH is not high on the priority/policy list, it is perhaps this type of research that would ultimately bring the issues to the fore, and thus best help to achieve truly sustainable change.

6.4 CONCLUSION

Having a healthy adolescent population with sound SRH knowledge is of immense benefit not only to the individuals or the communities themselves but for the countries at large: simply put, SRH programmes save lives. Whilst Lubek (2009) feels it should be the goal of all NGOs to ultimately disappear, it is far too early for this to occur in Laos and Cambodia as their health systems are vastly underdeveloped and under-resourced to deal with their populations' health needs. It is then perhaps a case of making the most of whatever resources and existing opportunities are available and accepting restraints such as short term funding, at least until the countries build their political, economic and health systems to a stronger vantage point. It is hoped that this research will stimulate further

productive discussion about the serious needs of not only the SWs in Laos and Cambodia but vulnerable youth in general.

One of the hardest aspects of conducting this study has been knowing that whilst we debate sustainability today, tonight a young woman will go out and sell beer for little money and face the risk of HIV and violence that comes with sex work. Acting swiftly is of the utmost importance. This thesis has shed light on the complex range of factors that lead to accessible, sustainable and effective SRH programmes, so as to ultimately give the young women of Laos and Cambodia a chance to live long and healthy lives to their full potential. Sex work may be part of their history but it should not define their future.

APPENDIX 1
LIST OF INTERVIEWEES

RHIYA/Laos

- Ms Viengthong Manivone, Currently employed as a Project Officer at UNFPA, Vientiane Laos (Previously employed as a Project Officer at CARE International in Lao PDR on the RHIYA)

- Ms Suzie Albone, Project Coordinator, Legal Rights for Vulnerable Working Women, CARE International in Lao PDR

- Mr Tingthong Phetsavong, Senior Project Officer, CARE International in Lao PDR

- Ms Dalayvanh Keonakhone, Managing Director, Vientiane Youth Centre

Cambodia/SiRCHESI

- Professor Ian Lubek, International Advisor SiRCHESI, Department of Psychology, University of Guelph Canada

- Dr Sarath Kros, Project Director SiRCHESI and Director, Provincial AIDS Office, Siem Reap, Cambodia

- Ms Neela Griffiths, Assistant Programme Manager/English Instructor (Hotel Program), SiRCHESI, Siem Reap, Cambodia

APPENDIX 2
INTERVIEW QUESTIONS

The following questions were used as a guideline for interviews with staff from CARE Laos and SiRCHESI. At the outset it was explained to each interviewee that the term 'sustainable' encompasses not only individual health benefits but also institutional sustainability and capacity building in the recipient community.

The overall aim of the interview was to explore what the obstacles and challenges to sustainable reproductive health initiatives are, as well the successes and achievements and why this has been the case.

RHIYA Laos – Reproductive Health Initiative for Youth in Asia

- In RHIYA's mission statement it was hoped that the initiative would be run 'using sustainable approaches where possible'. What aspects of RHIYA would you say have utilised sustainable approaches? What have been the key characteristics of RHIYA's strategies to achieve sustainability?
- What would you say are the main obstacles to achieving sustainability?
- Is any of RHIYA's infrastructure still in operation? Drop-in centres? Vocational retraining schemes? Peer educator networks or communication with CARE staff or Lao Youth Union members? Is there any data on participants that may have gained new jobs as a result of vocational retraining programmes?
- Are there any other components of RHIYA that have been ongoing and if so what has enabled them to do so post-funding?
- What role, if any, has the Lao Government or the Lao Youth Union had post-RHIYA in regards to RHIYA activities?
- Community participation is often cited as being an important factor in contributing to successful and sustainable public health initiatives, what part did/does the local community play?
- Peer education was utilised during RHIYA, what role did this method play in contributing to sustainable outcomes?

- How would you describe the pros and cons of government mainstreaming vs. a community embedded approach?
- Do you see the turnover of staff and projects with finite time frames playing a part in achieving sustainability? And if so to what extent? Short term vs. long term?
- Do you have any suggestions for future policy/programme development that could contribute to truly sustainable outcomes for reproductive health initiatives?

SiRCHESI (Siem Reap Citizens for Health, Educational and Social Issues)

- What emphasis has SiRCHESI placed on using sustainable approaches in its programmes/policies?
- What methods has SiRCHESI used to achieve sustainable health initiatives?
- How important has participatory action research been as tool in contributing to sustainability?
- What would you say are the main obstacles to achieving sustainability?
- Has the Cambodian Government participated in any way in SiRCHESI initiatives?
- Community participation is often cited as important as being an important factor in contributing to successful and sustainable public health initiatives, what part did/does the local community play? SiRCHESI is a community-based organisation, what role has this played in striving for a sustainable approach to reproductive health?
- Peer education is a method utilised by SiRCHESI, what role did this method play in contributing to sustainable outcomes?
- How would you describe the pros and cons of government mainstreaming vs. a community embedded approach?
- Do you see the turnover of staff and projects with finite time frames playing a part in achieving sustainability? And if so to what extent?
- Do you have any suggestions for future policy/programme development that could contribute to truly sustainable outcomes for reproductive health initiatives?

APPENDIX 3
ETHICAL ISSUES CONSIDERED IN THIS RESEARCH

A range of ethical issues were taken into consideration whilst undertaking the interviews that form the basis of my research. These are summarised below, following guidelines from Connor, Treloar et al. (2001), Macquarie University's Ethics Guidelines for Human Research, and from my own previous research with CARE (Kirkwood 2006):

- Informed consent
- Participants have the opportunity to withdraw at any stage (without giving reason)
- Participants have the opportunity to retain data and to receive feedback about the study results
- Data collected remains anonymous and confidential, unless otherwise specified (as per the tick box on the information and consent form)
- Formal approval of institutional ethics committee prior to any research taking place
- Disclosure of any funding sources (Macquarie University travel grant – approved October 2008)
- The interviewer must be sensitive at all times to the community from which information is gathered
- The interviewer must maintain the highest professional standards in the conduct of their research

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