

## **Providers' Perspectives in Addressing Adolescent Sexual and Reproductive Health Needs in Northern Thailand**

*Arunrat Tangmunkongvoraku<sup>1</sup>, Sangworn Sombatmai<sup>2</sup>,  
Chonticha Ruangyuthikarn<sup>3</sup>, Sobhon Bopodhi<sup>3</sup>*

<sup>1</sup>*Faculty of Nursing, Chiang Mai University, Thailand*

<sup>2</sup>*Faculty of Medicine, Chiang Mai University, Thailand*

<sup>3</sup>*Research Institute for Health Sciences, Chiang Mai University, Thailand*

### **ABSTRACT**

In Thailand, as in other settings, unmarried youth face a host of obstacles in obtaining sexual and reproductive health information, counselling and services. Studies have generally focused on the perspectives of unmarried youth themselves. Fewer studies have explored the perspectives of providers that would shed light on their experiences and barriers in serving unmarried youth. This paper draws upon data from a qualitative study in Northern Thailand and sheds light on the perspectives of a range of providers, their experiences in and attitudes towards providing services to unmarried youth. A range of providers highlight barriers at various levels, policy and programme, facility and client that inhibit their ability to provide optimal services to youth. Some obstacles reiterate and others go beyond those expressed by youth. Findings also shed light on provider perceptions of optimal services for unmarried youth in Thailand and are intended to guide the development of sexual health services for young people.

### **1. Introduction**

There is increasing evidence in Thailand of changing sexual norms among young people. In study after study, large proportions of young males and significant minorities of young females report pre-marital sexual experience (Koetsawang, 1987; Chaipak, 1987; Nuchanart, 1988; Srisupan, 1990; Thevaditthep, 1992; Chanakok, 1993; Puthapuan, 1994). Moreover, there is evidence that despite relatively high levels of risk awareness, disturbing proportions of sexually active adolescents have engaged in risky sexual behaviour, characterised by early age at initiation, casual and multiple partner relations, and irregular condom use (Thevaditthep, 1992; Rudpao, 1995). Disturbing proportions, moreover, have experienced, as a consequence, unwanted pregnancy, abortion, sexually transmitted infections and even HIV (Taneepanichsakul, 1995; Natpratam et al., 1996). Despite this evidence, programmes have remained largely focused on adults and on the married, and both programmes and research have generally neglected the obstacles unmarried young people face in acquiring information, Counseling, contraceptive and other sexual and reproductive health services (see, for example, Rudpao, 1995).

In principle, contraceptive services and counselling, for example are available to married couples through mother and child care centres, clinics, hospitals, as well as profit and non-profit private organisations. However, this is not the case for unmarried and young people. Although evidence from Thailand is sparse, research findings from many developing country settings suggest that unmarried young people face a host of obstacles in their efforts to seek information, Counseling, contraceptive and other sexual and reproductive health services. Prominent among these are individual and community level obstacles including embarrassment and fear of disclosure of their sexual activity status and misperceptions concerning their exposure to risk and service and provider level barriers. In study after study young people report that such barriers as inconvenient clinic timings, lack of affordability, lack of privacy and in particular, judgmental and threatening provider attitudes have inhibited them from seeking services (see, for example, Senderowitz, 2000). Studies of providers, likewise, have largely corroborated the perceptions of young people (see, for example, Koff, 1983). And indeed, findings from at least one study in Thailand suggest that young people prefer to receive services from drugstores than from clinics, and that advice and care provided at both private clinics and drugstores by them was reported to be unsatisfactory (Benjarattanaporn et al, 1997).

The objective of this paper is to fill this gap in what is known about obstacles young people face in acquiring sexual and reproductive health services in Thailand, with a specific focus on provider attitudes and perspectives on services for unmarried youth. Data are drawn from a qualitative study in Northern Thailand intended to shed light on the perspectives of a range of providers, their experiences in and attitudes towards providing services to unmarried youth. Findings are intended to guide the development of sexual health services for young people.

## 2. Background

Thailand contains a population of 60 million and is divided into four geographic regions and further into seventy-six provinces. The study was based in Chiang Mai, a capital in the northern region, and Lamphun, a small province located 30 kilometres away from Chiang Mai. The large majority of the population is Buddhist (95%). Most speak both Northern, and Central Thai dialect. The northern region records the highest rates of HIV infection in the country (Royal Thai MOPH, 1994).

Despite pervasive parental controls, it is clear that social norms have changed and opportunities have expanded for young people in Thailand. Young people, for example, enjoy social interaction in mixed sex company, whether in schools, the workplace, or entertainment spots (Yoddumnern-Attig, 1992). Compelling evidence is available that suggests that large proportions of unmarried Thai youth are engaged in sexual activity, but at the same time that huge gender double standards persist and sexual activity among young females in particular is strongly disapproved (Soonthornhdada, 1992). A survey by Koetsawang (1987) on sexual experiences of college students in Bangkok (1607 males and 1813 females) revealed that 45.2 per cent of male and 5.3 per cent of female students aged 19 years or less were sexually experienced, as were 62.2 per cent of males and 7.5 per cent of females aged 20 and older. Another study in Khonkhen Province, North Eastern Thailand, found that 62 per cent and 12 per cent, respectively, of male and female vocational school students aged 15 - 19 were sexually experienced (Chaipak, 1987). A third, in Suphanburi Province, Central Thailand, reports that 41 per cent and 7 per cent of male and female students, respectively, had sexual experience (Nuchanart, 1988). Studies in Chiang Mai suggest a largely similar pattern: surveys, using self administered questionnaires, conducted among adolescents in schools, colleges, and universities, found that between 19 to 52 per cent were sexually experienced (Srisupan, 1990; Thevaditthep, 1992; Chanakok, 1993; Puthapuan, 1994).

The evidence also confirms that sexual activity is largely risky. Age of sexual debut reported in studies of adolescents in schools and colleges in Chiang Mai for example ranged from 15 to 19 and over half of all males reported debut with commercial sex workers. Moreover, condom use was irregular, and rarely practised in sexual relations with girlfriends (Srisupan, 1990; Thevaditthep, 1992; Chanakok, 1993; Puthapuan, 1994). Another study conducted among adolescent factory students in Chiang Mai found that of 601 male adolescents, aged 16-21 years, 82 per cent had sexual experience and most reported risky behaviours: average age of first sexual intercourse was 16.5 years. For almost half, debut occurred with a commercial sex worker (CSW) and for another third (35%), it occurred with a casual partner whom they did not expect to marry. Condom use at debut ranged from 20 per cent if the partner was not a sex worker and 54% if the partner was a sex worker. Indeed, some 17 per cent of young sexually active males reported that their first sexual intercourse occurred at under 16 years of age without condom use. Thirty-three per cent of male respondents reported multiple partners within the past twelve months. Among female adolescents (609), 42 per cent reported sexual experience, mostly within the context of marriage; however 15% reported sexual debut report sexual debut with a man who was not a husband, with low condom use (16 per cent) (Rugpao, 1995).

Studies have also documented the adverse consequences of risky sexual activity among young people. The rate of teenage pregnancy has increased sharply in Thailand: Between 1989 and 1992, approximately 13 per cent of all births were to teenage women (the same as in the United States and twice as high as that of the UK) (Thailand Public Health Statistics, 1993; Brown, 1991; Kane and Wellings, 1999). Anxiety and depression are reportedly significantly higher among teenage compared to adult mothers (Piyasil, 1998). Rates of HIV-1 infection were observed to be increasing

among pregnant adolescents attending Ramathibodi Hospital in Bangkok between 1991-1995 (Taneepanichskul et al., 1995). In Lamphun, a study of industrial workers (with a mean age of 22) found that almost 4% of both female and male respondents tested positive for syphilis (VDRL) and 6.6% of males and 1.3% of females were HIV positive (Natpratan et al., 1996). A second conducted among a rural population in the Chiang Mai area (Nelson et al., 1992) reported that 5.9 per cent of males and 3.3 per cent of females were HIV positive. And a study of young men aged up to 21 in military service in Northern Thailand fell from 11.4% in 1991 to 4.8% in 1996 and to 5.4% in 1997 (Nelson, 1997).

Despite evidence of risky sexual activity among unmarried youth, community norms and attitudes remain conservative and the topic of adolescent sexuality remains sensitive. Gender double standards persist. For example, a study of unmarried male and female factory workers in the Central region of Thailand reports that pre-marital sex is considered unacceptable for 'respectable women' and highly damaging to the reputation of the young woman and her family. In contrast it is widely accepted for young males; men are expected to have a strong sexual drive which demands 'release' and indeed it is virginity for young males that is perceived as unacceptable. Attitudes to contraception and condoms are also polarised. Young women would like to know more but fear that seeking or requesting contraception will disclose their sexual activity status and subject them to stigmatisation. In contrast, condoms are more widely available to young males, but are used irregularly in contacts with sex workers and rarely in relations with girlfriends. Despite these patterns, contraception is viewed as the women's responsibility (Saiprasert et al, 1992).

### **3. Data and methods**

Data are drawn from a qualitative study intended to probe, through in-depth interviews, the experiences and attitudes of a range of providers concerning sexual and reproductive services for unmarried youth. Findings were intended to inform the design and planning of youth friendly sexual health services for young people in Northern Thailand. The sample comprised a total of 44 health care providers drawn from 15 diverse sexual health settings providing services to unmarried youth, including government and non-government family planning centres, provincial health offices, sub-district health centres, STD clinics, and anonymous HIV testing clinics located in Chiang Mai and Lamphun area. Between two and five clinic staff were interviewed at each site, including doctors, staff nurses, health educators, and social workers; a criterion for selection was their involvement in delivering services to adolescents.

In-depth interviews were conducted by trained interviewers who explained the objectives of the study and sought permission to take field notes and tape the interview. In some cases, repeated in-depth interviews were conducted.

Providers were asked about their experience in providing services to young people, the nature of such services, the barriers they met, their opinions about the possibility of providing special services (clinics or outreach programs) to sexually active unmarried people and adolescents, and their perceptions of what makes an ideal service. Four themes were addressed. In the first, socio-demographic background characteristics of providers were obtained, including educational and professional qualifications and training, and current employment details including nature of work. Second, information was sought on experiences in providing sexual and reproductive health services to adolescents, and notably the number of young clients served, the kinds of needs expressed by young clients, and experiences in serving youth as compared to adults, as well as providers' views on current policies for serving youth in Thailand. Third, investigators probed provider perspectives with regard to sexual health services for unmarried youth, notably their attitudes, the constraints they faced in serving unmarried youth and their perceptions of the factors inhibiting adolescents from seeking timely care, their perceptions of youth needs and rights, including confidentiality, information and so on. Finally, providers were asked to recommend how best to shape policies and programmes for sexual and reproductive health services to unmarried youth in Thailand, the components of an "ideal" service for youth, how best to balance youth needs

with notions of acceptability at community level and ideas about informing young people of available services in an acceptable way.

#### 4. Findings

##### *a. Socio-demographic background*

Socio-demographic characteristics of the sample are provided in Appendix Table 1. A listing of providers in the 15 selected settings suggested that unmarried youth tended to obtain services largely from nurses and health educators. Hence the 44 participants included 7 doctors, 16 nurses, 10 health educators, 6 counsellors, and 5 other health professionals (such as social worker, program Coordinator, and manager, who run special programmes for the youth). Respondents ranged in age from 25 to 63 years (mean age 40.5 years). In general, staff of NGO facilities tended to be younger than those of public health facilities. Providers were overwhelmingly female (33), however, only one of the seven physicians was female. Most respondents were well educated, with a minimum of a Bachelor's degree. About half worked in hospitals, and mainly in public health facilities (30).

Selected providers came into contact with unmarried youth in a variety of settings, including family planning, gynaecological and ante-natal clinics, as well as delivery rooms, STD clinics, health promotion and other health centres. They also provided services to young people in the course of outreach programs conducted largely by NGOs in schools, work places, and other community settings. Some were involved in recently established youth friendly service settings including the Youth Centres and Services, the 'Friends Corner', and peer outreach programmes.

##### *b. Sexual and reproductive health services provided to youth*

Collectively, providers reported a range of services sought by unmarried youth, both in clinic settings and in outreach programmes. Providers in clinic settings report that unmarried youth may account for between ten and thirty percent of their clients. Some NGO programmes are, however, focused on youth and these respondents reported a larger proportion of youth among their clients.

##### *Information and Counseling:*

Provision of information and Counseling of youth were reported by many providers. Information and Counseling are reportedly provided in the course of visits for other services, or through such dedicated mechanisms as telephone counseling and special programmes (for example, Chiang Mai Youth Counseling Programmes). Common concerns for which young people seek Counseling include pregnancy, abortion, family problems, school problems, love, sexual relationships, contraception, safe sex and modes of transmission of infection. In some instances, it is clear that Counseling and information activities remain quite separated from service delivery:

*Adolescents using the service here mainly are the girls. They started to have sex when they were grade 7 or 8. Most of them do not use any protections. The girls are persuaded to come here by our young staff. Our young staff does their work so well. Anyway, our job here is only for Counseling and health education. We do not give any treatment. We refer those cases to the hospital where we have connection with the doctors.*

*Health officer, male, 46 years*

Information and education are frequently provided in outreach activities in schools and work places, and also among such special populations as homeless children and male sex workers. For example, respondents reported providing information and Counseling through such mechanisms as classroom lectures, life-skills camps, and exhibitions, and where necessary at times at which young people are free.

*We give health education to teenagers at schools or factories while we have mobile clinics. We discuss with them many topics. One of the issues to provide is about reproductive health. We do not give them the information of sexual health alone.*

*Health educator, hospital, female, 28 years*

Respondents from non governmental organisations also report peer outreach programmes in which young outreach volunteers provide information, distribute condoms and pills to their peers, provide follow-up, and make referrals for facility based services at NGO clinics as needed. The program also has hotline service to young people.

*We give small incentives to the volunteers. They help us giving health education, and selling condoms and pills to their friends. We monitor the program by having a meeting with them every month. They will show us their work outcomes, and we discuss about the problems they faced. Sometimes we invite their friends who are clients to join us to discuss how to provide them services, which are more acceptable.*

*Program manager, NGO, female, 28 years*

#### *Services:*

Providers reported a range of services sought by unmarried youth, ranging from treatment of menstrual problems to HIV testing. Services included:

- physical examinations and treatment of menstrual problems ( cramps, miss periods, vaginal bleeding).
- family planning information and provision of contraceptives.
- antenatal care and assistance at delivery. Providers observed that adolescent pregnancy appeared to have increased, and reported clients aged as young as 13-14 from Grades 8 and 9 who had to leave school because of pregnancy. In recognition of this growing trend, providers reported the establishment in some hospitals of an ‘Unwanted Child Prevention Program’ intended to counsel, support and provide services to pregnant adolescents, and a home (‘Baan Ping Jai’) providing emergency services for young girls in crisis, including adoption.
- Post abortion care, for example uterine curettage. However, nurses at Maternal and Child hospital reported that around 70 per cent of females presenting with vaginal bleeding after an unsafe (illegal) abortion were students aged under 20 years.

*Many of the patients here (Septic Unit, Delivery Room) are aged at 16 to 19 years. They had induced abortion and then had cramps or bleeding. Most of them used tablets inserted into vagina. They did by themselves. From the record, we found that around 70 to 80 percent of them were students.*

*Nurse, hospital, female, 45 years*

- HIV testing and STD treatment for male teenagers and also for young female sex workers among whom testing is mandatory. Here, providers acknowledged that young clients comprised, disproportionately, young males and female sex workers:

*The clients using services here mainly are sex workers. However, male clients do not mind to come here. There are some male teenagers come to see us. The main problems are Dysuria and Gonorrhoea. For young girls, if they are not sex workers, they do not come here.*

*Doctor, STD clinic, male, 41 years*

#### *Special youth friendly initiatives:*

Several respondents were associated with special youth friendly initiatives. One such initiative is the Youth Health Center established 2 years ago to provide Counseling and contraceptive supplies to young people. Convenient timings were established and efforts made to enable adolescents to overcome difficulties in gaining access to ordinary health care settings. Despite this, providers report that the centre did not succeed in attracting young clients, hence necessitating awareness

raising activities in schools, work places, places of recreation (for example gay bars), and residences (dormitories or homes).

*We found that there were not many young people to come to use our service. So we try to promote the program by distributing the brochure at schools, gay bars, or even the malls. Still, the clients who usually come here are ages over 20. This might be because we provide free services, and the older people are not as hesitant about seeing us.*

*Counselor, male, 38 years*

To overcome this effective lack of access to services, the Ministry of Public Health has initiated the establishment of ‘*Friends Corners*’ or centres established in accessible places where youth congregate – in shopping centres for example – that provide both sexual and reproductive health services and other facilities of interest to youth. Providers in the study described this about-to-be-launched programme that is intended to provide not only Counseling for adolescents and parents, but also marketing of condoms and oral contraceptives and computer facilities for playing games, reading fortunes, and accessing internet services.

*c. Facility and provider level obstacles to adolescent health seeking*

Despite the fact that an array of services are provided, and indeed are availed of by unmarried youth, providers report several obstacles at various levels: policy and programme ambivalence, facility level obstacles, inhibitions of adolescent clients, and gatekeeper attitudes. Interestingly, few providers point to their own attitudes as factors inhibiting adolescent health seeking.

*Policy and programme level ambivalence*

In general, providers (especially those in the public sector) reported that the lack of clear government guidelines concerning services for unmarried youth has posed a major obstacle in delivery of services to this group. Indeed, it appears that providers are sensitive to the needs of young people – they recognise, for example, that although a pregnant adolescent needs more than the Counseling and regular services that are available to adults, these cannot be provided under existing policies. They also point out that the current policy of providing sexuality education and sexual and reproductive health services to youth as one component of general health activities including nutrition, dental health, exercise, drugs, and violence, may actually serve to deter attention from sexual health needs of youth. Although many are critical of the ambiguity of government policies, they are reticent, in the absence of clear policy level directives, to modify existing adult focused activities. They highlight, for example:

*There are no rules or laws to help us feel secure in providing services to young girls who have sexual health problems, especially related with missing period or having unwanted pregnancy. There should be a group or committee to help decide what we could do. The fact is we don't have such a group. No one wants to get involved with this sensitive issue.*

*Doctor, hospital, female, 39 years*

Services for Counseling, testing and treatment of sexually transmitted infections similarly do not differentiate between adult and adolescent clients. Respondents argue that the very term “STD Clinic” inhibits young people, particularly young females, from attending, but noted that policies and programmes have not responded to provider initiated suggestions to employ less stigmatising names. Providers also note government ambiguity in initiating special facilities for young males and females in the sex industry.

*I would say that there should be a policy for this group in the future. We thought about that, but now there is no policy from the head department to give special services to unmarried young people. However, it would be OK if some sites want to launch a service to this group.*

*Doctor, STD clinic, male, 41 years*

Indeed, several respondents described measures taken on the initiative of staff of different facilities to fill gaps in services to adolescents: these included pre-marital Counseling activities, school- and work place-based health education activities, a special clinic outside the facility setting for STI/HIV testing and Counseling for commercial sex workers. Recently there has been some attempt to reverse traditional government ambivalence -- a new policy from Ministry of Public Health has outlines plans for the launch of youth friendly services by way of the 'Friends Corners' discussed earlier. Providers anticipate that such an activity may go a long way in clarifying government thinking on issues relating to adolescent sexual and reproductive health.

Respondents from the NGO sector report greater flexibility in dealing with adolescents. However, these programmes focus largely on outreach activities, are modest in reach, are hugely dependent on donor support and providers recognise that while NGO programmes have clear policies and guidelines, continuity and sustainability of these programs are uncertain.

*Facility based obstacles:*

A clear tension was exhibited in in-depth interviews between those expressing a need for dedicated youth friendly sexual and reproductive health services and those arguing that adolescent concerns must be addressed in the context of services provided to the population at large. By and large, although administrators were aware of the health needs of adolescents, the perception among them was that the magnitude of these problems did not warrant a special programme for sexually active youth. As a result, even NGOs were unable to establish reliable referral networks for adolescents in need. Study participants also reported, moreover, that within large big hospitals, there was limited co-operation between departments, and complicated lines of command inhibited use of services by adolescents.

Within facilities, providers recognised several procedures that would inhibit young clients. First, lack of privacy in consulting rooms likely inhibited the discussion of sensitive issues with young clients. Second, many providers reported that they were authorised by government to provide oral contraceptives to married women only, thus posing yet another obstacle to young people seeking to avoid pregnancy. Third, inconvenient procedures, such as undue waiting times for OPD cards and consultations inhibited use of facilities by unmarried youth. Fourth, inconvenient clinic hours and intimidating and stigmatising names (such as STD Clinic) inhibited young people from seeking care in those facilities. While NGO facilities have been designed to enable youth to overcome these obstacles, their limited reach and lack of sustainability uncertain funding support pose a different kind of obstacle to services for youth. Finally, some providers noted that providers themselves had limited knowledge of adolescent sexual health needs, and were insufficiently trained and lacked the skills to interact with adolescent clients.

*The system here does not offer support to build up an effective programme to prevent reproductive health problems of youth. The responsible unit is the community health department, which educates adolescents on all health issues. Our OB/GYN department cannot take part in this activity, although we realize that it is important to promote sexual and reproductive health among young people more specifically. What we do now is treat them when they already have severe problems.*

*Doctor, hospital, female, 39 years*

*I think that the number of programmes for adolescents here (in Chiang Mai) is inadequate to serve the large numbers of adolescents with high-risk sexual behaviour. Most existing programmes are small, not well known among youth, and the programmes operate irregularly, from time to time. Most adolescents turn to friends for help, and do what their experienced - friends advise.*

*Counselor, NGO, male, 29 years*

*Provider perceptions of adolescent clients:*

Findings confirm the concerns expressed by young people in many studies about negative provider attitudes. Although many providers did appear to be sensitive to changing norms and the need to

provide services to sexually active youth, it was clear that by and large, attitudes continued to be negative.

Providers recognised that the negative attitudes of providers, especially hospital staff, toward sexual behavior of adolescent female clients posed a major obstacle to young people's use of public health services. Yet many expressed ambivalence about pre-marital sexual relations, particularly among females, and highlighted the incompatibility of pre-marital sexual relations with traditional Thai culture and social standards of sexual conduct. Attitudes to abortion are particularly negative.

Clearly, interactions between providers and young clients were not always friendly. In the course of interviews, counsellors complained about the inordinate amount of time required in developing rapport with adolescent clients, and eliciting from them the exact nature of their problem (particularly in the case of pregnant adolescents seeking abortion). Providers located in government facilities in particular reported that time constraints inhibited them from spending time or probing adolescent needs at length. Many reported that they were inhibited in discussing sexual matters with unmarried adolescents, and few reported willingness to discuss abortion options with clients seeking to terminate an unwanted pregnancy. And many reported an inability to building rapport with young clients:

*When we gave them the knowledge, they did not respond anything. They kept quiet, and had no interaction at all. So, we could not know whether they understood what we tried to explain to them. We have so much work to do in the clinic, and sometimes it caused us to feel annoyed about dealing with them. A staff member of the Labour Room complained that some girls would jump out of the bed when she did the PV (vaginal exam) on them.*

*Nurse, hospital, female, 37 years*

Some providers expressed frustration at adolescents' reluctance to disclose their sexual histories and health needs, or to comply with Counseling or treatment provided. Some accused adolescents of *not telling all of their story* or *telling lies*, thereby inhibiting them from making an accurate diagnosis or providing appropriate treatment.

*Some girls did not want to tell us the truth. They had bleeding per vagina, and told us that they had an accident. But, when we had an exam, we found the pieces of "Cytotec" left the in the vaginal canal.*

*Doctor, hospital, male, 37 years*

There appeared to be a lack of sensitivity to adolescents' fears and embarrassment about disclosing their problems and being judged by providers. Providers revealed, moreover, an impatience about addressing adolescent needs: Adolescents were described as confused about their own problems (love & sex & family & school), requiring considerable provider time and effort, and lengthy Counseling sessions. They were accused of agreeing to follow the advice, but not doing so once out of the facility. Providers providing outreach services through mobile teams in schools reported that even students practising high risk behaviours would report 'no problems,' paid them little attention and did not comply with treatment or even return to receive notification of results of blood tests. One respondent described how even when outreach services in a gay bar conducted voluntary HIV testing through mobile services, young male workers neglected to return to the clinic to obtain test results, but rather, *just disappeared*.

In addition, providers were somewhat ambivalent about the appropriateness of maintaining the confidentiality of their young clients, and described government reporting requirements that made it difficult for them to allow young clients complete anonymity. Providers reported that many young clients did not use their real names and addresses, yet government policy required that real names and addresses are reported in order to receive services, so as to enable follow up. Providers asserted that this requirement could inhibit adolescents from seeking care at public clinics, choosing rather the anonymity of drug stores or private clinics.

*Since we have to send the report to the central department at ministry of public health, we are only able to provide pills to married women identifying their real names and address. We are only following the hospital rules, and we are afraid that for these reasons young girls may not be willing to come. For the boys, I don't think they want to come to see us in the hospital. They have other places to go like drug stores or private clinics.*

*Nurse, hospital, female, 37 years*

Others described their reluctance in responding to efforts adolescents made in obtaining information about emergency contraception and medical abortion, their use and side effects in an anonymous way. Providers reported that they were reluctant to respond to these questions unless they were assured that the client would make appropriate use of the information provided.

*Some teenagers called me at the clinic, and asked about how to use the some drugs to terminate pregnancy. They told me that they would present this topic in the class, or write a report. I advised them to have formal letters from their school, and send to the clinic, and I will give them the details. All of them did not follow it, and just disappeared.*

*Nurse, hospital, female, 40 years*

Other providers clearly disapproved the strategies unmarried youth employed to avoid disclosure of their sexual activity. For example, they pointed out that some young women seeking contraceptive or post abortion care tended to come to facilities unaccompanied by parents. Providers were often unwilling to take the responsibility of providing services to these young women, and, moreover, viewed their inability to pay for services as a financial burden for the institution.

*The problems we always face are that the girls come to the hospital with friends. The parents do not know about their daughter's problems. After the treatment, which usually end up with uterine curettage and a set of antibiotics, the girls may not have enough money to pay. Some of them live in a flat or rental house, and could get some help from friends, not from partners.*

*Nurse, hospital, female, 50 years*

Providers do of course also express frustration that they are unable to address the needs of adolescents until an adverse consequence has been experienced. They acknowledged that adolescent clients tend to delay seeking services, preferring to seek care from friends, treat themselves or obtain care from unqualified providers or drug stores. They recognised that services were sought from hospitals and clinic settings usually as a last resort. These providers regretted that they were unable to intervene in a more timely fashion to provide preventive or promotive services. Some expressed guilt at their inability to prevent unwanted pregnancy or infection, or follow up young clients.

*Role of community gatekeepers:* Providers also describe the ways in which parents who accompany their adolescent children to facilities tend to inhibit their children from expressing their needs or seek advice. They observe that occasionally, parents are unwilling to accept their child's problems and thwarted provider attempts to provide Counseling to adolescent clients. Frequently, it would be parents who would make health related decisions for adolescents, discouraging adolescents from expressing their preferences. Occasionally, providers – particularly those from NGOs – reported that parents accused NGO programmes of providing their adolescent children with information that would lead to sexual experimentation. Some school-teachers refused to allow sexuality education activities in their schools, believing that their students had no need for sexuality education. Community level opposition to NGO programmes was also experienced:

*The kids love to spend time with us. They do activities and hang out with friends. Some stayed over night at the program office. For this reason, I was called by the parents and blamed for exposing their kids to sex issues. Even the teachers used to call me and blame me for this. They just don't understand their kids, and see me as the leader spoiling their*

*children. Some say that I sell drugs to young people. That hurts. We have to spend a lot of our times explaining.*

*Program Counselor, NGO, female, 36 years*

*d. Perspectives in addressing adolescent reproductive health needs*

Respondents unanimously reported the need for special programmes to provide services for sexually active young people. There was also unanimity in the design and content of these programmes.

Respondents noted the need for both education and health services. Those emphasising the need for education, argued for sex education in schools or the work place that would focus on traditional models of Thai lifestyles, implying presumably, virginity and abstinence.

*It's quite difficult to think about how to promote adolescent sexual health. If we do not promote them properly, it seems like we guide them to sex issues since they are only young. We need to think about it carefully.*

*Health educator, health office, female, 38 years*

Recommendations concerning service provision were more far reaching. Many ranked unwanted pregnancy as a leading problem confronting adolescents, but were less clear about the kinds of strategies required to address this problem. Some noted the need for inter-departmental services to be provided with representation from staff of such departments as OB-GYN, community health, and psychiatry, operating in extended office hours, and over the weekends. Some suggested measures to modify laws pertaining to induced abortion, and to enable termination of pregnancy clinic conducted by trained medical personnel.

Other providers – particularly those engaged in providing reproductive health services over a long period of time – focused more on making clinics and other facilities more youth friendly. These providers argued for the provision of services at locations and timings convenient for young people, with less threatening and judgmental provider attitudes. They recommended that services be integrated, that clinic services are complemented by outreach programmes. They argued for the participation of youth in the design and management of services for young people. And they emphasised the need to reorient providers, facilities and government reporting systems to accommodate young people's need for confidential services.

*What is needed now is to change our attitudes toward sexuality when we give services to young people. We need to see it as a step of adaptation from childhood to adulthood. I would say it could happen. At this point we should give them services in a positive atmosphere. In the same way, adolescents need to feel secure, comfortable, and confidential. If we can do this, I believe this would help.*

*Doctor, hospital, male, 43 years*

Indeed, respondents provided a comprehensive picture of ideal, youth friendly sexual and reproductive health services.

*It's time to think about setting up a clinic for adolescents, especially young girls, for check up, screening, and treatment focusing only on sexual and reproductive health. They will come to use the service if we set a clinic just like what they want.*

*Counselor, Health center, male, 38 years*

Several features were emphasised:

- The clinic should be set up in an easy accessible urban area and not in an existing health service institution.
- It should provide a friendly, home-like, and relaxing atmosphere, and timings that are convenient for school-going and working adolescents alike, and “walk in” facilities requiring no prior appointments.

- Multiple services must be provided, including physical check ups, pap smears, STD screening, pregnancy and HIV testing, sex and reproductive health education, as well as Counseling services – namely, a ‘one stop service’ and should be provided in fixed clinic facilities backed up by mobile facilities.
- Private waiting rooms, providing information in an entertaining yet rigorous way.
- Access to telephone Counseling.
- Providers must be carefully selected to include an array of skills (medical doctors, nurses, and counsellors) and genuine understanding and positive attitudes to sexually active young people.
- Where possible, same sex providers should be available for adolescent clients, although some believed that female providers were acceptable to both adolescent females and males.
- Client confidentiality was stressed – suggestions were made about ensuring privacy of records, apprising clients that their problems would remain confidential, and not requiring adolescents to reveal their names and addresses if reluctant.
- Quality of care and interaction with young clients was mentioned but not elaborated upon.
- Measures must be taken to build rapport with the community and particularly with parents. Some providers raised the possibility of providing services for parents. Providers suggested that the media will be employed to raise awareness of the need for services for young people.
- Social marketing of condoms and other contraceptives was suggested as a measure that would address concerns for anonymity.

## 5. Summary and recommendations

This paper has explored the perspectives of a range of providers on the difficulties encountered in providing sexual and reproductive health services to unmarried youth in a setting in northern Thailand, and has sought their recommendations on ways of promoting young people’s access to services. Findings suggest that providers are aware that unmarried youth are increasingly exposed to risky sexual behaviour, yet face an array of obstacles in acquiring appropriate information and services in an acceptable way. In some instances – notably in describing the nature of the provider-client interaction -- barriers expressed by providers complements those articulated by young people. And finally in other instances, obstacles reported by providers go beyond those articulated by young people, providing insights into other policy and programme, and facility level barriers that inhibit the ability of providers to address the needs of unmarried youth in a youth-friendly way.

In describing many facility level barriers, providers echoed young people’s concerns. Facility level obstacles, including the lack of privacy in clinic settings, undue waiting times and inconvenient clinic hours for example were acknowledged by providers – as by young people – as factors inhibiting their ability to serve unmarried youth.

As far as provider-client interaction is concerned, the perspectives of providers show an interesting corollary to those expressed by unmarried youth. The ambivalence about providing services to unmarried youth who are sexually active is evident. Not only do some providers express negative attitudes, but there is a tendency to perceive young clients in a negative light, a lack of understanding of the difficulties young clients may encounter in expressing their needs and admitting their sexual activity status, and the range of fears they may have whether of violation of confidentiality or ability to pay for needed services. Providers also expressed some unwillingness to accommodate the additional time requirements of young people who sought counselling or other services, and some frustration about young people’s unwillingness to reveal their sexual histories and follow up on prescribed treatment.

Finally, in describing policy and programme level obstacles, providers added a third dimension of barriers to services for young people that have not been articulated in studies of young people. Providers pointed to the lack of clarity and direction at policy and programme level with regard to services for unmarried youth. Such issues as lack of clarity in whether oral contraceptives could be issued to the unmarried, lengthy reporting procedures, content of reporting that required complete details of clients including names and addresses, poor referral facilities, and lack of co-ordination

between various hospital departments and between facility and outreach programmes were described as factors that inhibited them from providing youth friendly services. In general, however, providers favoured special youth friendly service initiatives, some of which have recently been established in Thailand.

Programmatic recommendations are clear. Findings suggest, as other studies have, the need for training and sensitisation of providers who serve unmarried youth, and for more stringent recruitment practices that ensure that those providing services to unmarried youth do indeed have positive attitudes and necessary skills to build rapport with young clients. Also, as other studies have suggested, facilities offering services to youth need to be reoriented to be more inviting to young clients. While convenient timings, privacy in waiting areas and consulting rooms and easier admission procedures are some ways of accomplishing this, it is vital that young people themselves are involved in designing and monitoring the youth friendliness of clinics. Special youth friendly initiatives that have been launched offer promising directions for serving young people but their sustainability and potential for upscaling may suggest that efforts be made to incorporate its central features into established facilities. Finally, it is essential that policy and programme level ambiguities are addressed, that providers are given clear guidelines on services for unmarried youth and reporting requirements are streamlined to accommodate young people's needs.

#### ACKNOWLEDGEMENT

*This investigation received financial support from the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction, World Health Organisation, Geneva. The authors are grateful to Drs Shireen Jejeebhoy and Iqbal Shah for comments and suggestions.*

## References :

- Brown H L et al (1991) Obstetric complications in young teenagers. *South Med J* 1991; 84: 46-8.
- Carlin E M, et al (1995) Evaluating a designated family planning clinic within a genito-urinary clinic. *Genito-Urinary Med*; 71: 106-108.
- Chaipak S (1987) Compliance and Use of Contraceptives in Vocational School Adolescents : A Study in Khonkhan Province, Thailand. A Thesis in Master's degree (Medical Social Sciences). Graduate School, Mahidol University.
- Chanakok A, et al (1993) The Relationship Between Knowledge and Attitude to Risk Reduction Related to HIV Infection in Vocational School Students in Chiang Mai. A research report. Faculty of Nursing, Chiang Mai University, Thailand.
- Elias C J, and Leonard A (1995) Family planning and sexually transmitted diseases: the need to enhance contraceptive choice. *Current Issues in Public Health*, 1, 191-197.
- Hagenfeldt K (1991) Reproductive Technologies, Women's Health, and Career Choices. *Women Work and Health: Stress and Opportunity*. Frankenharuser M, Lunberg U, Chesney M (eds.). New York and London.
- Grimes D A, and Cates W Jr. (1990) Family planning and sexually transmitted diseases, in K K Holmes et al, eds., *Sexually Transmitted Diseases*, McGraw-Hill.
- Kane R and Wellings K (1999) Reducing the rate of teenage conception. An international review of the evidence: data from Europe. Oxford: HEA (in press).
- Koetsawang S (1987) Siriraj Adolescent Counseling Program 1983-1985 Report. Theera Press, Bangkok.
- Koff S and Cohen J (1983) Services for teenage pregnancy: providers' perspectives. *Journal of Health and Human Resources Administration*. 5:439-53.
- Natpratan C et al (1996) Feasibility of Northern Thai factory workers as participants in HIV vaccine trials. *Southeast Asian J Trop Med Public Health*, Vol 27 No. 3 Sep 1996.
- Nelson KE, Suriyanon V et al (1994) The incidence of HIV-1 infections in a village population of Northern Thailand. *AIDS*, 8: 951-55.
- Nelson KE, Celentano DD, Eiumtrakul S et al (1996) Changes in sexual behavior and a decline in HIV infection among young men in Thailand. *N Eng. j Med*. 1996; 335:297-303.
- Nelson KE, Eiumtrakul S, Celentano DD et al (1998) HIV infection in young men in Northern Thailand; 1991-1997: increasing role of drug use. 12th World AIDS Conference, Geneva, Switzerland, June 28-July 3, 1998(abst. no. 43555).
- Nuchanart J (1988) Sexual Relationships and Use of Contraceptives in High School Students in Suphanburi Province, Thailand. A thesis in Master's degree (Reproductive health and demographic planning). Graduate School, Mahidol University.
- Piyasil V (1998) Anxiety and depression in teenage mothers: a comparative study. *J Med Assoc Thai*, 81:125-9, 1998 Feb.
- Public Health Statistics (1993). Adolescent pregnancy. Ministry of Public Health, Bangkok, Thailand.

Puthapuan C (1994) Attitude and Risk Behavior Related to HIV infection in Health Science University Students in Chiang Mai. A research report. Faculty of Nursing, Chiang Mai University, Thailand.

Royal Thai Ministry of Public Health, Division of Communicable Disease Control HIV/AIDS Surveillance Data, Bangkok, 1994.

Rugpao S (1995) Sexual Behavior in Adolescent Factory Workers. A final report to WHO. Research Institute for Health Sciences, Chiang Mai University, Thailand.

Saiprasert S, Ford N (1993) Gender construction and changing nature of the sexual life-style of Thai youth. Qualitative Methods for Population and Health Research. Mahidol University, Nakornprathom, Thailand.

Soonthorndhada A (1992) Adolescent role behavior, expectation and adaptation. In Changing Roles and Status of women in Thailand: a documentary Assessment. Institute for Population and Social Research, Mahidol University, Thailand.

Srisupan V, et al (1990) Knowledge, Opinion, and Sexual Behavior of High School, Vocational College, and University Students in Chiang Mai Province. A research report. Faculty of Nursing, Chiang Mai University.

Stedman Y, and Elstein M (1995) Rethinking sexual health clinics [editorial]. *BMJ*, 310, 342-343.

Taneeapanichskul S, and Phuapradit W (1995) Adolescent pregnancy with HIV-1 positive in Ramathibodi Hospital in 1991-1995. *J Med Assoc Thai*, 78:688-91, 1995 Dec.

Thevaditthep K, et al (1992) Sexual Risk Behavior Related to STDs in University Students in Chiang Mai, A research report in the second health behavior conference, September 1992. Chiang Mai Orchid Hotel, Chiang Mai, Thailand.

Wellings K, et al (1994) Sexual behavior in Britain. The National Survey of Sexual Attitudes and Lifestyles. Penguin Books.

Wissarutrat S (2001) Unwanted Pregnancy among Teenagers in Chiang Mai. *The Nation*, August 9<sup>th</sup>, 2001.

World Bank (1994) Integrated Approaches in Reproductive Health. Population and Development : Implication for the World Bank, Washington, DC.

World Health Organization (1995) World Health Report Guiding the Gaps. World Health Report, Switzerland, WHO.

Yoddumnern-Attig B (1992) Thai family structure and organization: changing roles and duties in historical perspective. In Changing Roles and Status of women in Thailand: a documentary Assessment. Institute for Population and Social Research, Mahidol University, Thailand.

**Appendix Table 1: Background of respondents**

Code	Age	Sex	Marital Status	Education	Profession	Place of Work	Remark
P10	41	Male	Married	Doctoral degree	Doctor	STD clinic	GO
P23	39	Female	Married	Doctoral degree	Doctor	Hospital	GO
P25	35	Male	Married	Doctoral degree	Doctor	Hospital	GO
P37	54	Male	Married	Doctoral degree	Doctor	CMCC	NGO
P34	37	Male	Married	Doctoral degree	Doctor	Hospital	GO
P41	43	Male	Married	Doctoral degree	Doctor	Hospital	GO
P42	46	Male	Married	Doctoral degree	Doctor	Health office	GO
P02	50	Female	Married	Bachelor's degree	Nurse	Hospital	GO
P04	42	Female	Married	Bachelor's degree	Nurse	Hospital	GO
P06	46	Female	Married	Bachelor's degree	Nurse	Hospital	GO
P07	40	Female	Single	Bachelor's degree	Nurse	Hospital	GO
P09	45	Female	Married	Professional training	Nurse	Hospital	GO
P11	54	Female	Married	Bachelor's degree	Nurse	STD clinic	GO
P14	47	Female	Married	Professional training	Nurse	STD clinic	GO
P20	29	Female	Married	Bachelor's degree	Nurse	Hospital	GO
P21	45	Female	Married	Professional training	Nurse	Hospital	GO
P22	35	Female	Married	Professional training	Nurse	Hospital	GO
P24	37	Female	Married	Bachelor's degree	Nurse	Hospital	GO
P28	50	Female	Single	Bachelor's degree	Nurse	Hospital	GO
P29	43	Female	Married	Bachelor's degree	Nurse	Health center	GO
P31	31	Female	Married	Professional training	Nurse	Health center	GO
P32	37	Female	Single	Master's degree	Nurse	Hospital	GO
P33	36	Female	Married	Master's degree	Nurse	Hospital	GO
P01	63	Female	Widow	Professional training	Counselor	Hospital	GO
P15	36	Female	Married	Bachelor's degree	Counselor	PPAT	NGO
P16	25	Male	Single	Professional training	Counselor	PPAT	NGO
P19	29	Male	Married	Bachelor's degree	Counselor	PPAT	NGO
P26	42	Female	Married	Professional training	Counselor	Hospital	GO
P35	43	Female	Married	Bachelor's degree	Counselor	CMCC	NGO
P03	28	Female	Widow/divorce	Professional training	Health Educator	HIV testing clinic	NGO
P13	45	Male	Married	Master's degree	Health Educator	STD clinic	GO
P17	47	Female	Married	Bachelor's degree	Health Educator	PPAT	NGO
P27	37	Female	Married	Bachelor's degree	Health Educator	Health office	GO
P30	38	Female	Married	Master's degree	Health Educator	Health office	GO
P38	33	Female	Married	Master's degree	Health Educator	CDC 10	GO
P39	35	Female	Married	Bachelor's degree	Health Educator	CDC 10	GO
P40	38	Male	Widow/divorce	Bachelor's degree	Health Educator	CDC 10	GO
P43	49	Female	Single	Bachelor's degree	Health Educator	HP 10	GO
P44	40	Female	Married	Master's degree	Health Educator	HP 10	GO
P05	38	Female	Single	Bachelor's degree	Coordinator	HIV testing clinic	NGO
P18	28	Female	Single	Bachelor's degree	Coordinator	PPAT	NGO
P08	46	Female	Married	Master's degree	Social Worker	Hospital	GO
P12	25	Female	Single	Bachelor's degree	Social Worker	STD clinic	GO
P36	57	Male	Married	Bachelor's degree	Manager	CMCC	NGO

PPAT = The Planned Parenthood Association of Thailand

CMCC = Chiang Mai Community Clinic

CDC 10 = Communicable Disease Control Center Region 10

HP 10 = Health Promotion Center Region 10

Sites included: 1) family planning clinic at University Hospital, 2) Chiang Mai Provincial Hospital, 3) Lamphun Provincial Hospital, 4) Maternal and Child Hospital, 5) Chiang Mai Health Office, 6) Lamphun Health office, 7) Baan-glang Health Center, 8) Muang-nga Health Center, 9) Chiang Mai STD clinic, 10) Lamphun STD clinic, 11) Youth Health Center of CDC region 10, 12) Friends Corner of Health Promotion Center region 10, 13) The Planned Parenthood Association of Thailand, 14) Chiang Mai Community Clinic, and 15) Euang Pueng anonymous HIV testing Clinic.