Providers' Perspectives in Addressing Adolescents' Sexual and Reproductive Health Needs in Northern Thailand

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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 meeting their needs. This paper draws upon data from a qualitative study in Northern Thailand and explores the views of a range of providers, their experiences of and attitudes towards providing services to unmarried youth. Providers highlight barriers at various levels, policy and programme, facility and client that inhibit their ability to provide optimal services to young people. Some obstacles reiterate and others go beyond those expressed by young people themselves. Findings also explore provider perceptions of optimal services for unmarried youth in Thailand and are intended to guide the development of sexual health services for young people.

Key words: Health Care Providers, Adolescents, Experiences, Attitudes, Sexual and Reproductive Health Needs, Northern Thailand

INTRODUCTION

There is increasing evidence in Thailand on changing of 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; Nuchanart, 1988; Srisupan, 1990; Thevadithep, 1992; Chanakok, 1993; Puthapuan, 1994; Rugpao, 1995; Gray, 1999; Wissarutrat, 2001; Thianthai, 2004). Despite pervasive parental controls, it is clear that there has been a relaxation in sexual morals as opportunities have expanded for young people. Increasingly, they enjoy social interaction in mixed sex company, whether in schools, the workplace or entertainment spots (Soonthorndhada, 2002).

At the same time, double standards persist and sexual activity among young females in particular is strongly disapproved (Soonthorndhada, 1992; Yoddumnern-Attig, 1992). Surveys reveal wide disparities in the reported behaviour of young men and women. Koetsawang (1987), reporting on the sexual experiences of college students in Bangkok, revealed that 45.2 per cent of male and 5.3 per cent of female students, aged 19 years or less,

were sexually experienced. Another study in Khon Kaen Province, North Eastern Thailand, found that 62 per cent of male and 12 per cent of 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). The same pattern is seen in Chiang Mai, North Western Thailand, the location for the study reported here.

Moreover, there is evidence that despite relatively high levels of risk awareness, increasing 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 (Thevadithep, 1992; Rugpao, 1995). Condom use is irregular and rarely practised in sexual relations with girlfriends (Srisupan, 1990; Thevadithep, 1992; Chanakok, 1993; Puthapuan, 1994). 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 (Puthapuan, 1994). A study conducted among adolescent factory workers in Chiang Mai found that average age of first sexual intercourse was 16.5 years and most young people reported risky behaviour (Rugpao, 1995). 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. 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, though 15% with a man who was not a husband, with low condom use (16 per cent) (Rugpao, 1995).

As a consequence, concern has grown over the risk of unwanted pregnancy, sexually-transmitted infections and even HIV amongst young people in Thailand (Taneepanichsakul, 1995; Natpratarn, 1996). The rate of teenage pregnancy has increased sharply. Between 1990 and 1992, approximately 13 per cent of all births were to teenage women which was the same as in the United States and twice as high as that of the UK (Brown, 1991; Thailand Public Health Statistics, 1993; Wellings et al., 1994).

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 and Phuapradit, 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, 1996).

Despite this evidence, programmes to provide sexual health services remain largely focused on adults and on the married, and both interventions and research have generally neglected the obstacles that unmarried young people face in acquiring information, counselling, contraceptive and other sexual and reproductive health services (Rugpao, 1995; Gray, 1999). Evidence from Thailand has thus far been sparse, but research from other developing country settings suggest that unmarried young people face obstacles in their efforts to seek sexual and reproductive health services. Prominent among these are factors at the individual level, such as embarrassment and fear of disclosure of their sexual activity. They also include service and provider level barriers, including inconvenient clinic timings, lack of affordability, lack of privacy and, perhaps most crucially, judgmental and threatening provider attitudes have inhibited them from seeking services (Mehra, 2002; Tu, 2002). Studies of providers,

likewise, have largely corroborated the perceptions of young people (Koff and Cohen, 1983; Gubhaju, 2002). Findings 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 were reported to be unsatisfactory (Wissarutrat, 2001; Thianthai, 2004).

The objective of this paper is to fill the gap in what is known about obstacles young people face in acquiring sexual and reproductive health services in Thailand, with a specific focus on providers' 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 in Thailand.

MATERIALS 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. The aim of the study was to inform the design and planning of youth-friendly sexual health services for young people in Thailand. The data in this study were collected from March 2001 to March 2002 and based in Chiang Mai, a capital in the northern region and Lamphun, a small province located 30 kilometres away from Chiang Mai. The majority of the population is Buddhist (95%). Most speak both Northern and Central Thai dialect.

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 to 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 to get more information. Northern or Central Thai dialect was used during the interviews and translated into English by the research team during the process of analysis.

Providers were asked about their experience of providing services to young people, the nature of such services, the barriers they encountered, 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 domains 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 providers' 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's 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's needs with notions of acceptability at community level and ideas about informing young people of available services in an acceptable way.

RESULTS

Socio-demographic background

The socio-demographic characteristics of the sample are provided in Appendix Table 1. 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), though only one of the seven physicians was female. Most respondents were well-educated, minimum qualifications being generally a first 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 programmes 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.

Sexual and reproductive health services provided to young people

Providers reported a range of services sought by unmarried youth, both in clinic settings and in outreach programmes. Those in clinic settings reported that unmarried youth accounted for between perhaps ten to 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 counselling were reportedly provided during the course of visits for other services, or through such dedicated mechanisms as telephone counselling and special programmes (for example, Chiang Mai Youth Counselling Programmes). Common concerns for which young people sought counselling included pregnancy, abortion, family problems, school problems, love, sexual relationships, contraception, safe sex and modes of transmission of infection. In some instances, it was clear that counselling and information activities remained quite separate 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 protection. The girls are persuaded to come here by our young staff. Our job here is only for counselling and health educa-*

tion. 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. Respondents reported providing information and counselling through classroom lectures, life-skills camps, and exhibitions, and where necessary at times at which young people are free. There was some evidence of censorship in the topics discussed, and a tendency to ensure that sexual activity was discussed largely in the context of procreation.

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

Health educator, hospital, female, 28 years

Respondents from non-governmental organisations reported peer outreach programmes in which young volunteers provided information, distributed condoms and oral contraception to their peers, provided follow-up and made referrals to facility-based services at NGO clinics as needed.

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, missed periods, vaginal bleeding).

• family planning information and provision of contraceptives.

• ante-natal 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. Nursing at Maternal and Child hospital was not uncommon, despite being illegal, and it was 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 records, we found that around 70 to 80 percent of them were students.

Nurse, hospital, female, 45 years

• HIV testing and STD treatment were provided for male teenagers, and also for young female sex workers among whom testing is mandatory. Providers admitted 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 coming here. 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 was a *Youth Health Centre* recently established to provide counselling and contraceptive supplies to young people. Convenient timings were established and efforts made to enable adolescents to overcome difficulties in gaining access. However, it was reported that the centre did not succeed in attracting young clients, despite awareness raising activities in schools, work places, places of recreation (for example, gay bars) and residences (dormitories or homes).

> *...not many young people came to use our service. So we try to promote the program by distributing brochures at schools, gay bars, or even the malls. Still, the clients who usually come here are aged over 20. The older people are not as hesitant about seeing us.*
>
> *Counsellor, male, 38 years*

Obstacles to adolescent health seeking

Providers reported obstacles to service use at various levels. These include ambivalence among those launching the programmes, 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 posed a major obstacle in delivery of services to this group. Despite the fact that many providers are sensitive to the needs of young people, these cannot be met under existing policies. They also pointed out that the current policy of providing sexuality education and sexual and reproductive health services to young people as part of a generic health services (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 take the initiative in changing the current system of adult focused services themselves activities.

> *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*

Some respondents argued that the very term "STD Clinic" inhibits young people, particularly young women from attending, but noted that policies and programmes have not responded to provider- initiated suggestions to adopt 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*

Several respondents described measures taken on the initiative of staff to fill gaps in services to adolescents, including pre-marital ccounselling activities, health education activities and a special clinic outside the facility setting for STD/HIV testing. Recently there has been some attempt to reverse traditional government ambivalence—a new policy from Ministry of Public Health has outlined plans for the launch of youth-friendly services by way of the "Friends Corners', aimed at providing not only counselling for adolescents and parents, but also marketing of condoms and oral contraceptives and computer facilities for playing games, reading fortunes and accessing internet services. Providers anticipated 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 programmes are uncertain.

Facility-based obstacles:

Views tended to polarise between those in favour of dedicated youth friendly sexual and reproductive health services and those who felt young people should use services provided to the population at large. The majority view, however, was that the magnitude of these problems did not warrant a special programme for sexually-active youth.

> *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.*
>
> *Counsellor, NGO, male, 29 years*

Within facilities, providers recognised several procedures likely to inhibit young clients. These included lack of privacy in consulting rooms, making discussion of sensitive issues difficult; government authorisation to provide oral contraceptives only to married women only, thus posing yet another obstacle to young people seeking to avoid pregnancy;

incon-venient opening times and long waiting times by unmarried youth; intimidating and stigmatising names (such as STD clinic) and lack of knowledge and training on the part of providers.

While NGO facilities have been designed to enable youth to overcome these obstacles, their limited reach and lack of sustainability uncertain funding support were seen as posing their own brand of obstacles. They too were unable to establish reliable referral networks for adolescents in need.

Attitudes towards young clients:

Although many providers claimed to be sensitive to changing norms and the need to provide services to sexually-active youth, by and large, attitudes continued to be negative. Many recognised that this posed a major obstacle to young people's use of public health services. At the same time, however, many also 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 were particularly negative.

Interactions between providers and young clients appeared to have been not always friendly. Complaints were made about the amount of time required in developing rapport with adolescent clients, and eliciting from them the exact nature of their problem. This was especially the case for those located in government facilities. Many reported that they were inhibited in discussing sexual matters with unmarried adolescents, were unwilling to discuss abortion options and had difficulties in building a rapport with young clients:

> *When we gave them the knowledge, they did not respond to 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 made us feel irritated 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 counselling 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 by vagina, and told us that they had an accident. But, when we had an exam, we found the pieces of inserting tablets (for induced abortion) left 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 lack of awareness that they feared being judged by providers. Providers revealed, moreover, an impatience about addressing adolescent needs. Adolescents' confusion about their own problems was seen as requiring considerable time

and effort. They were accused of agreeing to follow 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 an instance of outreach services in a gay bar conducting voluntary HIV testing through mobile services, where 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 as making it difficult for them to allow young clients complete anonymity. Many young clients reportedly did not use their real names and addresses, yet government policy required that these details should be reported to facilitate follow up. This requirement was seen as inhibiting young people from seeking care at public clinics, forcing them instead to choose 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 addresses. 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 made by young people to obtain information about emergency contraception and medical abortion 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 how to use 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 would then give them the details. Not all of them followed it, they just disappeared.*
>
> *Nurse, hospital, female, 40 years*

Some providers clearly disapproved of the strategies unmarried youth used to avoid disclosure of their sexual activity. 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 ends 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 also expressed frustration that they were unable to address the needs of adolescents until an adverse event had 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:

At the same time, there was recognition that accompanying parents may tend to inhibit their children from expressing their needs or seeking advice. Occasionally, too, parents were reportedly unwilling to accept their child's problems and so thwarted providers' attempts to provide help. Frequently, it would be parents who would make health-related decisions for adolescents, discouraging the young person's autonomy. Some providers–particularly those from NGOs–claimed that parents accused them of providing their children with information that would lead to sexual experimentation. Some school-teachers refused to allow sexual health education 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 Counsellor, NGO, female, 36 years*

Perspectives in addressing adolescent reproductive health needs

Respondents unanimously accepted the need for special sexual health education programmes for sexually active young people. There was also unanimity in the design and content of these programmes. However, in emphasising the need, the case was made for sex education 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 facing young people, 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. They also 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 towards 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*

Many painted an optimistic 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 as they want.*
>
> *Counsellor, Health centre, 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 Counselling 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 Counselling.
- 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.

DISCUSSION AND CONCLUSION

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.

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 up-scaling may suggest that efforts be made to incorporate its central features into established facilities. 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.

Finally, parents and communities also deserve attention. We have seen that parents hold traditional gender double standards in the ways in which their children are socialised and that, as a result of norms that stigmatise sexual activity among unmarried females, adolescent girls are unlikely to seek the support or assistance of their parents in addressing sexual health problems. Parents are unwilling in several instances to agree to the provision of sex education to their adolescent daughters, while at the same time being reluctant to discuss these matters with them directly. What is required then are programmes addressed to parents, that sensitise them to the risks that young people, including young females may face, and support them in overcoming reluctance to communicate on these issues with their children and particularly their daughters.

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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 centre	GO
P31	31	Female	Married	Professional training	Nurse	Health centre	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	Counsellor	Hospital	GO
P15	36	Female	Married	Bachelor's degree	Counsellor	PPAT	NGO
P16	25	Male	Single	Professional training	Counsellor	PPAT	NGO
P19	29	Male	Married	Bachelor's degree	Counsellor	PPAT	NGO
P26	42	Female	Married	Professional training	Counsellor	Hospital	GO
P35	43	Female	Married	Bachelor's degree	Counsellor	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

Code	Age	Sex	Marital Status	Education	Profession	Place of Work	Remark
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 Centre Region 10
HP 10 = Health Promotion Centre 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.