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Peer education in sexual and reproductive health programming: a Cambodian case study

Sarah Knibbs and Neil Price

This article analyses in detail the impact and effectiveness of peer-education projects implemented in Cambodia under the Reproductive Health Initiative for Asia (RHI), in an attempt to provide important lessons for the design and implementation of such interventions and to contribute to the development of best practice. Under RHI, which was the first programme in Cambodia designed specifically to address the sexual and reproductive health needs of young people, peer education was implemented as if it were a directly transferable method, rather than a process to be rooted in specific social and political contexts. Consequently, peer-education concepts of empowerment and participation conflicted with hierarchical traditions and local power relations concerning gender and poverty; peer educators were trained to deliver messages developed by adults; and interventions were not designed to reflect the social dynamics of youth peer groups.

KEY WORDS: Social sector; Gender and diversity; Methods; SE Asia

Introduction

Peer health-education interventions with young people are often divorced from the social and political context in which they are implemented (Turner and Shephard 1999). Power relations that form an important part of the social dynamics among young people, such as those relating to gender and poverty, are regularly overlooked in many peer-education programmes and interventions. Despite the mismatch between the rhetoric and the reality of peer education, and a distinct lack of evidence-based planning, engaging young people in interventions concerning sexual and reproductive health in a way that aims to increase their autonomy remains attractive to development-assistance agencies.

In this article, after briefly setting the scene and outlining our research methodology, we present the findings from primary and secondary research into the impact and effectiveness of peer-education projects implemented over a five-year period in Cambodia.

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Background

The projects researched were part of the Reproductive Health Initiative for Asia programme (RHI), funded by the European Commission (EC) and managed by the United Nations Population Fund (UNFPA). RHI was implemented in seven Asian countries, directing sexual and reproductive health interventions to underserved populations, through partnerships between national and European NGOs. In Cambodia the RHI programme, which ran between 1998 and 2002, aimed to improve the sexual and reproductive health of young Cambodians aged 12–25 through a variety of strategies, including peer education.

RHI in Cambodia consisted of seven projects, executed by European NGOs in partnership with 23 Cambodian (implementing) NGOs, and co-ordinated by the UNFPA Country Office in Phnom Penh. The seven projects, six of which adopted peer education, were designed and funded as distinct entities, with each European NGO holding financial and technical autonomy and authority. This was reflected in variations in the ways in which the Cambodian NGOs implemented interventions, including peer education.

Research methods

The main source of our primary data is an extensive four-month participatory research exercise, undertaken in 2002, involving peer educators, young people, community members, and NGO staff. Six implementing agencies from the 23 Cambodian NGOs were selected to provide urban, peri-urban, and rural community sites for the research. Participatory Learning for Action (PLA) tools and methods were used with 35 implementing-agency staff and 150 young people (both peer educators and the 'target' group). Semi-structured interviews were conducted with staff of the European NGOs (the executing agencies); and focus-group discussions were held with young people and community members (parents, teachers, monks). The results of this participatory research are documented in Perry (2002a, 2002b). Participant observation of the RHI peer-education projects and interventions was undertaken by one of the authors (SK), who was the RHI Project Officer in the UNFPA Country Office from 1998 to 2002. In this role, she was responsible for co-ordinating the sexual and reproductive health programmes for young people in which the peer-education initiatives discussed here were implemented, and she also led the steering group which designed the methodology for, and supervised, the participatory research undertaken in 2002. In addition to the primary research referred to above, we also used quantitative and qualitative data collected by the RHI Regional Monitoring and Evaluation Project, which in Cambodia included interviews with key informants, undertaken over four weeks in December 2000. We gained further insights and primary data from a number of other published and unpublished secondary sources, produced by RHI and its component projects.

Our research had two main objectives. First, to analyse the inter-relationships between political and social factors and the peer-education interventions, for which we specifically posed two research questions: to what extent were the peer-education projects truly participatory and empowering, and what effects did power relations have on the interventions? The second objective was to explore in detail the impact and effectiveness of peer education as a strategy for addressing the sexual and reproductive health needs of young people in Cambodia, which we sought to achieve in terms of five key criteria.

The importance of context for the design and implementation of peer-education projects

Cambodia has recently emerged from an extended period of civil upheaval, including the 1975–1979 Khmer Rouge regime. Although the country has enjoyed relative peace and political

stability since 1998, experiences of trauma and repression, as well as the loss of skilled people, continue to exert an impact. Cambodia's human-development indicators are among the worst in South-East Asia. More than one third of Cambodians live below the poverty line (UNDP 2003: 317); the infant-mortality rate is 83 per 1000 live births (National Institute of Public Health, National Institute of Statistics & ORC Macro 2006); and the maternal-mortality ratio is 437 per 100,000 live births (various WHO, UNFPA and UNICEF sources). Cambodia has a generalised HIV and AIDS epidemic, with an adult HIV prevalence of 1.9 per cent (WHO/UNICEF/UNAIDS 2006). Over 60 per cent of the population is aged between 12 and 25 years (National Institute of Statistics 1999), and young people lack access to appropriate information and services for sexual and reproductive health, reflecting both the inadequate health infrastructure and the persistence of social and moral norms about young people's sexuality and reproductive health.

In the aftermath of the 1991 Paris Peace Agreement, and the UN-sponsored election that followed, there was an influx of external development agencies. This was paralleled by the growth of indigenous NGOs, some of which arose directly from the initiative of external agencies, such as the United Nations Transitional Authority in Cambodia.[1] These indigenous NGOs were heavily dependent on external project-based funding, and influenced strongly by their funders' visions of development and civil society.

Participation and empowerment

Reconstruction was the priority for development agencies entering Cambodia in the early 1990s, and few development agencies gave much attention to the social dynamics of Cambodian communities. Cambodia now has an emerging development establishment of its own, but to a large extent NGOs remain externally driven and continue to work with often inadequate attention to social and cultural contexts. Development interventions in Cambodia attempt to integrate concepts of empowerment, participation, and self-realisation in a context where hierarchy, patronage, and experiences of trauma and authoritarian leadership have led to local perceptions of power as a negative concept. Cambodian development workers regularly express discomfort with the concept of empowerment, because it is associated with giving 'power over' another (O'Leary and Nee 2001).

Empowering young people, whose age places them low in the social hierarchy, is particularly problematic in Cambodia. Lessons from RHI showed that peer education's rhetoric of empowerment was incompatible with the dominant ideas held by adult programme staff about safeguarding young people. The discourse concerning young people's health problematises young people, mixing public-health concerns with moral issues, and a tendency towards control. This is further complicated in the Cambodian context by the country's recent history. The personal and social experience of trauma and violent disruption among the generation of Cambodians who are now parents, policy makers, and practitioners creates a significant generation gap and stimulates nostalgia for a more ordered past. Tarr (1997: v) notes a 'tension between traditional or hegemonic discourses that older Cambodians value or feel more comfortable with and the sexual practices of young Cambodians which reflect a society that is less like the Cambodia of the 1950s and 1960s than most older people would care to imagine'.

Two major narratives dominate the discourse about young people in Cambodia. One, focused through the lens of the HIV and AIDS epidemic, sees young people primarily as a vulnerable group, decontextualises their sexual behaviour, and undervalues their competence. A second narrative is expressed through moral panics in the media about drug use, pre-marital sex, and young male delinquency. Both these narratives informed the views of the RHI NGO staff,

who identified young people as in need of protection and control, in contrast to the views of young people themselves, who expressed aspirations for experimentation and autonomy. Peer education was understood within RHI as a tool of social control, with village chiefs and head teachers in one project asked to select peer educators whose behaviour was considered to be acceptable to adults. This reflected the NGO's wish to make its project acceptable to 'gatekeepers', and an assumption that young people who won adult approval by studying hard, respecting adults, and avoiding deviant behaviour would be able to influence their peers to do the same.

The short timeframe of RHI spanned a period of rapid social change, with sexual experimentation, recreational drug use, and gang formation becoming more common among young people. The attitudes of staff in the projects echoed the wider social disquiet about such behaviours, as expressed in the moral-panic narrative about Cambodian youth. For example, at an RHI meeting among partner NGOs, one NGO representative described a young man who had been a gang member in the squatter community in which he lived but was now an active peer educator, delivering health messages and condoms to his friends in snooker halls. Representatives from some of the other NGOs warned of the dangers to the project's reputation and stated that they excluded anyone with a reputation for anti-social behaviour from being a peer educator. Adult perspectives and social control underpinned both sides of this argument: while the reformed gang member was legitimised as a peer educator by one NGO because older people in the community approved his rehabilitation, for others the risk of losing control of their projects' reputation by engaging with deviancy was too great.

Peer education under RHI represented an instrumental use of participation. RHI translated the term 'participation' as *ka-cholroom*, which in Khmer is synonymous with joining. Participation implied only that young people took part in project activities, even when they did so as passive recipients of information. Peer educators were recruited, trained in a pre-existing curriculum, and asked to deliver messages which project staff had designed. As such, participation remained something to be elicited from young people, rather than an expression of young people's agency. Young people were attracted to take part in project activities by the provision of leisure activities like karaoke, games, dancing, and live music. NGO staff considered a project to be participatory if it succeeded in getting young people to take part, even if only as audience members. Conversely, where it was difficult to get young people to engage, this was perceived as a failure on the young people's part, rather than a failure of the project to make itself relevant to them.

Participation in RHI did not imply young people setting agendas or challenging adult authority. NGO staff in RHI were, however, prepared to challenge some social norms in encouraging discussion of sexual issues. For instance, they regarded increases in young people's confidence, exemplified by being able to speak in public or reporting that they had been able to negotiate with a sexual partner, as a positive indicator of the success of the project. But confidence was acceptable only within limits, and empowerment was circumscribed. As noted in other sexual and reproductive health interventions on behalf of young people (see, for example, Horizons 2001; Price 2004), adults working in RHI found it difficult to cede much control to young people. For instance, the organising committee for the end-of-programme forum for peer educators, set up by the staff of RHI NGOs, was unwilling to allow young people to be members.

Power relations: gender and poverty

Gender is a significant determinant of young Cambodians' sexual and reproductive health, including vulnerability to HIV and AIDS. A woman's virginity at marriage is valued, and

rumours that a young woman has had premarital sex can be damaging to her future and her family's honour. Young women feel that by moving away from their families they might damage their reputation; they expressed this in the participatory research in terms of their fear of being labelled as 'going against what our culture expects of a good woman'. These norms make it difficult for young women to seek information or services, or to negotiate within sexual relationships. Gender norms also make young men vulnerable in a culture in which it is seen as 'macho' to take risks, and to have multiple sexual partners.

Attention to gender was very limited in RHI. Interviews with key informants revealed that most project staff were unable to describe how the sexual and reproductive health needs of young men and of young women might differ, and how interventions should address these differences. Staff demonstrated their commitment to 'gender' (a term which they always expressed in English during Khmer-language interviews) by declaring support for equitable treatment of men and women, interpreted as giving the same information to girls and to boys, and by their rationale for working in mixed-sex groups, even where this made girls reluctant to take part. The difficulty of surmounting young women's shyness was a frequent complaint made by project staff. Male and female peer educators expressed the view that young women were harder to reach and engage with than young men, and one survey of young people in RHI target communities found that 47 per cent of young men had had contact with a peer educator, compared with only 26 per cent of young women. Similarly, staff recognised constraints on young women's access to sexual and reproductive health services, but tended to emphasise physical barriers related to concerns about women's security and mobility, rather than analysing attitudinal issues. Young women repeatedly stated in the participatory research that they would prefer the opportunity to talk about sexuality and reproduction in single-sex groups.

The peer-education projects tended to reinforce gender norms that had the effect of increasing young people's vulnerability. In most interventions, young women were informed about condom use and the dangers of sexually transmitted infections and unwanted pregnancy, without any discussion of how they might negotiate safe sex with their partners. All they gained from such sessions was a sense of fear and powerlessness. Where discussions about sexuality took place in a group dominated by young men, young women tended to stay silent. Staff were unable to challenge such dynamics: gender being a concept that most Cambodian development workers consider culturally alien (O'Leary and Nee 2001). However, one project devoted time and effort to creating an environment where project staff could discuss and question their values about gender; and in another project, staff spent time in single-sex groups discussing *inter alia* gender-specific issues like the pressures of male gender roles. It is striking that neither of these projects used peer education as a main strategy, preferring to equip professional staff to work directly with young people.

The poorest young people are particularly vulnerable in terms of their sexual and reproductive health, because they are less able to access services and information and are more likely to be exposed to additional risks such as trafficking, transactional sex, migration, and homelessness. Although some of the groups targeted by RHI NGOs, such as street children and those living in slum areas, were by definition poor, there was little evidence that poverty was analysed as a determinant of young people's vulnerability. The projects' capacities to reach poor young people were not routinely monitored.

In one RHI peer-education project working in a remote rural area, there was clear recognition of the dynamics related to poverty and hierarchy in the community. Because of local fears that the project was a cover for religious proselytising, political activity, or trafficking, the implementing NGO sought the support of village chiefs who offered their homes or gardens as venues for health-promotion activities. However, later in the project it emerged that significant

numbers of young people were excluded from activities; most often these were from families and parts of the village considered to be poor and low down in the social hierarchy.

Staff and volunteers in Cambodian NGOs are upwardly mobile in social terms, and those with higher qualifications, particularly medical doctors, tend to have come from affluent social backgrounds. Their distance from the poverty experienced by some young people can be problematic. In an NGO-run clinic offering services to young people, for example, services were provided free or at a reduced price to 'poor' youth. However, the clinic staff were left to decide who was poor, and this proved contentious. Some young clients who were referred to the clinic by an NGO working in a slum community were refused free treatment because clinic staff judged from their appearance that they were not poor. It transpired that young people borrowed clothes and jewellery to wear to the clinic because they were ashamed to look poor.

These examples illustrate the lack of awareness within RHI of the social dynamics affecting poor young people. Economic pressures on young people were identified as a barrier to peer education, where the need to contribute to the family's income made volunteering a luxury that few young people could afford. Some NGOs dealt with this by providing peer educators with rice under the World Food Programme's 'Food for Work' scheme, while others provided financial incentives. These strategies created conflict among NGOs: some expressed concern that if unpaid peer educators met those from another project who were paid then they would also demand payment. But the debate about strategies to engage poor youth in peer education rarely got beyond such territorial issues, with little attention paid to how far poverty determined who was able to become a peer educator, and which young people they could access.

The paucity of resources and services also influenced peer education under the RHI. Peer educators were often the only health resource available in their communities. Some peer educators reported in the participatory research that older people sought them out to ask questions about sexual and reproductive health; they also described how they tried to act as 'para professionals', offering diagnoses on matters of sexual and reproductive health to people who asked for help. This behaviour by peer educators was linked to power dynamics: peer educators felt confident in the status accorded to them and regarded referral to a service as an admission of failure. In an exercise undertaken as part of the research to explore what a peer educator needs to know, some peer educators displayed clear diagnostic ambitions about sexually transmitted infections, as well as proposing that they should find out about young women's menstrual cycles in order to instruct them in the calendar method of birth spacing.

In summary, peer education as implemented by RHI in Cambodia was characterised by a number of key problems, relating to the applicability of concepts of empowerment and participatory development practice, and the failure to take adequate cognisance of the social context and the power relationships that structure peer-education interventions.

An analysis of the impact and effectiveness of peer education

RHI is not unique in its failure to question the appropriateness of importing peer health-education strategies and interventions that have been developed and applied in other contexts. There is abundant evidence that peer education is not easily transferable, as different social contexts influence its relevance and effectiveness. The uncritical importation of peer health education by RHI was – implicitly at least – informed by a number of assumptions and rationales in the literature on development practice (see Turner and Shephard, 1999, for a summary). Five of these assumptions are explored below, on the basis of evidence from the RHI, in order to draw out lessons learned, and to contribute to the identification of good practice in working with young people in the Cambodian and wider contexts.

Peer educators are credible sources of information

The credibility of peer educators in RHI interventions is assessed according to three criteria: person-based, experience-based, and message-based (Shiner and Newburn 1996). As noted, many peer educators were selected by adults because they were perceived as being 'well behaved'. Such peer educators had person-based credibility with only a limited number of their peers: the very reasons why they were selected, such as good school reports, made them unpopular or unapproachable in the eyes of many in their age group. Experience-based credibility was obscured in RHI, because peer-educator training emphasised the transference of factual information, rather than encouraging peer educators to reflect on or use their own experiences. Message-based credibility was particularly problematic. Peer educators emphasised the importance of detailed technical or scientific knowledge in their peer-education work. More than 95 per cent of peer educators who were asked during the participatory research about the type of information that a peer educator needs to know in order to fulfil his/her role responded that they needed to know the correct anatomical terms associated with the male reproductive system and to understand the anatomy and physiology of menstruation; in contrast, less than half of the staff of the implementing NGOs felt that this was important (Perry 2002b: 32). Peer educators' demands for such technical information need to be understood in the context of prevailing attitudes to learning, teaching, and knowledge in Cambodia. Although most of the peer-education interventions took place outside schools or other formal institutions, there was a tendency for the language and practice of peer education to emphasise the values of formal education. Peer educators spoke of 'studying sexual and reproductive health subjects' and 'teaching their peers', and said that they invited young people to 'come and learn'. While many peer-education sessions were conducted in a lively way and some peer educators proved to be talented educators, their practice was built on a didactic model of knowledge transmission. This derives from the pervasive influence of experiences of a school system in which factual knowledge is highly prized, rote learning is emphasised, questioning authority is frowned upon, and teachers are accorded high respect (O'Leary and Nee 2001). The emphasis on facts and correct answers meant that it was difficult for NGO workers and peer educators to acknowledge that some issues are complex and cannot be 'solved', and many described feeling under pressure to offer solutions to young people's problems.

Peer education builds on existing interactions

The RHI experience indicates that the idea of peer education building on existing interactions between young people can be contested on two levels. First, the kinds of interaction in which young people engage are not necessarily the positive and supportive exchanges assumed in the simplistic view of social dynamics between young people that underlies peer-education practice. Second, interactions between peer educators and their peers in Cambodia tended to be hierarchical. Peer education is based on the assumption that young people prefer to seek information and advice from other young people rather than from adults. The participatory research findings challenge this assumption. Young people emphasised that they are most influenced by and most likely to seek support from older family members. Young women working in garment factories describe one of the hardest parts of their transition to urban life as the distance from their families, especially their mothers. It is only among those young people who live on the streets, often following family breakdown, violence, or abuse, that friendship ties are perceived as replacing family ties. Young people expressed varied feelings about friendships with their peers. Young men in particular identified friends as a potential source of problems, with one

describing how there 'can be jealousy between friends and they can persuade us to do bad things like steal and gamble and go to brothels'.

There is a paucity of information on what young Cambodians talk about to their peers, and whether they talk about sexual matters. Peer educators in the RHI programme stated that they found the discussion of sexual issues with their peers challenging. It is not clear whether this was because they were uncomfortable with the subject of sex, or because the kind of conversation they were being asked to have was markedly different from their usual interactions. Peer educators were most comfortable in explaining factual information, but were less confident talking about sexual relationships and puberty. Male peer educators specifically expressed discomfort discussing issues about puberty and sexual relationships with female teenagers. In assuming that it would be appropriate for a young man to discuss such sensitive topics with a younger woman, RHI was demonstrating an interpretation of peer education that took insufficient account of the dynamics of young people's interactions, especially in relation to gender.

Peer education rests upon an idealised view of relationships between young people, in which interactions are assumed to be positive and altruistic (Dilorio *et al.* 1999). However, recent research (GAD Cambodia 2003) shows that sexual violence (including rape) by young men in Cambodia is more common than previously acknowledged. This was confirmed by the RHI participatory research, which showed that young people from all social backgrounds (but especially young women and street children) fear being the victims of physical (including sexual) violence, including abuse at the hands of other young people. Violence was present as a shadowy issue at the margins of the RHI, and inadequately addressed in the projects. None of the partner NGOs had codes of conduct to advise on how peer educators should work appropriately with their peers, or procedures to deal with abuses of the peer-education interaction.

Peer education in RHI was hierarchical, with peer educators clearly possessing a higher social status than their peers. RHI emphasised the passing on of knowledge, through a hierarchical educational model in which peer educators 'taught' other young people. Peer educators learned to decontextualise sexual and reproductive health and see it as a technical discipline. New knowledge gave the peer educators status and power; field observation of peer educators at work confirmed that they had gained a higher status than their peers. These differentials in status and power made many peer educators unapproachable, as their 'ability to empathise with other young people is altered and "professionalised" to conform to the educational messages given out to young people by NGO[s]' (Perry 2002a: 18).

Young people identify with their peers

Our observations and data from the participatory research indicate that, with peer educators having higher status and more power than other young people, the concept of peer identity does not play a significant role in the practice of peer education in Cambodia. Adult discourses about young Cambodians articulate 'youth culture' and 'youth identity' as threats to social order. RHI practice reflected these discourses, with NGO field staff willing to engage with youth culture as a medium for raising awareness, but not accepting that young people's worldview was a valid alternative to their own.

Young people who took part in the RHI participatory research expressed the view that although Cambodia has an emerging youth culture (or subcultures), the values that young people define as 'traditional' and 'Khmer' remain important, especially for young women. The family is still perceived as an important source of support and of obligation, but young people recognise that this conflicts with their own lifestyles and the norms of their peer group. Many young people stated in the research that having sex outside marriage, drinking alcohol, and using recreational drugs were important leisure activities among their peer

group. One group of young men from a poor rural area in Prey Veng concluded: 'We want to be different. We want to have long hair or shave our heads, we want to listen to our kinds of music and watch sexy videos. We want people to know that we are different from children and adults.'

Another problem with identification was that the peer educators, as in many peer-education programmes, were a highly motivated and self-selecting group who were not typical of their age group. In RHI, some NGOs used authority figures like teachers or village leaders to select peer educators on the basis of their acceptability to adults, not to their peers. Project staff also emphasised criteria such as the ability to read and write, because of their own concern about the difficulty of training illiterate peer educators, and also to avoid issues that such peer educators might face in reaching better-educated young people.

Peer educators act as role models

The RHI peer-education interventions shared an underlying assumption that peer educators would act as role models, an assumption which underpins much of peer-education theory and practice (Ochieng 2003). However, the expectation of role modelling was not clearly articulated in RHI peer-educator training, or monitored during project implementation. References by NGO staff, albeit infrequently, to peer educators as role models were made in relation to their social skills rather than their ability to role-model safe-sex behaviour. For example, while one project officer expressed her hope that young female peer educators would be role models for girls to be more assertive, and that relationships between male and female peer educators would model a positive way for the sexes to relate as equals, she did not consider negotiating condom use as an appropriate role model for young women. Some peer educators articulated the difficulties that they faced in putting safe-sex messages into practice. In an informal interview with a particularly energetic male peer educator, who wrote and performed songs about safe sex, he admitted that he felt unable to put his own messages into practice. Although unsure of his HIV status, he felt that – as a former street child – his sexual history meant that it was too late to start using condoms for personal protection. Such anecdotal evidence suggests that peer educators' tendency to decontextualise the issues they talked about was sometimes a coping strategy, and that they had not had the opportunity to resolve their own concerns about sexual issues.

Peer education benefits peer educators

As has been observed in other contexts (for example, Ochieng 2003), the benefits of peer education for peer educators are relatively easy to demonstrate. In a context where opportunities for training and career advancement are rare, where economic pressures are acute, and many young people are unemployed or underemployed, the prospect of becoming a peer educator is very attractive. Peer educators gained skills and knowledge, small financial incentives, and payments in kind. Observation of peer-education activities indicated that many peer educators developed training and facilitation skills and increased confidence. Peer educators reported that they made more friends and were better able to communicate with adults. Some were able to secure full-time employment with NGOs.

As in other peer-education interventions, however, some peer educators in RHI appeared to be affected negatively by their role. Some NGO staff, for instance, reported that peer educators were subjected to slander and gossip, with accusations by adult members of the community that they knew too much about sex and/or were infected with HIV. Also, given the paucity of health services in many communities, some peer educators were burdened by tasks that were not always appropriate. In one case, peer educators were given young people's HIV test results

by the testing centre and were expected to pass on the results to the clients. As well as evidently breaching confidentiality, this information was enormously powerful in a context where discrimination against HIV-positive people is severe. Peer educators, in their late teens and early twenties, who had received only a half a day's training in counselling, had an unfair psychological burden placed on them, with some unsurprisingly expressing anxiety about communicating positive results.

Conclusions

Within the RHI, an externally legitimated critique of Cambodian sexuality, resting on an inadequate interpretation of cultural values, meant that staff working with peer educators lacked opportunities to reflect on their own values or the value-based messages of their work; and that they were left to tread their own path between discourses of reproductive rights and participation, outsiders' judgements of Cambodian sexual *mores*, personal moral values, and the harsh social realities in which young people negotiate their sexual lives. Concepts of empowerment and participation conflicted with hierarchical traditions, and this clash was further complicated by recent experiences of repression and trauma. Young people were perceived as being both vulnerable and potentially deviant, and it was difficult for adults to take a positive view of greater autonomy for young people. Peer education was conceived as a means to reach young people with messages that adults felt would be good for them.

The failure to base interventions on social realities limited peer education's potential as an effective tool for promoting sexual and reproductive health. Peer education was implemented as if young people's interactions and communications about sexual issues could be divorced from their social context. Social dynamics concerning gender and poverty shaped peer education under the RHI, but these dynamics were experienced as constraints to implementation, rather than taken into account in the design of interventions. Implemented in a somewhat 'gender blind' manner, peer education risked reinforcing gendered power relations, limited young women's involvement, and missed opportunities to challenge gender norms that contribute to the vulnerability of both sexes. Other power relations that form an important part of the social dynamics among young people, such as those related to poverty, were also inadequately reflected in the model of social relations that informed these peer-education interventions. Peer education was taken on by RHI as if it were a proven and transferable method for health promotion, rather than a social process that needed to be rooted in the specific social dynamics of diverse peer groups.

All but one of the dominant rationales for peer education can be contested on the basis of the RHI interventions in Cambodia. The processes and practices of peer education in RHI were at variance with the ideal suggested by these rationales because the social, political, and cultural context was so different from the societies where peer education developed. The absence of research data on the social interactions, dynamics, and allegiances of young people in Cambodia meant that peer education in RHI was based on optimistic assumptions. The only rationale for peer education that was vindicated is that peer educators themselves benefit from the process. The credibility of peer educators was problematic, because they were delivering messages devised by adults, and the messages had a disease-control perspective, tended to be decontextualised, and emphasised the delivery of facts rather than the discussion of how knowledge might be transformed into safer behaviour. This style of peer education was didactic and hierarchical and could not be regarded as building on existing interactions, which in any case were not well understood. Similarly, ideas of peer identity and role modelling could not be effectively applied, because the social dynamics of youth peer groups in Cambodia were not thoroughly

understood; instead, these interventions built on generic assumptions about how young people might communicate with and influence one another.

The popularity of peer education lies in part in its emotional and intuitive appeal as a methodology that exhibits young people's capacity to be altruistic, energetic, and creative. In practice this can mean that peer education is accepted as a good thing in itself and not analysed critically. The young people who worked as peer educators in the RHI often proved to have far greater capacity than the NGOs and funding agencies had envisaged, but the peer education that they delivered was constrained by the social and political context, the didactic style of the training they received, and the pervasive adult control over their interventions. Our analysis does not suggest that peer-education methodology is incompatible with the Cambodian context. Rather, it highlights the importance of learning lessons from some of the early examples of peer-education interventions in Cambodia in order to inform the design and practice of future interventions. If peer education is to achieve its potential as a means of health promotion that can enrich and empower those who participate in it, there is a need to develop paradigms of peer education that are built on a realistic understanding of the dynamics of specific social groups. In the case of Cambodia, this would include improving knowledge of social relations among young people, designing interventions that take account of Cambodian power relations, and supporting practitioners through the difficult process of relinquishing control over interventions.

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Note

1. UNTAC was the caretaker administration which oversaw the country from 1991 to 1993, during which time a new constitution was framed, national elections were held, and some 350,000 refugees returned from camps on the Thai border.

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