

A Multi-method Assessment of SiRCHESI's Hotel Apprenticeship
Program for Women Formerly Selling Beer in Cambodia

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Abstract

A multi-method assessment of the Hotel Apprenticeship Program (HAP) run by the NGO SiRCHESEI was undertaken. HAP was designed to help Cambodian women change from a toxic work environment where they sell beer, to a healthier, safer and more secure workplace in hotels in Siem Reap, Cambodia. Following eight months of classes in English, Khmer, and health, life and social skills, in addition to daily shifts of mentored hotel training, participants had sixteen months of further contracted work. Effectiveness of the program was demonstrated in improving some measures of health-related behaviour (except condom use), self-esteem, and job satisfaction. Less consistent quantitative results were found in evaluating the educational and or job-training performance. However, qualitative investigation reveals overall improvement for participants. An examination of the hotel environment is also undertaken, revealing potential barriers to further collaboration. Participants who left the program are considered, to determine any factors that might predict future dropouts. Implications of the research for future study and future iterations of the program are discussed.

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A Multi-method Assessment of SiRCHESEI's Hotel Apprenticeship Program for Women Formerly Selling Beer in Cambodia

In the aftermath of the genocidal reign of Pol Pot and the Khmer Rouge, Cambodia ranks as the 24th poorest country in the world, according to the United Nations Development Programme's Human Poverty Index (2007). With international assistance, the country began rebuilding in the 1990s, as a new horror emerged in Cambodia, in the form of the HIV/AIDS pandemic. By 2000, it was being described as having one of the highest prevalence rates in South East Asia. The non-governmental organisation (NGO) SiRCHESEI (Siem Reap Citizens for Health, Educational and Social Issues), begun in 2000, introduced a model of community-based participatory action research (PAR) (Lewin, 1946; Chataway, 1997) to engage, on the one hand, with local Siem Reap citizens, officials, health workers, and change advocates; and on the other, with international researchers, educators and students. Together, they would investigate and confront the HIV/AIDS situation in Cambodia. Although interventions and interviews have been conducted since 2000 with a wide range of groups, one primary focus has been women beer sellers. They are referred to in the industry as 'beer promotion women' or 'promotion girls,' and by local men as 'beer girls,' or, in Khmer, 'srei lancé.' The women are employed by international beer companies to sell particular beer brands in bars and beer gardens in Siem Reap, throughout Cambodia, and around the world, e.g. Singapore, China, Laos, Australia, New Zealand, Canada and the United States. These women have been described in several studies (Quinn, 2003, Bury, 2005, Klinker, 2005 , some in conjunction with SiRCHESEI investigations (McCourt, 2002; Schuster, 2006; Pagnutti, 2006). They are variously described as: i) not receiving a "fair " or "living wage", ii) receiving inadequate training in sexual health issues, iii) often wearing sexually provocative uniforms or outfits, iv) being subject to

violence, sexual harassment and sexual coercion in the workplace, and v) being forced to drink large quantities of alcohol nightly with their customers. Some are forced to sell sex to make financial ends meet, and female beer sellers are often classified as 'indirect female sex workers' (National Center for HIV/AIDS, Dermatology, and STDs [NCHADS, 2003]). Despite this, they are generally excluded from the international health plans and HAART (Highly Active Anti-Retroviral Therapy) programs run by international breweries for whom they may be the major sales modality (van Merode, Dy, Kros, & Lubek, 2006).

Private corporations have often proven to be effective partners for NGOs (Austin, 2000; Heap, 2000), so efforts have been made by SiRCHESEI and other NGOs to engage the beer industry to help these women in the workplace; but these efforts have been met with some recalcitrance and little success (Lubek, 2005). Following much local discussion and data collection, a new initiative, SiRCHESEI's Hotel Apprenticeship Program, was created as a partnership with the major industry in Siem Reap, the hotel industry. The SiRCHESEI program involves a two-year course for former beer sellers, including training in English and Khmer literacy, social and life skills, and reproductive and sexual health; combined with an internship in one of nine local partner hotels, with a 'living wage' guaranteed.

This thesis project follows from a series of individual research courses/internships supervised by Professor Ian Lubek, a founding member and research partner of SiRCHESEI. Some of the questions to be explored below originate from earlier experiences in data analysis with the large volume of survey and interview data collected from beer sellers in Siem Reap between 2004 and 2008. These analyses have tried to determine whether workplace conditions had changed over the years, and have sought to evaluate the outcomes of previous efforts by NGOs and by the beer industry itself to improve the situation of the beer sellers. Much of this research is not yet published in scientific journals, but has been reported in various conference presentations (e.g. Lubek, 2008a,

b), in press reports in countries such as Netherlands, Denmark, Cambodia and Singapore, and/or in SiRCHESE's own press releases (Lubek, 2008c) available as "Resources" at www.fairtadebeer.com. Additional data is being first released in this thesis.

Cambodian Historical and Economic Context

While on the surface Cambodia appears to be a nation full of shiny, happy people, a deeper look reveals a country of contradictions.... Angkor is everywhere... a symbol of nationhood and fierce pride, it's a fingers-up to the world, stating no matter how bad things have gotten lately, Cambodians built Angkor and it doesn't get better than that.... The contrast with the hellish abyss into which Cambodia was sucked by the Khmer Rouge has left people profoundly shocked.... Such suffering takes generations to heal. Meanwhile the country is crippled by a short-term outlook that encourages people to live for today, and not to think about tomorrow because a short while ago there was no tomorrow (Lonely Planet, 2006. p. 57).

The Lonely Planet guide, *Southeast Asia on a Shoestring* (2006) contains an extensive section on tourist travel to Cambodia, highlighting the country's natural beauty, beautiful architecture including the temples of Angkor Wat, and active nightlife. However, even if one experiences Cambodia in the often superficial and selective manner of tourists, the lasting impact of the country's dark twentieth century history cannot be ignored. The American bombardment campaign, circa 1970, killed hundreds of thousands, and was followed (1975-1979) by the genocidal regime of Pol Pot and the Khmer Rouge. It is estimated that approximately 1.5 million Cambodians died in the 'Killing Fields' or of forced starvation during this time. The Vietnamese occupation then lasted more than a decade until 1991, when the United Nations' Transitional Authority in Cambodia (UNTAC) arrived to oversee the preparation of democratic elections in 1993, and despite their presence, factional fighting continued until at least 1997. These three decades of upheaval have left Cambodia one of the region's poorest countries (Tarr & Aggleton, 1999); and has left indelible marks on the Cambodian psyche (Lubek & Wong, 2001)

As the country began rebuilding in the 1990s, tourism grew rapidly, eventually becoming one of two major industries propelling the Cambodian economy, alongside textiles (Central Intelligence

Agency, 2008). After the departure of UN peacekeeping troops and the ratification of the Cambodian constitution in 1993, foreign visitors increased from 118,000 in 1993, to 177,000 in 1994, to an estimated 200,000 in 1995 (Leung, Lam, & Wong, 1996). By the new millennium, growth was increasing dramatically, with international visitors to Cambodia almost doubling between 2004 (1,055,202) and 2007 (2,015,128) (Ministry of Tourism, 2007). This tourist boom was accompanied by a hotel-building boom in Cambodia (Lubek, Wong, McCourt, Chew, Dy, Kros et al., 2002). However, as is common in Southeast Asia, many visitors have been sex tourists (Truong, 1990), and along with the many soldiers and tourists of the 1990s came a new challenge: the HIV/AIDS pandemic.

The first detection of a case of HIV in Cambodia was reported in 1991 (Marseille & Garbus, 2003). Cambodia's conflicts had decimated its infrastructure, and much of Cambodia's educational, legal and health care systems had been crippled by the Khmer Rouge's systematic killing of the country's 'intellectuals' (Lubek et al., 2002). The disease hit particularly hard and by 1997, there were a reported 210,000 Cambodian adults living with HIV/AIDS. This number declined rapidly in the following years, and by 2007 had reached 70,000 (Joint United Nations Program on HIV/AIDS [UNAIDS], 2008). However it has been suggested that this decline in prevalence may reflect the high mortality rate for those first infected, rather than an actual decline in incidence of the disease (Marseille & Garbus, 2003). Between 1991 and 2000, it is estimated that HIV/AIDS killed 37,000 Cambodians (Marseille & Garbus, 2003). Anti-retroviral therapies (ARVT) began entering Cambodia in 2002. Nonetheless, in 2007, 6,000 Cambodians died of HIV/AIDS (UNAIDS, 2008).

Creating Effective HIV/AIDS Interventions

International health workers have suggested in the past that a purely biomedical approach to HIV/AIDS was inadequate to deal with all the emerging complexities of the pandemic (Asthana & Oostvogels, 1996). There exist risk factors in the transmission of HIV/AIDS at all levels of society:

cultural, economic, political, social, and individual. Each level must be addressed in any comprehensive approach to confronting HIV/AIDS in Cambodia. Thus to fight against HIV/AIDS across all levels, the World Health Organisation's (WHO) 1996 Global Programme on AIDS advocated "integrated, community-based strategies which involve peer educators and support groups and which seek to take into account the wider social, cultural and economic factors associated with the risk behaviours" (Asthana & Oostvogels, 1996, p. 113). This is again echoed in more recent WHO reports (2008) that continue to emphasize the importance for healthcare workers to engage with the local populace in creating interventions. Such programmes, which rely on support from members of the communities they hope to affect in addition to institution-level public health efforts, have both pragmatic and political/psychological benefits. From a pragmatic standpoint, community-based strategies provide access to normally stigmatized and marginalised groups (Chataway, 1997) – and several of the demarcated risk groups for HIV/AIDS, such as men who have sex with men, intravenous drug users, and sex workers, fit into those categories of marginalization (MAP, 2005). Members of these groups often feel suspicious of initiatives organised by the powerful echelons of society (Nutbeam, Blakey, & Pates, 1991). There is also indigenous knowledge that comes from those directly involved in the community (Fine et al., 2001), and the background indigenous understanding of cultural practices, and both are important to consider in implementing an intervention (Asthana & Oostvogels, 1996). Campbell (2003), in describing a comprehensive HIV/AIDS intervention program for miners and other community groups in South Africa, emphasises the importance of respecting and utilizing local and cultural practices in designing an effective intervention. Community participants are invaluable in ensuring that the program works within the context of the pre-existing community practices.

Community participation also has advantages from a political (and psychological) perspective as well, because of its potential to empower its participants (Fine et al., 2001). From this perspective,

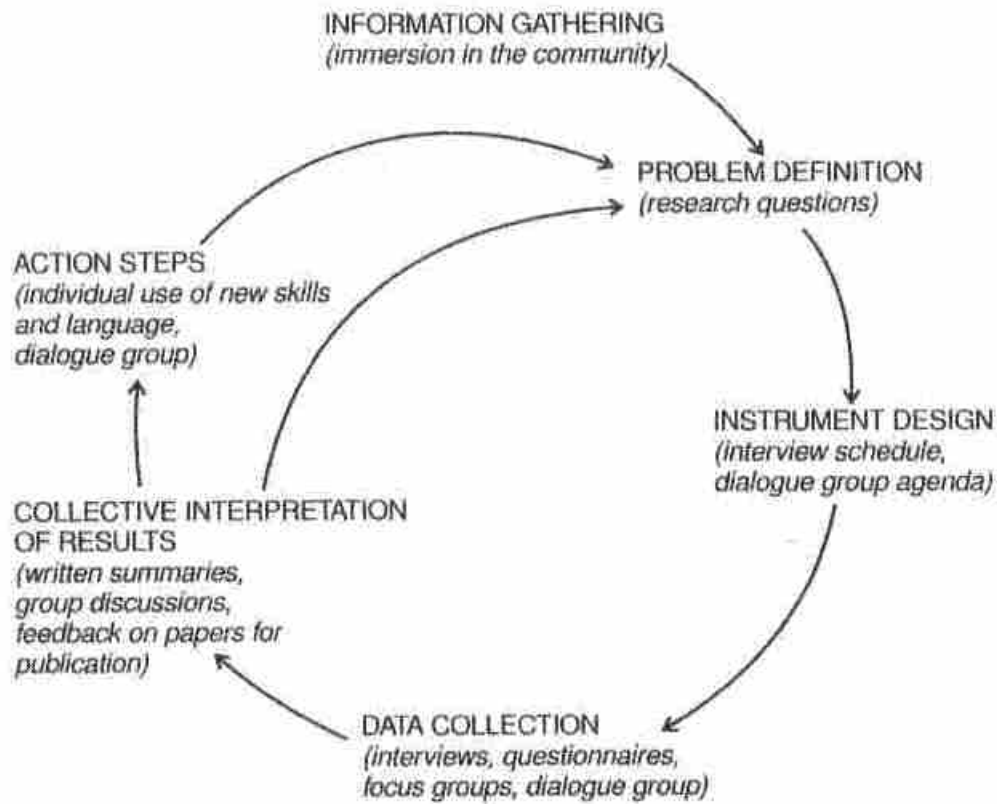
community participation is not just a means to an end, but an end in and of itself (Asthana & Oostvogels, 1996). Campbell & Mzaidume (2001) explain how, in the absence of regulation and intervention from those in power, organisation through community participation interventions establishes an environment of 'social capital' in which community members feel a sense of integration that encourages collective decision-making, relationships of trust among the community members, and relationships of reciprocal help and support. Such participation allows the communities to confront and reduce factors from outside the community, such as "economic exploitation, gender subordination, racial, ethnic, and nationalistic conflict and human rights abuse" that are among the root causes of the HIV/AIDS pandemic (Asthana & Oostvogels, 1996, p. 135).

'Action research' is a long-standing theoretical and methodological framework for empirically-based, community-organised interventions, introduced to psychologists by Kurt Lewin (1946), and later expanded into 'participatory action research' (PAR) by Chataway (1997) and others. For Lewin (1946), any intervention designed for a specific community must be responsive not only to the problem it intends to address, but also to the wider context in which the problem occurs, the community's present line of action, and the individual characteristics of that community's members. Otherwise, the intervention will not succeed. In order to accomplish this, he suggests a feedback loop between empirical research into the situation, intervention design, and intervention implementation, with empirically-generated evaluations of early forms of the intervention guiding development of the later forms (Lewin, 1946).

This research model was expanded in Chataway's (1997) PAR (see Figure 1). Before even establishing the research topics or intervention goals, the first step for Chataway is an immersion in the target community for the purposes of information-gathering. Thus, it is community members who establish what may be needed as an intervention, and what form that intervention should take (Chataway, 1997). Then, as research progresses, the Lewinian feedback loop establishes new

research goals and methodologies. PAR “draws on multiple methods, some quantitative and some qualitative, but at its core it articulates a recognition that knowledge is produced in collaboration and in action” (Fine et al., 2001, p. 173)

Figure 1. A model for Participatory Action Research, as proposed by Chataway (1997, p. 753).



Using PAR principles, a series of in-depth, semi-structured interviews was conducted in 2000 by Ian Lubek in Siem Reap and Phnom Penh, Cambodia, as a form of community needs assessment. Citizens were asked to explore the psychological aftermath of the Khmer Rouge period, their current lifestyle (including social and sexual risk-taking in the midst of the HIV/AIDS pandemic), and the possible futures they saw for Cambodia (Lubek & Wong, 2001). What emerged from the interviews was a collective view of the desperate current situation and a prioritized list of social changes needed in the community. Following a PAR model, the participants of the interviews were collectively informed of the results. Following discussions, they themselves decided to initiate new strategies for health promotion in Siem Reap. They created a Cambodian NGO – the Siem Reap Citizens for Health, Educational, and Social Issues (SiRCHESEI). This group of Cambodian citizens welcomed local and international collaborators, among them psychologists, medical practitioners, students, officials, and social change advocates (Lubek, 2008b). Health issues appeared in these interviews as the top priority for SiRCHESEI (Lubek & Wong, 2001), and that category included sexual health education, condom use, and HIV/AIDS protection, especially among community groups of women at risk.

Previous research (Wong, Chan, Chua, & Wee, 1999; Wong, Chan, Koh, & Wee, 1999) had demonstrated the effectiveness of a PAR-based 100% condom-use education campaign in Malaysia and Singapore in reducing rates of gonorrhoea and HIV/AIDS infection. With the guidance of Dr. Mee Lian Wong from the National University of Singapore, SiRCHESEI first adapted these Asian “best practices” and then, in Khmer focus groups, culturally fine-tuned them for the first health education workshops. Cambodia-specific images were added into educational materials, an instructional videotape was converted to audio-cassettes to suit local media practices and understanding, and advertising posters and teaching aids were ‘toned down’ to make them less

overtly sexual (Lubek, 2008a). Initial workshops were conducted with women beer sellers and married women – both identified by the community and by local medical experts as high-risk groups. Later, following the suggestion of community members, the workshop was adapted for use with other groups, including local men and young persons who work as merchandise vendors near the temples at Angkor Wat, and who are often subject to the sexual advances of tourists (Tarr & Aggleton, 1999).

Cambodian Beer Sellers

One group in particular was identified as a high-risk group in the community needs assessment interviews conducted in 2000, and corroborated in periodic government epidemiological data on HIV/AIDS prevalence (e.g., NCHADS, 2003). These were the women beer sellers, and they have become a focal point for much of SiRCHESEI's efforts. Women hired for these positions are generally young and attractive, and were often asked to wear revealing, branded uniforms representing the beer they competitively sell in Cambodia's bars, restaurants, and beer gardens. They often sit and talk with the primarily male clientele, and continuously encourage them to drink their brand, pouring additional beer into the glass, opening new bottles or cans, adding ice to cool the beer, and drinking glasses of beer themselves. The beer companies operating in Cambodia include Heineken and its partner/subsidiary brands (ABC, Tiger, Anchor, Guinness, Kingway, Cheers, Bintang, etc.), the Carlsberg family of beers (Angkor, Beer Lao, Holsten, Hite, Royal Stout, etc.), and AB-Inbev/Interbrew brands (Beck's, Cass, Budweiser, Bass, Branik, Corona, Labatt Ice, 3 Horses, Stella Artois, etc.). As well, numerous other beer brewers – in addition to wine, scotch and cognac producers – also have women selling their products (e.g. Asahi, Mittweida, Oettinger, Bavaria, Hollandia, Leo, Pax, Singha, and San Miguel) (SiRCHESEI, 2008). It is estimated there are over 4000 beer sellers employed in all of Cambodia (Bury, 2005). It is, however, by no means a job exclusive to Cambodia – though Cambodian beer sellers do face obstacles not encountered in all countries where beer sellers work.

Schuster (2006) compared beer sellers in Cambodia and Canada. Canadian beer promoters were hired through modelling agencies—earning about \$25 hourly-- or from universities, and work part-time at beer festivals and for promotions in bars and clubs. The “beer sellers”, by contrast, are hired in bars and restaurants to sell multiple brands, and generally earn about \$10.00/hour; when tips are added in, this amounts to \$846.10 mean earnings per month; more than double their monthly expenses (Schuster, 2006). There are strict guidelines enforced upon the industry by governmental regulating bodies, and Smart Serve Ontario (1999) trains all beer sellers before they can start work in alcohol-selling establishments. Thus legislated regulations, criminal and civil court procedures, as well as culturally-entrenched practices and norms all ensure that Canadian beer sellers are safe in their workplaces: they are forbidden to drink on the job, may not be touched by customers inappropriately, are responsible to prevent alcohol abuse, are highly-trained and highly-knowledgeable about sexual and reproductive health issues, and have workplace mechanisms in place to deal with harassment and violence. In Schuster’s sample (2006), 88.4% of Canadian beer sellers generally enjoyed their jobs, while 71.6% said it improved their self-esteem/self-image, and 60.1% said it made them feel empowered.

The situation in Cambodia is startlingly different. Cambodian beer sellers in Schuster’s sample (2006) were paid a mean of \$58.30 per month, which covered only 48.7% of their monthly expenditures. They had more dependents on average – 3.33, compared with 0.08 in Canada – and so felt additional economic pressures from the wage gap between needed monthly income and actual earnings (Schuster, 2006). Cambodian beer sellers frequently drank with customers: 71.7% reported drinking in the workplace during their most recent shift, as compared to 19.4% of the Canadian sellers, with many only drinking at the end of the shift, after the bar was closed. Strikingly, 97.8% of Cambodian beer sellers said they believed their drinking had become hazardous to their health, compared with 4.2% of Canadian sellers (Schuster, 2006).

Preliminary re-analyses of data are reported from 411 Cambodian beer sellers between 2004 and May, 2008. This includes Schuster's [2006] data but omits 2 data samples from August, 2008, N=68). Overall, her assertions about the dangerous alcohol consumption by beer sellers are supported: 70.3% of beer sellers reported drinking alcohol on the two consecutive nights included in the survey research, while only 6.0% abstained from drinking on both nights. Furthermore, relevant indicators suggest that when the women beer sellers drank, they drank to excess.

It is difficult to identify exactly how much alcohol constitutes excessive drinking, or is harmful to the human body, as personal alcohol tolerances may vary with individual body build and gender (World Health Organization, 2007). The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) (2005) state that **more than one standard drink per day is harmful to women's health**, and define a 'standard drink' (or 'standard unit of alcohol') as any drink containing 8 grams of ethanol – equivalent to 250 mL of beer with 5.0% alcohol content. Both the standard drink definition and the classification of safe daily alcohol consumption are subject to variability from country to country (International Centre for Alcohol Policies, 2005), but both of these American standards have been adopted by the major global brewer Heineken, which employs beer sellers in Cambodia. While now included on Heineken's 'Enjoy Heineken Responsibly' website for its American customers (Heineken International, 2008), the new Cambodian language site suggests women drink 1-2 glasses nightly, although Khmer women are about 30% smaller than their American counterparts and absorb alcohol less well. The American standards have been adopted by SiRCHESEI researchers, and will also be used in this thesis. Between 2004 and May, 2008, beer sellers, on nights when they drank alcohol ($n = 376$), consumed an average of 1.62 litres of beer, or more than six standard drinks. Furthermore, they reported working an average of 27.17 days per month ($n = 381$), further increasing the danger of their situation. It should

be noted that, here and elsewhere, sample sizes in SiRCHESEI's research may vary, due to omission of some questions in short, field interviews, informed consensual non-response, etc.

Cambodian beer sellers, unlike their Canadian counterparts, receive little occupational health and safety training; and the training they do receive may be inadequate, ineffective in reducing harm, or too late to be effective. In designing a training programme for Cambodian beer sellers, the international NGO CARE suggested sellers should be receiving three full days of training before beginning work; followed by one-day refresher training every six months (CARE Cambodia, 2005). Among the beer sellers in SiRCHESEI's sample (2004-May, 2008) who were asked about health training ($n = 387$), 44.7% received no training whatsoever. Among those who did receive training ($n = 214$), only 37.1% reported receiving the CARE-recommended three-day training, and only 22.0% received training on or before the first day of work.

The lack of health and safety training for beer sellers, combined with high levels of intoxication among both patrons and sellers, often leads to a dangerous work environment. A study of 640 beer sellers across Cambodia conducted by CARE International (Bury, 2005) discovered a disturbing pattern of sexual and physical abuse perpetrated by customers. 83.1% of beer sellers reported experiencing derogatory behaviour, 80.3% experienced unwanted sexual touching, 54.1% experienced physical abuse, 60.2% had been threatened or forced to do something they did not want to do, and 38.1% had been coerced to perform a sexual act in the workplace. Between 16.7% and 26.5% of beer sellers experienced these behaviours on a daily basis (depending on the behaviour); and a further 33.5% to 40.2% of beer sellers experienced the behaviours several times weekly. Many beer sellers also experienced coercion from the owners, management, and staff of the bars they worked in. They were forced to sit and drink with customers, forced to be intimate, and 15% of beer sellers reported being asked by management to have sex with customers. Coercion and harassment have also been reported coming from staff of the beer companies. Perhaps most puzzling of the

results of CARE's study (Bury, 2005) is the fact that, despite the various dangers experienced by beer sellers, often on a daily basis, 48% reported feeling safe in the workplace. Bury (2005) suggests this may indicate that this type of behaviour is considered normal for a beer seller – simply an expected element of the job. The CARE studies did not delve deeply into the quantification of alcohol consumed at work; though one question asked by Bury (2005) about frequency of drinking found that only about 20% of beer sellers drank less than one can per shift, 56% between one and five cans per shift, and 24% had more than five cans -- 1.65 litres or six standard drinks-- per shift.

However, there are other dangers associated with the working conditions for beer sellers. The women are intoxicated, are dressed provocatively, are provided with little health and safety training, are working in an atmosphere where sexual harassment is a norm, and are not paid a "living wage", where job income is sufficient to meet their family's monthly expenses (McCourt, 2002; Schuster, 2006; Pagnutti, 2006). Furthermore, in Siem Reap, closest city to the tourist destination of Angkor Wat, the bars are filled with foreign visitors and local men earning money from the tourism industry. One study by World Vision (Straits Times, 2001) estimated that approximately 22% of Cambodia's male tourists were sex tourists. Many beer sellers are propositioned to sell sex and some feel it may be necessary in order to cover the family and household expenses not covered by the wages from beer companies. There is a wide range of estimates of how many beer sellers in Cambodia actually sell sex: Schuster (2006) reported 70.7% of beer sellers reported they would sell sex as a way to make ends meet; while a government Behavioural Surveillance Survey estimate (Ministry of Health, 2001, as cited in Bury, 2005) reported that 30.6% said that they had in fact received money or gifts in exchange for sex in the past year. Women answering SiRCHESEI questionnaires between 2004 and 2008 ($n = 182$; including Schuster's 2006 sample) , indicated that about 30.8% of beer sellers reported selling sex as a way to supplement their insufficient main job income, more closely echoing the Ministry of Health's estimate.

The importance of economic factors in the decision to sell sex cannot be overstated. Leheny (1995) argued that, in Japan, the sex industry underwent serious changes, primarily due to social and economic changes. Over the previous forty years, Japan had greatly expanded options for women – educationally, politically, and economically. While some Japanese women do continue to sell sex, the majority of Japanese sex workers then were foreign-born, brought in to fill a domestic labour shortage, and willing to deal with the dangers of sex work in exchange for some sense of economic stability. Others were coerced into coming to Japan. Given the opportunities to choose other economically-viable careers, Japanese women do not, in general, choose sex work (Leheny, 1995).

The specific role of economic factors in sex work in Cambodia is further illuminated by Wong et al. (2004), who found that among Cambodian brothel-based sex workers, low income was a significant predictor of such risky sexual behaviours as inconsistent condom use. Economically, sex work may provide a very lucrative form of employment. In Vietnam, sex workers reported earnings seven times the national average; in Nepal, sex workers report weekly income six times the national average annual; and in Indonesia, sex work pays four times as much as factory work while taking up one-tenth the hours (MAP, 2005). Intervention programmes for sex workers thus must take into account the potential economic gain provided by sex work (MAP, 2005).

However, sex work does lead to increased risk of HIV infection, and beer selling in Cambodia frequently may involve exchanging sex for gifts or money. The Cambodian National Center for HIV/AIDS, Dermatology and STDs (NCHADS) releases a periodic HIV Sentinel Surveillance Report (NCHADS, 2003), which follows the progress of HIV/AIDS among specific risk groups. Beer sellers are included in this report, either separately or under the broader classification of 'indirect female sex workers' (IDFSW); a description which is increasingly common for beer sellers internationally (Harcourt & Donovan, 2005). This designation is a broad one, encompassing all situations in which the selling of sex is not seen as the primary component of the job, but may sometimes be involved.

This contrasts with direct female sex workers (DFSWs), who are explicitly and usually exclusively involved in the sex industry. Beer sellers receive salaries to sell beer, and may choose to supplement their income by selling sex; while brothel-based sex workers receive salaries for selling sex.

IDFSWs may be passed over for health interventions aimed at sex workers because of the ambiguous nature of their status, and the fact they are not working in a fixed location such as a brothel. Their situation may actually be worse than that of the DFSWs (Harcourt & Donovan, 2005). Some evidence of this is seen in Cambodia, a country which has been praised for its condom-use intervention programs for DFSWs (MAP, 2005; Marseille & Garbus, 2003). 45% of Cambodian policemen (one of the male risk groups) reported having unprotected sex with a DFSW in 1997; this number had reduced to 5% by 2001. However, because the intervention was limited to DFSWs, condom use during paid sex with IDFSWs remains “sporadic” (Marseille & Garbus, 2003, p. 42). And the IDFSW designation has come under critical scrutiny, largely because the women do not view what they do as sex-work (Harcourt & Donovan, 2005). There is also tremendous stigmatization associated with the identification of the job of the beer sellers with sex work, which has led to an increased stereotyped perception that beer sellers are immoral or ‘unclean’ women (Bury, 2005).

In the end, though, whether beer sellers are considered sex workers or not, their job is a challenging one, considering the economic hardships, health risks, and workplace abuse. The beer sellers themselves have evaluated the quality of their jobs in some of our samples, starting in 2005 and continuing until May, 2008 ($n = 181$). 69.1% state they do not enjoy working as beer sellers, 92.0% report that it does not give them good self-esteem/self-image, 96.8% that it does not give them respect in the cities where they live, 97.9% that it does not give them respect in the cities where their parents live, and 98.4% that it is a job that does not make them feel empowered.

Asthana and Oostvogels (1996), outspoken advocates of community participation, in designing an HIV prevention program for female sex workers in Madras, noted significant barriers to

prevention that extended beyond the possible contributions of the affected community. These factors included entrenched power structures that put pimps in control of prostitutes and put clients in charge of condom negotiations; the isolated, scattered, secretive, and ever-changing nature of the prostitution industry; and institutional factors that drive sex work underground (Asthana and Oostvogels, 1996). Similarly, Leheny (1995) describes the importance of international market forces in the tourism industry in establishing, perpetuating, and constantly altering the sex tourism industry. In Cambodia, the lack of formal enforcement mechanisms within the Cambodian Labour Code, lack of training about workplace safety measures for beer sellers, and lack of unions and employment contracts, may all indicate institutional barriers that perpetuate exploitation of local workers by international corporations, and may encourage the recalcitrance, neglect and/or complicity of the globalized brewers (Lubek, 2005).

Thus, while 'bottom-up' grassroots activism and evidence-driven community-based intervention have a distinct role to play in social change-directed programs, any complete health promotion or community betterment intervention must also attack the problem from a 'top-down' viewpoint and alter the situation at the level of those who hold community power (Lubek, 2008a). In the case of beer sellers, the multinational beer companies who employ the beer sellers (and who retain the majority of profits from Cambodian beer selling) appeared, from SiRCHESI's perspective, to be a natural fit as an institutional partner to improve health, safety, and financial security conditions of these women at risk.

NGO–Corporate partnerships

There is in fact a wide body of research on collaborations between for-profit corporations and non-profit organisations/NGOs. The traditional conception of an inevitable adversarial relationship, that "NGOs have a monopoly on principles while companies focus on profits," is a gross oversimplification (Heap, 2000, p. 557). The two are becoming ever-closer naturally; both

increasingly focusing on similar goals, such as marketing, branding, and customer satisfaction (Heap, 2000). The possibility of strategic alliances has begun to shift towards becoming a necessity, for the NGOs, because of an ever-increasing demand for services and ever-shrinking public support; and for corporations, it is because of an increased importance placed on corporate social responsibility (Berger, Cunningham, & Drumwright, 2004).

Beyond these basic necessities, business-NGO alliances yield additional benefits for both parties. For NGOs, the obvious benefit is access to the expanded resources of corporations – monetary resources certainly, but also volunteer hours provided by company employees and necessary goods and services donated by the corporations. For an NGO, any form of co-operation increases effectiveness beyond that which could be achieved by the NGO acting independently. New ideas, new styles, and new resources help NGOs to expand the breadth and depth of their services, increasing their visibility and awareness (Austin, 2000).

The benefits for corporations are even more diverse. Philanthropy has long been an element of corporate practice; but alliances with NGOs allow corporations to expand beyond mere cheque-writing, thereby enriching corporate strategies. This can have positive effects on human resources, as employees feel better working for socially responsible companies. As well, there may be equally positive effects on future business relations, as other corporations improve public perceptions by working with socially responsible corporations (Austin, 2000).

This is not to say that NGO-corporate partnerships are without difficulties. NGOs and corporations can have entirely different missions, perspectives, resources, management styles, work environments, target markets, and corporate cultures. They may have operating styles that are entirely separate from each other, or, at worst, work at cross-purposes (Berger, Cunningham, & Drumwright, 2004). These partnerships can also suffer from mismatches of power, especially when one side is more invested in a project than the other side, or there may also be simple mistrust. Berger,

Cunningham, and Drumwright (2004) emphasise the importance of finding the right fit between NGO and corporations.

Unfortunately, evidence increasingly indicates that the globalized beer industry may not be the obvious target for alliance with Cambodian NGOs concerned about the health, safety and financial security of the beer sellers. Some evidence of this comes from one of the largest of such alliances in Cambodia: the development of the 'Selling Beer Safely' workshop, created by the NGO CARE International in partnership with Heineken International and two of its partners in Cambodia, Asia Pacific Breweries and Cambodia Breweries Limited (Klinker, 2005). The program had its origins in Heineken's desire to help its employees, perhaps accelerated by research presented to Heineken officials in 2002 and increasingly negative press reports about the situation of beer sellers in Cambodia. CARE, the NGO partner, had experience developing programs related to gender relations and sexual health (e.g., among garment workers), and had the skill set to engage community participation for the program (CARE Cambodia, 2005). Heineken provided all but 10% of the costs for the development of the program, and ensured that beer sellers and Heineken corporate representatives would be available as needed by CARE. CARE was responsible for the development and implementation of the program.

The Selling Beer Safely program which CARE developed was a three-day teaching curriculum designed "to improve reproductive knowledge, attitudes and practices among the beer promoters, empower and equip them with skills to be able to make safe and informed health choices" (Klinker, 2005, p. 7). It was to be administered to all current beer sellers, and to new beer sellers before beginning work. As such, the program discussed gender roles and gender relations, sexual relationships, contraception, sexual health education, HIV/AIDS, behaviour skills for sexual health, condom negotiation and the consequences of sexual behaviour, definition and prevention of workplace harassment, alcohol and drug use, and health care options. A one-day refresher course was

also developed, to cover contraception, STI and HIV/AIDS, workplace harassment, and drugs and alcohol, and to be administered to beer sellers every six months (CARE Cambodia, 2005).

The program showed some success, improving sexual health knowledge and behaviour, although not reducing risk to zero. The number of beer sellers saying they did not believe themselves to be at risk of contracting HIV because they always used condoms, for example, increased from 12.0% at baseline in 2003 to 33.3% following workshop intervention in 2005 – a significant improvement, but still far from 100%. Similarly, knowledge of treatment options for HIV/AIDS increased from 77.7% at baseline to 87.7% following participation in the Selling Beer Safely (SBS) (Klinker, 2005). Although the program was largely ineffective in reducing alcohol consumption or curbing workplace violence, its moderate but evident successes were enough for CARE to recommend its continued use, including the one-day refresher course (Klinker, 2005), and Heineken seemed initially receptive to the idea (CARE Cambodia, 2005).

However, cross-sectional data collected by SiRCHESEI (2004-2008) indicate that the Selling Beer Safely workshop regimen does not seem to be well-implemented, and, indeed, that separate analysis of Heineken family beer sellers within SiRCHESEI's sample reveals little difference from the general sample's training results discussed earlier. Thus many Tiger and Heineken beer sellers are not currently receiving company-supplied health education in a timely and effective manner. Among Heineken family beer sellers (N=142) interviewed after the creation of SBS (between 2004 and May, 2008), 67.6% received no company-based training (either SBS or other forms of company-provided training – as distinguished from training from NGOs, government organizations, school, or other sources). Among those Heineken beer sellers who reported receiving company training (N=53), 50.9% received the CARE-recommended three days of training. In addition, training often did not occur before beer sellers actually begin work, as per CARE's recommendations (Klinker, 2005). Overall, from all brands, 39% (N=187) reported receiving no training, and for those beer sellers who

received training, only 21.9% received it promptly, on or before the first day of work. A further 36% received training within the first month, 24.5% received training within the first six months, and 17.5% received training later than that.

However, the partnership with CARE in creating the Selling Beer Safely program was not the only action by Heineken which was considered praise-worthy by CARE. Among the recommendations following CARE's Selling Beer Safely program development (CARE Cambodia, 2005) and repeated following their study of beer sellers workplace violence (Bury, 2005), was the creation of a beer selling industry association where the beer companies would come together and adopt a code of conduct for beer selling. This code of conduct would clarify the employment status of beer sellers, reject the uncertainty of commission-based work, develop beer sellers-approved uniforms, provide transport home for all beer sellers, create a standardized beer sellers training program to be administered before starting work, establish zero-tolerance policies against abuse and harassment, and clarify the expected roles of venue owners (Bury, 2005). The importance of actually adhering to such a code in practice also received brief mention in the recommendations (CARE Cambodia, 2005).

In October 2006, such an association was formed: Beer Selling Industry Cambodia (BSIC), founded by Heineken and Carlsberg, whose brand families together may represent up to 80% of beer sales in Siem Reap (Lubek, 2008c). As CARE had suggested, the industry published a Code of Conduct (in English) for Cambodian beer sellers in November (BSIC, 2006). The Code of Conduct covered all areas recommended by CARE, and added: "It is the policy of the BSIC that during working hours, [beer sellers] should not sit or drink with consumers" (BSIC, 2006, p. 2). The Code of Conduct is written in clear, precise language which lists specific plans of action, and not simply abstract goals.

However, despite the promises and concrete plans of the BSIC Code of Conduct, the cross-sectional research conducted by SiRCHESEI suggests that its implementation may have had little or no significant effect on the actual beer promotion industry in Siem Reap. As compared to beer sellers in 2004 through 2006 (before the arrival of the BSIC Code), beer sellers in 2007 and 2008 working for BSIC-affiliated brands reported equally high levels of witnessing other beer sellers being threatened with violence if they did not drink (69.9% in 2007-2008 versus 72.7% in 2004-2006), witnessing other beer sellers physically hurt in the workplace (43.7% in 2007-2008 versus 41.7% in 2006), and experiencing unwanted sexual touching (20.7% in 2007-2008 versus 16.7% in 2006). Beer sellers working for BSIC-affiliated brands seldom indicated that they enjoyed working as beer sellers (30.0% in 2007-2008 versus 35.7% in 2004-2006) or that the job was empowering (1.2% in 2007-2008 versus 3.6% in 2004-2006).

Among beer sellers working for BSIC-affiliated brands who reported receiving health education or training ($n = 75$), only 19.9% received it before starting work or on their first day. A further 40.0% received training during the first month, with 40.0% received training after that. However, 37.0% of beer sellers working for BSIC-affiliated brands ($N=208$) reported no health education or training at all, and much of the training that sellers did receive came from NGOs (such as SiRCHESEI) and the Provincial AIDS Office. Company-based training (including the Selling Beer Safely program developed by CARE) accounted for 31.1% of total ($n = 180$) training.

Somewhat more encouraging, SiRCHESEI findings among beer sellers working for BSIC-affiliated brands ($n = 198$) do indicate a significant increase in abstention from drinking. Since the introduction of the Code of Conduct, beer sellers working for BSIC brands have been significantly more likely to abstain from drinking while at work (10.7% abstained on two consecutive nights, as compared to 3.5% prior to the introduction of the Code of Conduct). When they drank, 183 beer sellers working for BSIC brands consumed an average of 1.30 litres of beer nightly— more than 5

standard drinks, with pre-2006 consumption at 1.36 litres (N=83) and 2007-8 nightly drinking at 1.24 litres (N=100), 5 standard drinks – still a harmful/hazardous level. . As of 2007-2008, 100% of BSIC-brand beer sellers agree with the statement ‘My drinking has become hazardous to my health,’ up slightly from 97.2% prior to the introduction of the Code of Conduct.

The Code of Conduct also aimed to provide non-exploitative, “decent” uniforms for beer sellers (BSIC, 2006, p. 1). However, there was little significant change across years in BSIC-brand beer sellers’ ($n = 92$) assessments of their uniforms. 55.2% indicated they didn’t like their uniform (as compared to 52.0% pre-Code), 23.9% called it demeaning (as compared to 32.0% pre-Code), and 19.4% said it made them feel vulnerable (as compared to 36.0% pre-Code). On a positive note, since the introduction of the Code of Conduct, fewer beer sellers said the uniform provoked sexual propositions (3.0%, as compared to 25.0% prior to the Code of Conduct).

While there appears to be willingness among Cambodian beer companies to provide an acceptable job environment, as evidenced both by Heineken’s willingness to partner with CARE to create sexual health education training programs for their employees, and the formation of an industry association and Code of Conduct, it seems there may be structural problems inherent to the industry which preclude significant improvements to the situation of beer sellers. CARE themselves indicated in their final report on their partnership with Heineken:

Some companies prohibit beer promotion women from sitting with or drinking with customers as a way of reducing harassment. But within venues, women fall under the effective control of outlet owners and managers. Some of these owners/managers respect the women’s refusal to sit with customers and drink. Others threaten the women that if they do not generally pander to customers then the owner will complain about them (on made-up grounds) to the company (CARE Cambodia, 2005, p. 20).

The Cambodian beer promotion industry is inherently decentralised; relying on entertainment establishment owners, managers, and local contacts from the international beer companies. It

therefore becomes difficult to organise all employees along any guidelines, such as Codes of Conduct or training curricula.

Partnering with Siem Reap's Hotel Industry

Between 2002-2006, SiRCHESEI experienced frustrations with suggestions to industry to reduce or remove risks to beer sellers within the workplace—e.g., from HIV/AIDS, harassment, and alcohol-related conditions. SiRCHESEI began implementing a primary intervention outside the beer-selling industry. This would actually remove beer sellers from a toxic or dangerous work environment, take away sources of risk or harm, and employ them in a safer workplace. The possibility of an NGO-industry partnership was viewed as an integral part of such a course of primary intervention, both from a practical economic standpoint, and from the standpoint of furthering community integration, capacity building and eventually working toward local community self-sustainability.

The hotel industry is the most prominent employer in Siem Reap. The tourism boom in Siem Reap has led to a dramatic increase in hotel construction (Lubek et al., 2002). The Cambodia Hotel Association listed fifty member hotels within Siem Reap in 2006, and this only represents a portion of Cambodia's hotels (Cambodia Hotel Association, 2006). By August 2008, it was estimated that there were just over 100 hotels doing business or nearing end of construction. Furthermore, despite a past history of not hiring women, gender equality in hiring practices was increasing. In 2006, 33% of hotel jobs went to women – as compared to 20% in 2002 (SiRCHESEI, 2006). There is, in fact, evidence that a number of beer sellers had, before applying for jobs in the beer industry, applied for hotel jobs. Among those asked in SiRCHESEI's sample (2006-May, 2008) ($n = 112$) about their job aspirations in Siem Reap, 32.1% of beer sellers indicated they had applied for hotel jobs, and were rejected, before becoming beer sellers. Among the reasons for exclusion from the hotel industry were the lack of necessary job skills, lack of Khmer literacy, and lack of conversational English.

Hotel jobs may offer many advantages over beer selling jobs. Because three-, four-, and five-star hotels need to create a safe vacation place for their guests, they are creating a safe, healthy and secure workplace at the same time. There is exceptional safety for employees, enforced by security teams. An increasing number of hotel employees are unionized, and enforced standards exist for salaries based on a living wage, and for a regimented system of promotions based on successful job performance. Hotel employees are forbidden from drinking on the job; their uniforms are designed to be modest, not sexually provocative; and they rarely receive sexual propositions in the workplace (I. Lubek, personal communication, July 24, 2008).

It is with this in mind that discussions with local educators and hotel owners began in 2005, and evolved into SiRCHESE'S Hotel Apprenticeship Program (HAP) (SiRCHESE, 2006). The program was designed to retrain beer sellers to work in local hotels, at the same time increasing their Khmer and English literacy, and improving their health-related knowledge and behaviour. The program begins with an eight-month apprenticeship stage, during which trainees participate in classes at the SiRCHESE school, as well as undertaking mentored apprenticeships in local three-, four-, and five-star hotels. The school portion of the day includes: i) classes in English and Khmer, with special emphasis placed on vocabulary useful to the hotel industry; ii) health-related education, including sexual health knowledge (e.g. HIV/AIDS, condom use), and knowledge about the dangers of alcohol; and iii) life and social skills education. The SiRCHESE school also has on staff a counsellor available to the trainees.

The in-hotel apprenticeship portion of the program includes nine-hour shifts training for jobs in various departments of the hotel – housekeeping, laundry, kitchen, dining room, public area cleaning, front office, gift shop, bar, etc. Hotels are responsible for providing a safe work environment, staff to conduct training, one meal per day, and uniforms. Hotels are also responsible for paying trainees salaries equivalent to what a typical hotel employee would receive during a

probationary period. Starting salaries in hotels tend to be no better than beer promotion salaries – often \$50 per month or less – but can dramatically rise within two years. SiRCHESEI, with its funding partner M.A.C. AIDS Foundation, therefore supplements the hotel salary to \$110 monthly, determined to be a “living wage” for beer sellers in Cambodia in 2006 (Lubek, 2008b). As trainees advance through the ranks, it was expected the proportion of the guaranteed \$110 per month salary that was paid by the hotel would increase, until they eventually pay the entire salary.

Following the eight-month apprenticeship period, trainees are given a guaranteed sixteen months contracted employment at the hotel, and SiRCHESEI continues to guarantee a living wage through its fellowship payments. During this time, SiRCHESEI continues to provide optional remedial English and Khmer classes, and the counsellor continues to be available. At the end of this program, though formal support from SiRCHESEI will cease, it is hoped the trainees will have formed loyalties to the hotels where they work, and will continue on as long-term employees of the hotels.

The program also involves an extensive system of trainee assessments and self-reports. During the apprenticeship period, school performance assessments are completed on a weekly or biweekly basis, by the English teacher, with input from the Khmer counsellor. Job performance assessments are filled out by the trainees' mentors on a biweekly basis. Trainees also fill out an extensive self-report questionnaire – covering demographics, financial situation, sexual and alcohol-related knowledge and behaviour, self-esteem, and job satisfaction – at five separate intervals during the program: near month 0, as baseline; near month 4, at the midterm of the apprenticeship phase; near month 8, at the end of the apprenticeship phase; near month 12, at the midterm of the program; and near month 24, at the end of the program.

Two cohorts have now entered the hotel training program. The first cohort consisted of fourteen beer sellers. Training began in November 2006, the trainees graduated the school portion in July 2007, and completed the program in November 2008. The second cohort, consisting of sixteen

beer sellers recruited from a SiRCHESI workshop conducted in August 2007, began the program in September 2007, graduated from the apprenticeship portion of the program in May 2008, and will complete the program in August 2009.

The Present Study: Evaluating The Hotel Apprenticeship Program (HAP)

The HAP features an extensive system of reporting which assesses the subjective self-reports of perception of the program, self-reports of knowledge and behaviour, and more objective measures of trainee progress in the school and on the job. Lewin (1946) reminds us that without extensive empirical evaluation of any intervention program, half the job of program designers is left undone. Empirical evaluation answers whether or not the program has succeeded or failed at what it was trying to accomplish; it may provide new insight into facets of the original problem, and, perhaps most importantly to Lewinian practice, it provides the basis for the next step in program development (Lewin, 1946). Lewinian Action Research depends on a cyclic nature – a constant feedback loop to modify and improve the intervention program. In this thesis, a systematic analysis of the available data will be the first step towards that goal.

Quantitative research can provide a certain amount of this information. As with past SiRCHESI research, this study involves multi-source, multi-method triangulation. Through semi-structured interviews conducted with women in the program, more qualitative data will be obtained. Following the model of Participatory Action Research (Chataway, 1997), all participants in the program must be viewed as co-owners of the program, each with an investment, and each with a unique perspective on the effectiveness of the program.

Though there exists data collection for trainees in both Cohort 1 and Cohort 2 of the program, the present study will only examine Cohort 1 students. This allows for a greater degree of focus on the situation of the 14 women in the Cohort. Furthermore, Cohort 1 began nearly a year before Cohort 2 and completed in November 2008, and therefore data for Cohort 1 is much more complete.

In addition to examining SiRCHESEI's HAP, it is seen as a secondary goal of the present study to develop methods and early results that may guide analysis of Cohort 2 students or re-analysis of Cohort 1 students. As such, there will be extensive examination of all quantitative and qualitative measures employed, to evaluate their appropriateness.

The present study examines seven areas considered important to the success of HAP:

Health knowledge and behaviour. It is expected that participants in HAP will display an increase, as compared to baseline, in health-related knowledge – including HIV/AIDS transmission and treatment. It is also expected that the increase in knowledge will be accompanied by a change in health-related behaviour – evidenced by increased condom use and reduced alcohol consumption.

Job satisfaction. It is expected that participants will express a much higher degree of job satisfaction in their hotel jobs as compared to their beer promotion jobs, and a higher degree of job-related self esteem as well.

Self-esteem. It is expected that participants in HAP will express a high degree of general self-esteem, as compared to beer sellers. This will extend to a sense of personal empowerment, pride in their jobs, and extensive hopes and plans for the future.

School performance. It is expected that participants in the HAP will display high levels of academic achievement – in literacy, health and social skills knowledge, and general classroom performance. There will be a gradual increase in performance during the 8 months of school.

Job performance. It is expected that participants in the HAP will also display high levels of job performance – both in work done, and in attitude at work. There will be a gradual increase in performance during the 24 months of the program.

Hotel comparison. Participants in Cohort 1 worked at three partner hotels: Lin Ratanak Angkor Hotel, Sokha Hotel and Resort Spa, and Angkor Howard Hotel. It is expected that participants at the three different hotels will display different levels of job satisfaction, job attitude,

job performance, and job-related self-esteem. It is expected that participants at the better-run hotels will display higher scores on all relevant job indicators.

Program attrition. Seven participants (of the original fourteen) left the program before the end of the HAP on November 30, 2008. It is expected that participants who did not complete the program will score differently on some of the above indicators; allowing those indicators to be used as predictors in later implementations of this or similar programs. Measures of attitude towards program elements – such as job attitude, general classroom performance, and job satisfaction – are expected to be lower for participants who have left the program.

Methods

Participants

All participants in the HAP's Cohort 1 were included in the current study. Participant recruitment for the program began at a health education workshop for beer sellers run by SiRCHESEI in March 2006, and continued for several months, through recruitment in the workplace conducted by SiRCHESEI staff and peer educator and health workshops through November, 2006. Entrance into the program required an application, followed by a screening interview with SiRCHESEI staff, and a final series of interviews with managers from the three partner hotels.

Selection criteria were based on requirements of SiRCHESEI staff and hotel managers. SiRCHESEI staff looked for candidates who were at increased risk for health challenges from HIV/AIDS, alcohol, workplace violence, harassment. In addition, factors that may have put the women at risk for accepting propositions for exchanging sex for money were considered, including having many dependents (especially when lacking other family contributors to household income) and a lack of formal education, with special focus placed on a lack of English and limited Khmer literacy. Furthermore, personality characteristics that might influence success in the program were considered; including general levels of motivation and commitment, desire to work in the hotel

industry, willingness to learn new skills, ability to endure long hours, suitability for proper hotel conduct, and willingness to learn personal hygiene. Hotel managers focused on morale issues involving honesty, respect for property of guests, previous related skills, politeness and deference, willingness to follow directions, and neatness of appearance.

All participants ($n = 14$) were female, and all were employed as beer sellers prior to the program, except for one participant, who had worked in the kitchen in a beer restaurant. All participants were between 19 and 31 years old ($M = 24.93$, $SD = 3.77$) at the beginning of the program. Participants had an average of 5.00 years of formal education ($SD = 2.08$), with a range of 2 to 8. Participants had between 1 and 8 dependents ($M = 4.36$, $SD = 2.37$); and between 0 and 4 other people contributing to household income ($M = 1.21$, $SD = 0.98$). Five participants had one child, and one participant had two children at the beginning of the program.

Matched baseline sample

Formal quantitative evaluations of participants in the HAP were not systematically administered at baseline. However, for purposes of data analysis, a matched sample of fourteen beer sellers was extracted from SiRCHESEI's cumulative database of health workshop questionnaires conducted with beer sellers in 2005-2007. It is believed that at least three of the fourteen HAP participants participated in either 2005 and 2006 workshops, but questionnaire anonymity does not permit exact matchups.

Matching was based on three categories: age, years of formal education, and beer company employer (based on current brand families, SiRCHESEI, 2008). Matches were considered acceptable if the difference in education was within 1 year, age was within 3 years, and beer company was the same – unless the beer was not one owned by one of the major three companies (Heineken, Carlsberg, AB-Inbev/Interbrew), in which case the participant was matched with another beer seller not selling for one of the major three companies. For the one participant who had not worked as a

beer seller, beer company was not considered as a matching criterion. When finding matches for the 14 women entering the program in November 2006, baseline data gathered in 2006 were given preference; as it was at the 2006 workshops where recruiting for the HAP was initiated. Data from 2005 or 2007 (again, within 1 year) were also considered acceptable.

For purposes of demonstrating closeness of matches: the correlation between the ages of the trainee group ($M = 24.93$, $SD = 3.77$) and the matched sample ($M = 24.50$, $SD = 3.35$) was highly significant, $r(12) = .917$, $p < .01$; as was the correlation between the years of education of the trainee group ($M = 5.00$, $SD = 2.08$) and of the matched group ($M = 5.07$, $SD = 2.23$), $r(12) = .962$, $p < .01$. Both groups had identical beer company affiliations, with three participants (and their matches) working for Heineken, one participant (and her match) working for Inbev/Interbrew, one participant (and her match) working for Carlsberg, and nine participants (and their matches) working for other brands.

Materials

Women's Questionnaire Assessing Beer Consumption and Other Risks

The primary assessment tool used by SiRCHESEI has been the 43-page Women's Questionnaire Assessing Beer Consumption and Other Risks, created in 2004 and further developed by Schuster (2006) (see Appendix A for version used by Schuster in 2005). The questionnaire covers demographics, finances, sexual health knowledge and behaviour, workplace training, job performance, job satisfaction, workplace sexual abuse, and alcohol consumption. The questionnaire has since been administered – with minor changes and additions over the years – to 411 beer sellers, before May, 2008. Adapted forms of this questionnaire have also been administered to men and to other IDFSWs, including karaoke workers and hostesses. A short 4-page version also exists for workplace interviews and breathalyser testing (see Appendix B for 2006 version).

A modified version of the baseline questionnaire was administered to the trainees in the HAP at various points during training. This occurred at approximately half-way through the school and apprenticeship stage (4 months into the program), at the end of the school and apprenticeship stage (8 months), almost half-way through the program (14 months), and close to the end of the program (21 months) (see Appendix C for version administered to Cohort 1 students at four months into the program). The HAP versions include a subset of questions present in the full questionnaire of 2005. Many questions specific to work as beer sellers were removed; while other questions were adapted for the new hotel situation. For example, question A6.5 'Please evaluate your current job (e.g. beer promoter, cook, waitress)' became 'Please evaluate your previous job before starting our program (e.g. beer promoter, cook, waitress),' and question A7.5 was added: 'Please evaluate your current hotel job (e.g., laundry, kitchen, housekeeping, dining room, etc)'. Furthermore, section F, consisting of four questions from the Rosenberg Self-Esteem Scale (Rosenberg, 1965) was added.

Hotel Performance Appraisals

In order to gauge the job performance of HAP trainees, a brief 15-item questionnaire was developed with the assistance of Chris Winkler of McQuarrie University, Australia, to be filled out by trainees' job mentors. The assessment was an aggregate measure, including questions pulled from a variety of empirically-developed Hotel Performance Appraisals (e.g., Woods, Sciarini, & Breiter, 1998), which were then modified, in partnership with local industry contacts, for Cambodian culture and for the hotel industry. Industry standard Hotel Performance Appraisals already in use in SiRCHESEI partner hotels, were also consulted in designing the Hotel Performance Appraisal; and one in particular (Sokha Hotels and Resorts, 2006) contributed to the format of the questionnaire.

The questionnaire created by SiRCHESEI (see Appendix D) included 11 job qualities (e.g. 'Quality of work done'), each rated on a 4-point scale from 1 (Fair/below standard) to 4 (Outstanding/excellent); and four questions for additional comment by the job mentor and department

head. These assessments were completed twice monthly during the eight-month apprenticeship stage of the HAP, and once every two months during the subsequent sixteen-month employment stage.

School Performance Appraisals.

A 14-item School Performance Appraisal was used to gauge classroom academic performance and attitude, as well as general progress within the SiRCHESEI program. The questionnaire was developed based on a review of academic assessment literature completed by Chris Winkler from Macquarie University, Sydney, Australia.

The questionnaire created by SiRCHESEI (see Appendix E) included 10 academic qualities (e.g. 'Dictation results'), each rated on a 4-point scale from 1 (Fair/below standard) to 4 (Outstanding/excellent), and four questions for additional comment by the English teacher and the program counsellor. These assessments were complete on a weekly basis between January and March 2007, and on a biweekly basis during April to July 2007. Due to the challenges of school start-up, no assessments were completed in December 2006, the first month of the program.

Procedure

Empirical evaluation of the HAP and other SiRCHESEI projects has previously been approved by the University of Guelph Research Ethics Board (REB # 06JL022); revised in 2008 to include the present study's author as research assistant (see Appendix G for Ethics Board certification). Informed consent for participation in research was obtained from all participants in the study, using forms designed for Cambodian use.

Quantitative assessments, described above, were filled out by participants, SiRCHESEI staff, and hotel staff throughout the program, as a contractually-obligated element of participation in the program. Completion of the questionnaires and the giving of regular feedback to the students encouraged constant communication between SiRCHESEI, the hotel managers, and the participants, so that the SiRCHESEI counsellor might be aware of and deal with any personal or job-related issues at

the hotels. This reliance on feedback loops is part of the guiding framework of Participatory Action Research.

The qualitative component of this research relies on semi-structured interviews conducted with trainees at the SiRCHESE school in August 2008, immediately after finishing the 21-month assessment questionnaire. A preliminary version of interview questions was developed by the author and approved by the University of Guelph Research Ethics Board. Additional probes were added as needed for understanding, some wording was refined, and some questions removed, during the course of the first few interviews, by the author and by the local staff assisting with interviews (see Appendix F for Interview question list). Interviews were conducted in Khmer, through a translator, with SiRCHESE's counsellor present, to provide a trusted and culturally sensitive 'friendly face' to provide additional interpretation for difficult questions. A research assistant (Natalie Lim) was also present, to transcribe interviews; and all interviews, with written consent of the participants, were videotaped. The thesis supervisor sat in on initial interviews, to provide some guidance. Interviews lasted approximately 20 to 30 minutes. Not all questions were asked in all cases; and additional probe questions were employed when appropriate.

Both the Hotel Performance Appraisals, filled in by mentors and hotel managers, and the School Performance Appraisals, filled in by the English teacher and the Khmer teacher/ program counsellor, had space for additional written comments, and these also provided qualitative data for analysis.

Analyses

Temporal Compression of Data

Due to the volume of data collected during the program, and due to the frequency of missing data, data from different time points was combined. Data originating from the Women's Questionnaire Assessing Beer Consumption and Other Risks (4, 8, 14, and 21 months, in addition to a matched baseline sample) was compared longitudinally. However, due to methodological constraints, not all participants were administered questionnaires at all times. Complete data ($n = 14$) exists for baseline and 4-month, but due to attrition and uncompleted questionnaires, there were smaller samples for 8-month ($n = 11$), 14-month ($n = 11$), and 21-month ($n = 9$). Complete data exists for only six participants.

Therefore, simpler two-way comparisons were also carried out, comparing baseline data with in-program data (from the mean score of the specific participant across 4-month, 8-month, 14-month, and 21-month questionnaires).

Data from Hotel Performance Appraisals – which were filled out biweekly during the eight-month training period, and bimonthly in the following employment stage – were compressed into four-month periods, using mathematical means of all available data from the specific participant during that time period, to account for random variability and missing data. Through this method, complete data was found for January to April 2007 ($n = 14$), but data remains incomplete (due to program attrition and incomplete questionnaire response) for May to August 2007 ($n = 12$), September to December 2007 ($n = 11$), January to April 2008 ($n = 10$), and May to August 2008 ($n = 10$). Through this compression, complete data was found for ten participants.

Finally, data from the School Performance Appraisals – which were completed weekly during the second, third, and fourth month of the program, then biweekly during the following four months during the eight-month training period – were compressed into one-month periods, using mathematical means of all available data from the specific participant during that time period, to

account for random variability and missing data. As not all questionnaires were filled in completely, data remained more complete for some indicators than for others.

Comparisons can also be made between participants who left the program prior to its end in November 2008 ('drop-outs', $n = 7$) and participants who remained in the program to the end ('non-dropouts', $n = 7$, including one participant who temporarily left the program and then returned at a later date). Comparisons of participants who worked each of the different hotels is also possible. For both these types of comparison, the means of all available measures taken during the program (not including baseline measures of the matched 14 beer sellers) were used.

Measurement Scales

In addition to this temporal compression of data, there was compression of data across variables. Due to the volume of data collected, particularly significant variables were selected for analysis, and several aggregate measures were developed to measure areas of interest.

Knowledge about HIV/AIDS prevention. The United Nations General Assembly Special Session on HIV/AIDS (UNAIDS) (2007) recommends five questions that best assess knowledge about HIV/AIDS prevention. All five questions are present in baseline questionnaires and those asked of our HAP trainees, in the Women's Questionnaire Assessing Beer Consumption and Other Risks. The five questions are:

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? [B1 – sex with multiple partners]
2. Can using condoms reduce the risk of HIV transmission? [B4]
3. Can a healthy-looking person have HIV? [B3]
4. Can a person get HIV from mosquito bites? [B1 – mosquito bites]
5. Can a person get HIV by sharing a meal with someone who is infected? [B1 – sharing food or drinks] (UNAIDS, 2007).

Correct answers to these questions will be aggregated to provide an HIV/AIDS prevention knowledge score out of 5.

UNAIDS assessment of condom use: According to UNAIDS (2007), the best indicator of condom use is a single question: "Did you or your partner use a condom the last time you had sexual intercourse?" This question is present in the baseline and in-program Women's Questionnaire Assessing Beer Consumption and Other Risks, as question B17. Another question present in the same questionnaire, asking participants if they *suggested* using a condom during the last sexual encounter (B16) may be of further interest. When combined (condom use when suggested versus condom non-use when suggested), these two questions provide an assessment of condom negotiation success rate.

Nightly alcohol consumption. Question D11, present in the HAP in-program Women's Questionnaire Assessing Beer Consumption and Other Risks (4-, 8-, 14-, and 21-month), asks how much alcohol participants drank the last time they drank. On the baseline assessment, questions D11 and D12 ask how much the participants drank in their last two shifts. A mean of these two questions provides a baseline assessment for nightly alcohol consumption in the matched beer-sellers prior to the HAP. In addition, the drinking of both the matched beer sellers and the HAP students can be compared against established standards of healthy drinking (HSS & USDA, 2005).

Weekly alcohol consumption. Question D11a, present in the in-program Women's Questionnaire Assessing Beer Consumption and Other Risks (4-, 8-, 14-, and 21-month), asks how many nights per week participants drink alcohol. In the baseline assessment, questions D11 and D12 have previously been used as a rough indicator of how often participants drink (e.g. Lubek, 2008c). Drinking during the last two shifts (non-zero responses for both D11 and D12) is considered to be consistent nightly alcohol consumption, and as beer sellers work nearly every day in a month, this can be extrapolated as being equivalent to drinking 7 nights per week. Drinking on one of the last two shifts (non-zero alcohol responses on either D11 or D12) is considered as partial abstention from

drinking, equivalent to drinking 50% of the time, or 3.5 nights per week; and not drinking on both nights (zero responses on both D11 and D12) is considered as full abstinence, or 0 nights of drinking per week. This provides a baseline assessment to compare weekly alcohol consumption of matched beer-sellers prior to and HAP trainees, and may be compared against established standards of healthy drinking (HSS & USDA, 2005).

Job Satisfaction

Job satisfaction scale. Three questions, present in baseline and in-program Women's Questionnaire Assessing Beer Consumption and Other Risks, assess overall job satisfaction (A6.5, A6.6, A6.7 for beer seller job; A7.5, A7.6, and A7.7 for hotel job), each scored out of 7. These questions will be scored together to provide an indicator of overall job satisfaction, out of 21.

Self-Esteem

Rosenberg self-esteem scale. Four questions from the Rosenberg Self-Esteem Scale (1965), each scored out of four, are included in all HAP in-program Women's Questionnaire Assessing Beer Consumption and Other Risks (questions F1, F3, F4, and F5). Adding scores on these five items provides an estimate of self-esteem on a 16-point scale. These questions were not asked at baseline.

Job-related self-esteem scale. Four items in the questionnaires explore different areas of self-esteem and social reputation related to job, each scored as a binary Yes/No: self-esteem/self-image (E41b), social reputation (E41c), social reputation for the family of the participant (E41d), and empowerment (E41e). These questions are included in baseline and in-program Women's Questionnaire Assessing Beer Consumption and Other Risks, applied to the beer selling job and applied to the hotel job (for in-program assessments). A total score for number of 'yes' answers, out of 4, will be calculated.

English proficiency learning scale. Four questions on the School Performance Appraisals (questions 1-4), each scored out of 4, discuss performance and learning in English class. These four questions will be scored together, out of 16, to provide a measure of English learning.

Health and social skills learning scale. Two questions (5 and 6) of the School Performance Appraisals relate to learning about health and social skills, each scored out of 4. A sum of the two scores provides a quantitative indicator of longitudinal health and social skills learning, on an 8-point scale.

General classroom performance scale: Four questions on the School Performance Appraisals (questions 7-10), each scored out of 4, discuss general attitude and performance in school. These four questions will be scored together, out of 16, to provide a measure of overall classroom performance.

Job performance scale: Six questions of the Hotel Performance Appraisals (questions 1-3 and 8-10), each scored out of 4, assess actual job performance. These questions will be scored together to provide an indicator of job performance, out of 24.

Job attitude scale: Five questions of the Hotel Performance Appraisals (questions 4-7 and 11), each scored out of 4, assess attitude and demeanour while at work. These questions will be scored together to provide an indicator of job attitude, out of 20.

Results

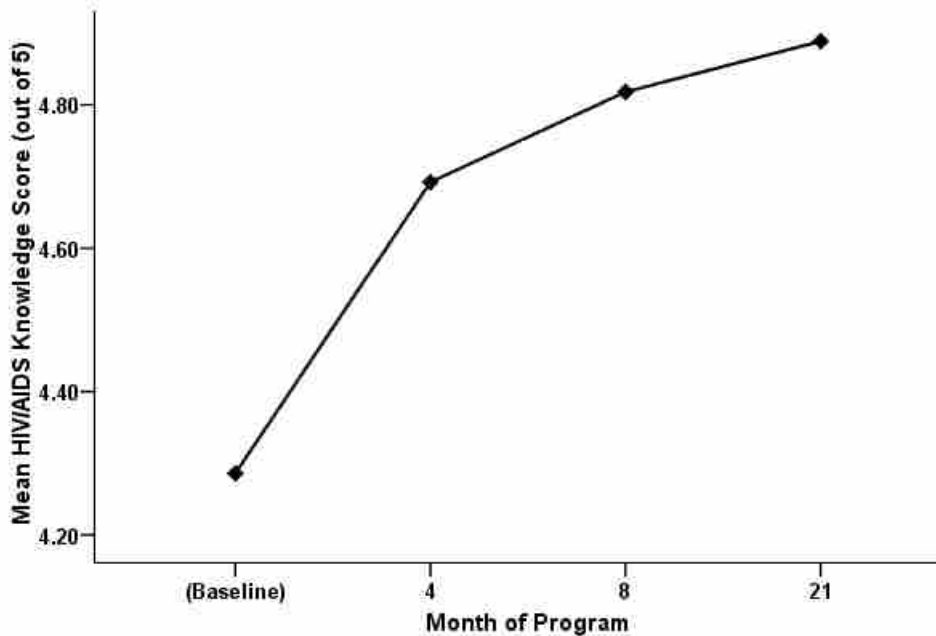
A note about how the results are displayed in Figures 2-18. The specific sample sizes for each of the longitudinal or cross-sectional analyses presented below are specified in the text description, and may be a sub-sample of the original N=14 participants' data, sometimes to meet the requirements of ANOVAs, etc.. The Figures generally display all data collected on that measure.

Health Knowledge and Behaviour

Knowledge About HIV/AIDS Prevention Scale

To determine if there was any significant change in knowledge about HIV/AIDS prevention, a one-way repeated measures ANOVA was carried out among the six participants for whom complete longitudinal data for this scale was available. Because means were identical at all but one level of the dependent variable, sphericity was assumed. There was a significant change in HIV/AIDS knowledge, $F(3, 15) = 7.50, p = .003$, between baseline ($M = 3.83, SD = 0.75$), 4-month ($M = 4.83, SD = 0.41$), 8-month ($M = 4.83, SD = 0.41$), and 21-month ($M = 4.83, SD = 0.41$) (question was not asked in 14-month assessment) (see Figure 2 for a comparison of all participants at all evaluation periods for which data was available).

Figure 2. Mean scores on UNAIDS (2007) standard measure of HIV/AIDS prevention knowledge, measured on a 5-point scale, at baseline ($n = 14$), 4 months ($n = 13$), 8 months ($n = 11$), and 21 months ($n = 9$). Relevant questions were not asked in the 14-month assessment



Trend analysis revealed a significant linear trend, $F(1,5) = 7.50, p = .041$, a significant quadratic trend, $F(1,5) = 7.50, p = .041$, and a significant cubic trend, $F(1,5) = 7.50, p = .041$ addition, to determine if there was any significant change in knowledge about HIV/AIDS prevention between baseline and intervention stages, a one-way repeated measures ANOVA was carried out ($n = 14$). There was a marginal, but not significant, change in HIV/AIDS knowledge, $F(1, 13) = 4.14, p = .063$, between baseline ($M = 4.29, SD = 0.73$) to intervention stage ($M = 4.79, SD = 0.38$). Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in HIV/AIDS prevention knowledge between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in HIV/AIDS knowledge, $F(1, 12) = 0.00, p = 1.000$, such that dropouts ($M = 4.79, SD = 0.39$) and non-dropouts ($M = 4.79, SD = 0.39$) had identical scores.

Condom Suggestion

A chi square test was carried out to determine if participants were requesting use of a condom during their last sexual encounter with a partner, again comparing baseline with all results during the program. There was no significant change in condom suggestion, $\chi^2(1) = 0.24, p = .622$, between baseline ($n = 12$ responses in baseline evaluation, 66.7% suggested) and in-program ($n = 23$ responses across all in-program evaluations, 73.9% suggested) (see Figure 3 for comparison across all evaluations and all participants).

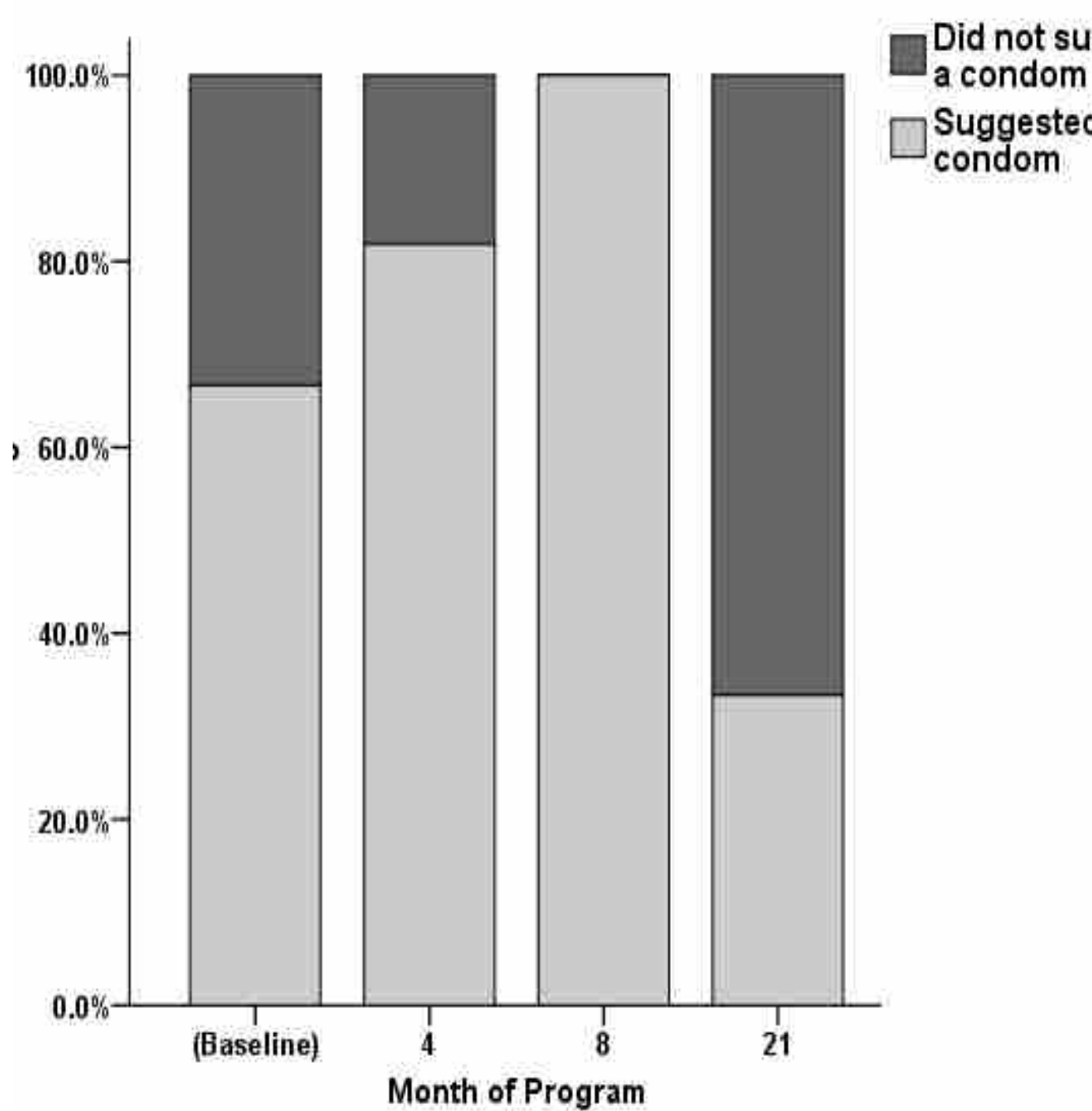


Figure 3. Suggesting use of a condom during most recent sexual encounter with a partner, at baseline ($n = 12$), 4 months ($n = 11$), 8 months ($n = 6$), and 21 months ($n = 6$). Relevant question was not asked in the 14-month assessment.

Furthermore, a chi square test was carried out to determine if there was a difference in condom suggestion during last sexual encounter (measured across all in-program assessments) between program dropouts ($n = 8$ sexual encounters) and participants who remained with the program ($n = 15$ sexual encounters). There was no significant difference in condom suggestion, $\chi^2(1) = 1.17, p = .278$, between dropouts (87.5% suggestion) and participants (66.7%).

Condom Use

To determine if there was a significant change in condom use since the beginning of the program, a chi square analysis was carried out, comparing condom use during the last sexual encounter with a partner at baseline with all assessment responses to the question during the program. There was no significant change in condom use, $\chi^2(1) = 0.60, p = .439$, between baseline ($n = 11$ responses in baseline evaluation, condom use 63.6%) and in-program ($n = 29$ responses across in-program evaluations, condom use 75.9%) (see Figure 4 for comparison across all evaluations and all participants). Furthermore, a chi square test was carried out to determine if there was a difference in condom use during last sexual encounter (measured across all in-program assessments) between program dropouts ($n = 7$ sexual encounters) and participants who remained with the program ($n = 15$ sexual encounters). There was a significant difference in condom use, $\chi^2(1) = 3.85, p = .050$, such that dropouts (100.0% use) had higher condom use rate than participants (60.0% use).

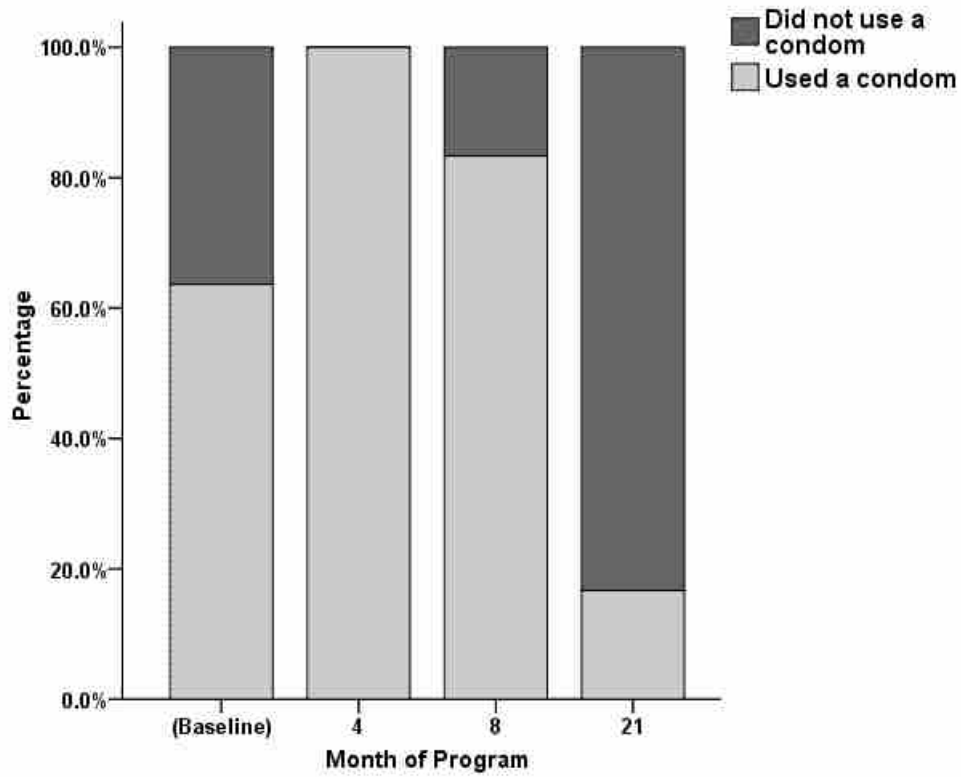
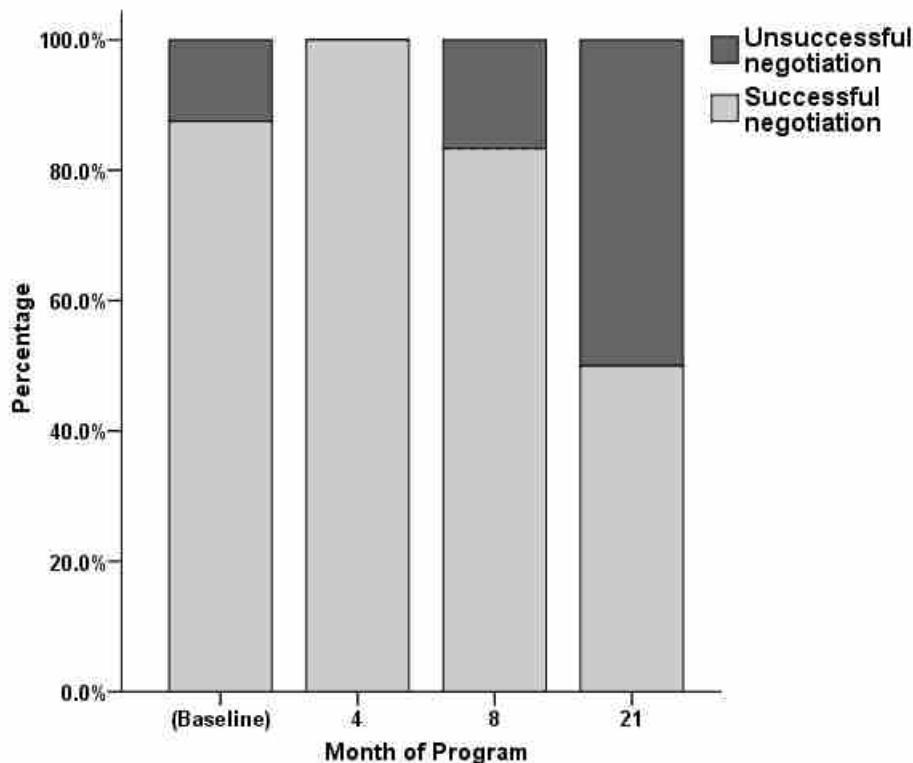


Figure 4. Condom use during most recent sexual encounter with a partner, at baseline ($n = 11$), 4 months ($n = 10$), 8 months ($n = 6$), and 21 months ($n = 6$). Relevant question was not asked in the 14-month assessment.

Condom Negotiation

A chi square test was carried out to determine success rate in condom negotiation among participants who suggested using a condom. Among those who suggested using a condom, there was no significant change in condom negotiation success, $\chi^2(1) = 0.00, p = .968$, between baseline ($n = 8$, responses in baseline assessment, 87.5% success rate), and in-program ($n = 23$ responses across in-program assessments, 87.0% success) (see Figure 5 for comparison across all evaluations and all participants). A chi square test was also carried out to determine if there was a difference in condom negotiation success during last sexual encounter (measured across all in-program assessments) between program dropouts ($n = 7$ condom negotiations) and participants who remained with the program ($n = 10$ condom negotiations).

Figure 5. Successful condom negotiation, represented as suggesting and actually using a condom during most recent sexual encounter with a partner (only assessed among those who suggested using a condom), at baseline ($n = 8$), 4 months ($n = 9$), 8 months ($n = 6$), and 21 months ($n = 2$). Relevant questions were not asked in the 14-month assessment.

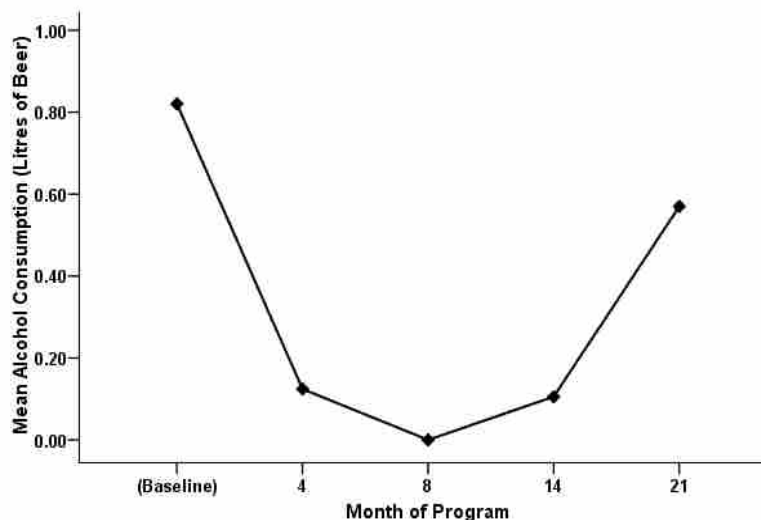


There was no significant difference in condom suggestion, negotiation success rate , $\chi^2(1) = 1.59, p = .208$, between dropouts (100.0% success) and participants (80.0% success).

Nightly Alcohol Consumption

To determine if there was any significant change in reported litres of alcohol drunk in a single night, a one-way repeated measures ANOVA was carried out among the six participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was significant, $\chi^2(9) = 24.07, p = .008$, so the Greenhouse-Geisser correction was used. There was a marginally non-significant change in beer consumption, $F(1, 6) = 5.32, p = .051$, between baseline ($M = 1.23, SD = 1.06$), 4-month ($M = 0.29, SD = 0.46$), 8-month ($M = 0.00, SD = 0.00$), 14-month ($M = 0.04, SD = 0.10$), and 21-month ($M = 0.18, SD = 0.14$) (see Figure 6 for a comparison of all fourteen participants at all evaluation periods for which data was available). Trend analysis revealed a significant linear trend, $F(1, 5) = 8.57, p = .033$, but no significant quadratic trend, $F(1, 5) = 6.18, p = .055$, or cubic trend, $F(1, 5) = 0.71, p = .437$.

Figure 6. Mean nightly alcohol consumption (measured in litres of 5.0% alcohol beer) at base-line ($n = 14$), 4 months ($n = 14$), 8 months ($n = 11$), 14 months ($n = 11$), and 21 months ($n = 9$).



In addition, a one-way repeated measures ANOVA was carried out to determine if there was any significant change in alcohol consumption between baseline and intervention stages ($n = 14$).

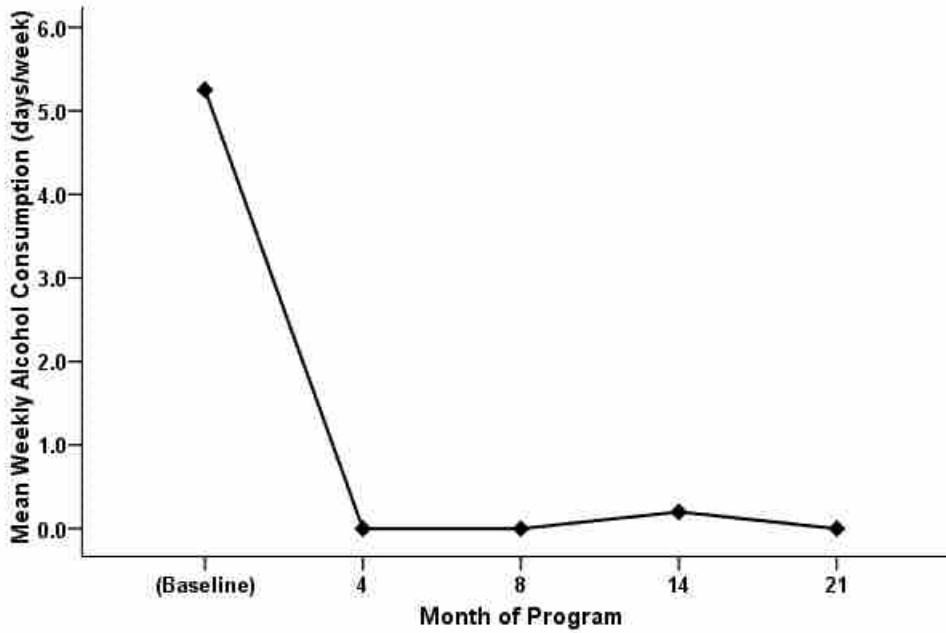
There was a significant decrease in alcohol consumption, $F(1, 13) = 7.49, p = .017$, from baseline ($M = 0.82, SD = 0.80$) to intervention stage ($M = 0.17, SD = 0.29$).

Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in nightly alcohol consumption between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in nightly alcohol consumption, $F(1, 12) = 0.99, p = .339$, between dropouts ($M = 0.10, SD = 0.11$) and non-dropouts ($M = 0.25, SD = 0.39$).

Weekly Alcohol Consumption

To determine if there was any significant change in the number of nights of alcohol consumption per week, a one-way repeated measures ANOVA was carried out among the sub-sample of two participants for whom complete longitudinal data for this scale were available. Because results were identical at all but one level of the dependent variable, sphericity was assumed. There was a significant change in frequency of beer consumption, $F(4, 4) = 9.00, p = .028$, between baseline ($M = 5.25, SD = 2.47$), 4-month ($M = 0.00, SD = 0.00$), 8-month ($M = 0.00, SD = 0.00$), 14-month ($M = 0.00, SD = 0.00$), and 21-month ($M = 0.00, SD = 0.00$) (see Figure 7 for a comparison of all 14 participants, at all evaluation periods with data available). Trend analysis revealed no significant linear trend, $F(1,1) = 9.00, p = .205$, quadratic trend, $F(1,1) = 9.00, p = .205$, or cubic trend, $F(1,1) = 9.00, p = .205$.

Figure 7. Mean days per week of alcohol consumption at baseline ($n = 14$), 4 months ($n = 12$), 8 months ($n = 4$), 14 months ($n = 10$), and 21 months ($n = 9$).



In addition, to determine if there was any significant change in nights of alcohol consumption per week between baseline and intervention stages, a one-way repeated measures ANOVA was carried out ($n = 14$). There was a significant decrease in weekly alcohol consumption, $F(1, 13) = 72.90, p < .001$, from baseline ($M = 5.25, SD = 2.28$) to intervention stage ($M = 0.05, SD = 0.12$).

Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in weekly alcohol consumption between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in weekly alcohol consumption in litres of beer, $F(1, 12) = 0.15, p = .167$ between dropouts ($M = 0.10, SD = 0.16$) and non-dropouts ($M = 0.00, SD = 0.00$).

Job Satisfaction

Job Satisfaction Scale

To determine if there was any significant change in satisfaction with their hotel jobs, a one-way repeated measures ANOVA was carried out among the six participants for whom complete longitudinal data for this scale was available; comparing mean assessments of job satisfaction with hotel job and previous beer selling job (both assessments carried out in all four intervention-stage questionnaires). Mauchly's test of sphericity was non-significant, $\chi^2(5) = 2.17, p = .831$, so sphericity was assumed. There was no significant change in hotel job satisfaction, $F(3, 15) = 0.33, p = .802$, between 4-month ($M = 19.00, SD = 2.53$), 8-month ($M = 18.17, SD = 1.17$), 14-month ($M = 17.83, SD = 2.56$), and 21-month ($M = 18.33, SD = 1.75$) (question not asked at baseline) (see Figure 8 for a comparison of all fourteen participants at all evaluation periods for which data was available, and compared to retrospective assessments of beer selling job). Trend analysis revealed no significant linear trend, $F(1, 5) = 0.37, p = .570$, quadratic trend, $F(1, 5) = 0.75, p = .427$, or cubic trend, $F(1, 5) = 0.01, p = .938$.

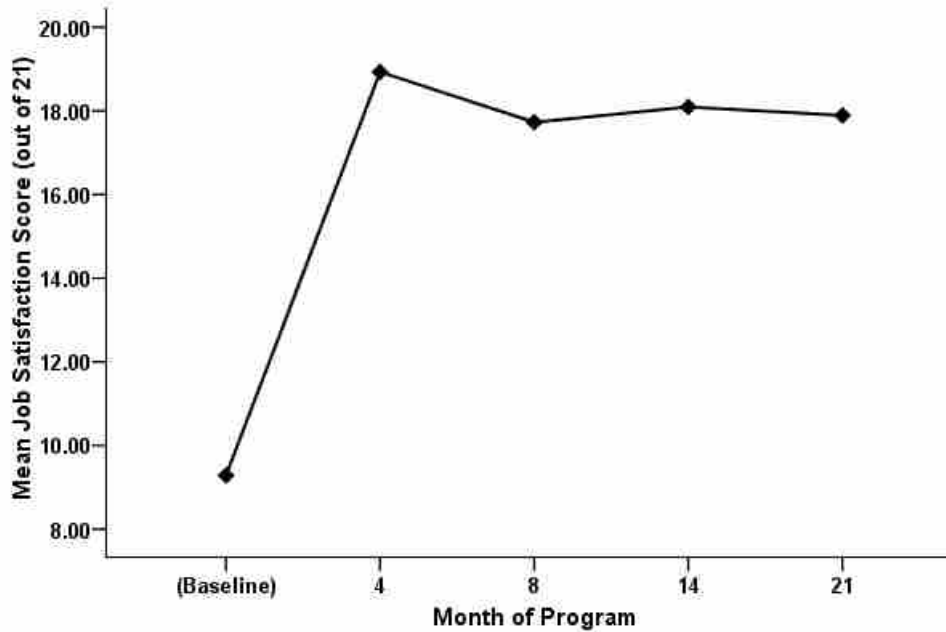


Figure 8. Mean scores on the job satisfaction scale, measured on a 21-point scale, at baseline ($n = 14$), 4 months ($n = 14$), 8 months ($n = 11$), 14 months ($n = 11$), and 21 months ($n = 9$). Baseline data refers to beer selling jobs (and refers to mean rating of beer selling, taken across the other four assessments); other data refer to hotel jobs.

In addition, to determine if there was a significant difference between satisfaction in hotel job and satisfaction in beer selling job, a one-way repeated measures ANOVA was carried out ($n = 14$) comparing mean assessments of job satisfaction with hotel job and previous beer selling job (both

assessments carried out in all four intervention-stage questionnaires). There was a significant difference in job satisfaction, $F(1, 13) = 80.04, p < .001$, between satisfaction with hotel job ($M = 18.21, SD = 1.12$) and satisfaction with beer selling job ($M = 9.40, SD = 1.99$).

To determine if there was a significant difference between job satisfaction at different hotels across all the assessments a one-way independent samples ANOVA was carried out ($n = 14$). There was no significant difference in job satisfaction, $F(2, 11) = 0.10, p = .910$, between Sokha Hotel ($M = 18.15, SD = 1.08$), Lin Ratanak Hotel ($M = 18.08, SD = 1.97$), and Angkor Howard Hotel ($M = 18.40, SD = 1.29$).

Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in job satisfaction between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in job satisfaction, $F(1, 12) = 0.12, p = .735$, between dropouts ($M = 18.32, SD = 1.34$) and non-dropouts ($M = 18.11, SD = 0.93$).

Self-Esteem

Rosenberg Self-Esteem Scale

Changes in self-esteem across the 4 HAP assessments were measured by a subset of questions drawn from the Rosenberg (1965) Self-Esteem Scale. Because the question was not asked at baseline, no 2-level ANOVA was completed to compare baseline and intervention stage scores. Rather, a one-way repeated measures ANOVA was carried out among the five participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was non-significant, $\chi^2(5) = 0.78, p = .780$, so sphericity was assumed. There was no significant change in self-esteem, $F(3, 12) = 1.54, p = .255$, between 4-month ($M = 15.40, SD = 1.34$), 8-month ($M = 14.20, SD = 1.79$), 14-month ($M = 13.20, SD = 2.95$), and 21-month ($M = 13.00, SD = 1.73$) (question was not asked in baseline assessment) (see Figure 9 for a comparison of all fourteen participants at all evaluation

periods for which data was available). Trend analysis revealed no significant linear trend, $F(1, 4) = 5.12, p = .086$, quadratic trend, $F(1, 4) = 0.30, p = .611$, or cubic trend, $F(1, 4) = 0.02, p = .893$

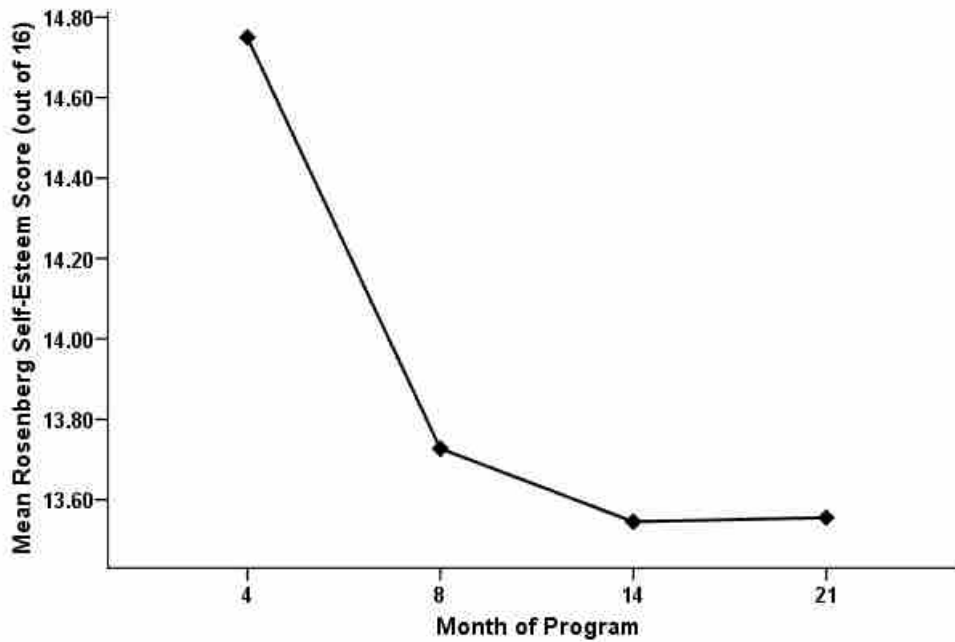


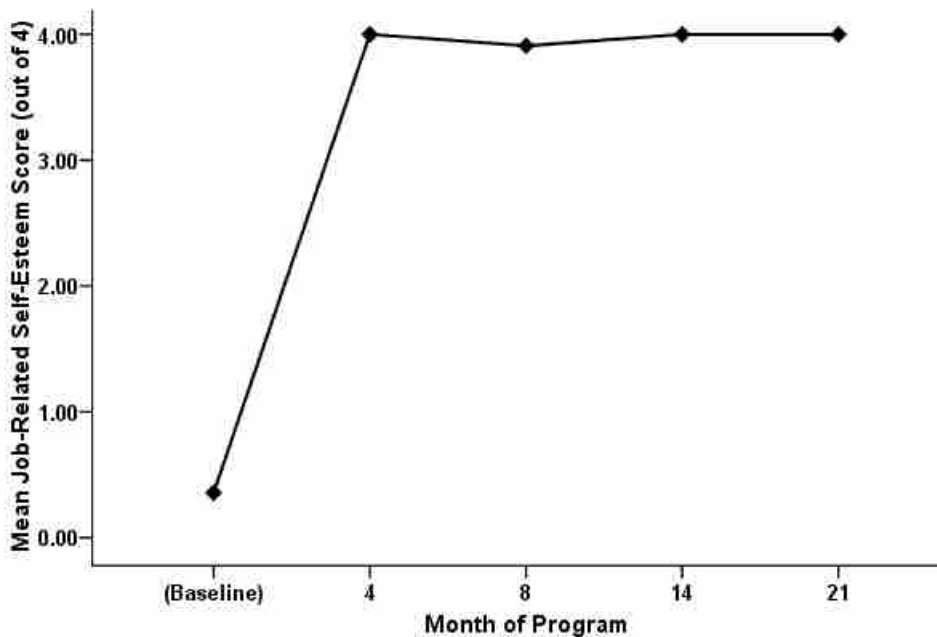
Figure 9. Mean scores on the abbreviated Rosenberg Self-Esteem Scale (1965), measured on a 16-point scale, at 4 months ($n = 12$), 8 months ($n = 11$), 14 months ($n = 11$), and 21 months ($n = 9$). Relevant questions were not asked in the baseline assessment.

In addition, a one-way independent measures ANOVA was completed to determine if there was any difference in self-esteem between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in self-esteem scores, $F(1, 12) = 0.12, p = .735$, between dropouts ($M = 13.19, SD = 1.34$) and non-dropouts ($M = 14.42, SD = 0.77$).

Job-Related Self-Esteem Scale

To determine if there was any significant change in job-related self-esteem during the program, a one-way repeated measures ANOVA was carried out among the five participants for whom complete longitudinal data for this scale was available. However, results were identical across all levels of the dependent variable ($M = 4.00, SD = 0.00$), so no statistical procedures were carried out (see Figure 10 for a comparison of all fourteen participants at all evaluation periods for which data was available).

Figure 10. Mean scores on the job-related self-esteem scale, measured on a 4-point scale, at baseline ($n = 14$), 4 months ($n = 13$), 8 months ($n = 11$), 14 months ($n = 11$), and 21 months ($n = 9$). Baseline data refers to beer selling jobs; other data refer to hotel jobs



To compare job-related self-esteem at hotel and beer selling jobs, a one-way repeated measures ANOVA was carried out ($n = 14$). There was a significant increase in job-related self-esteem, $F(1, 13) = 334.04, p < .001$, from baseline ($M = 0.36, SD = 0.74$) to intervention stage ($M = 3.96, SD = 0.13$).

In addition, to determine if there was a significant difference between job-related self-esteem at different hotels, a one-way independent samples ANOVA was carried out ($n = 14$). There was no significant difference in job-related self-esteem, $F(2, 11) = 0.88, p = .441$, between Sokha Hotel ($M = 4.00, SD = 0.00$), Lin Ratanak Hotel ($M = 4.00, SD = 0.00$), and Angkor Howard Hotel ($M = 3.90, SD = 0.22$).

Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in job-related self-esteem between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in job-related self-esteem scores, $F(1, 12) = 1.00, p = .337$, between dropouts ($M = 3.93, SD = 0.19$) and non-dropouts ($M = 4.00, SD = 0.00$).

School Performance

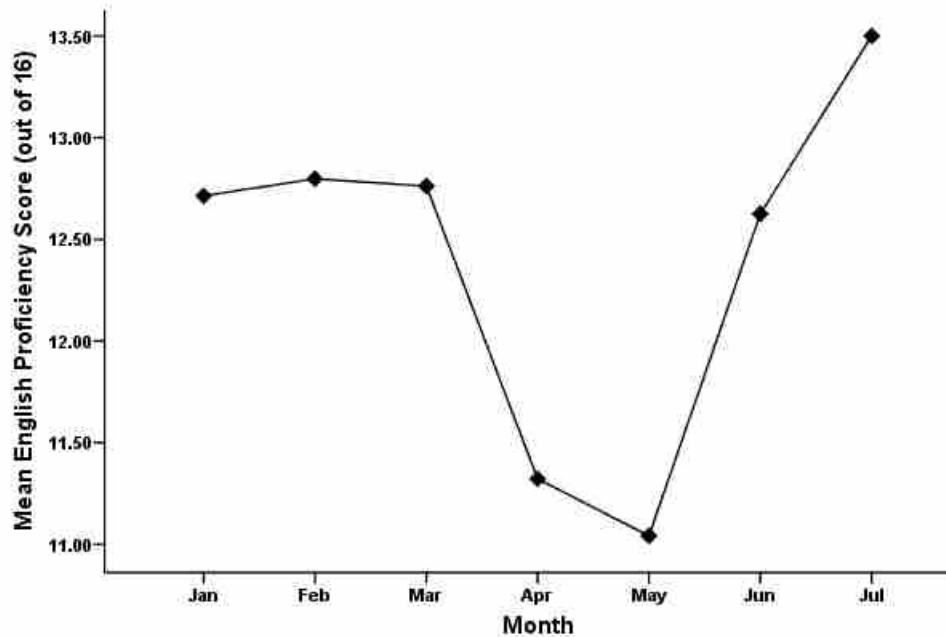
English Proficiency Learning Scale

To determine if there was any significant change in English learning, a one-way repeated measures ANOVA was carried out among the twelve participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was significant, $\chi^2(20) = 51.22, p < .001$, so the Greenhouse-Geisser correction was used. There was a significant change in English learning, $F(2, 31) = 6.37, p = .002$ between January ($M = 13.08, SD = 1.68$), February ($M = 13.06, SD = 1.96$), March ($M = 13.17, SD = 2.49$), April ($M = 11.96, SD = 1.99$), May ($M = 11.04, SD = 2.29$),

June ($M = 12.63$, $SD = 2.65$), and July ($M = 13.50$, $SD = 3.06$) (see Figure 11 for a comparison of all fourteen participants at all evaluation periods for which data was available). Further trend analysis revealed no significant linear trend, $F(1, 11) = 0.36$, $p = .562$; but there was a significant quadratic trend, $F(1, 11) = 12.41$, $p = .005$, and a significant cubic trend, $F(1, 11) = 18.48$, $p = .001$.

In addition, a one-way independent measures ANOVA was completed to determine if there was any difference in English learning between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in English learning scores, $F(1, 12) = 0.03$, $p = .872$, between dropouts ($M = 12.23$, $SD = 2.89$) and non-dropouts ($M = 12.43$, $SD = 1.48$)

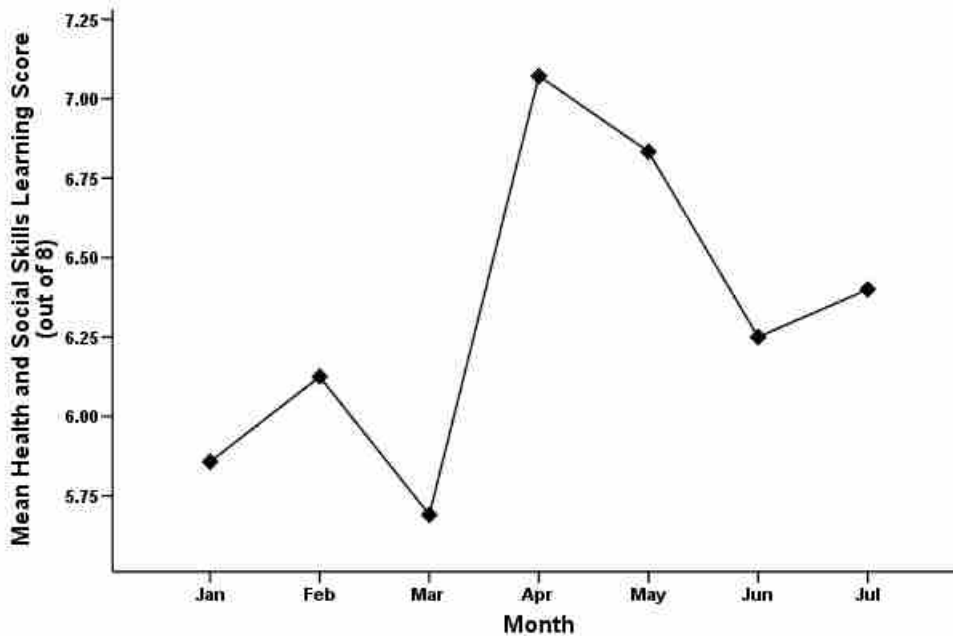
Figure 11. Mean scores on the English proficiency learning assessment, measured on a 16-point scale, collapsed into one-month periods during seven of the eight months of class (no assessments were conducted in December 2006): January 2007 ($n = 14$), February 2007 ($n = 14$), March 2007 ($n = 14$), April 2007 ($n = 14$), May 2007 ($n = 12$), June 2007 ($n = 12$), and July 2007 ($n = 12$).



Health and Social Skills Learning Scale

To determine if there was any significant change in learning about health and social skills, a one-way repeated measures ANOVA was carried out among the ten participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was non-significant, $\chi^2(20) = 27.97, p = .144$, so sphericity was assumed. There was a significant change in health and social skills learning, $F(6, 54) = 2.62, p = .027$ among the 7 measured months, starting at January ($M = 6.00, SD = 0.94$ and ending July ($M = 6.40, SD = 1.58$). (See Figure 12 for a comparison of all fourteen participants at all evaluation periods for which data was available). Further trend analysis revealed no significant linear trend, $F(1, 9) = 0.94, p = .358$, quadratic trend, $F(1, 9) = 2.65, p = .138$, or cubic trend, $F(1, 9) = 0.27, p = .615$.

Figure 12. Mean scores on the health and social skills learning assessment, measured on an 8-point scale, collapsed into one-month periods during seven of the eight months of class (no assessments were conducted in December 2006): January 2007 ($n = 14$), February 2007 ($n = 14$), March 2007 ($n = 14$), April 2007 ($n = 14$), May 2007 ($n = 12$), June 2007 ($n = 12$), and July 2007 ($n = 10$).

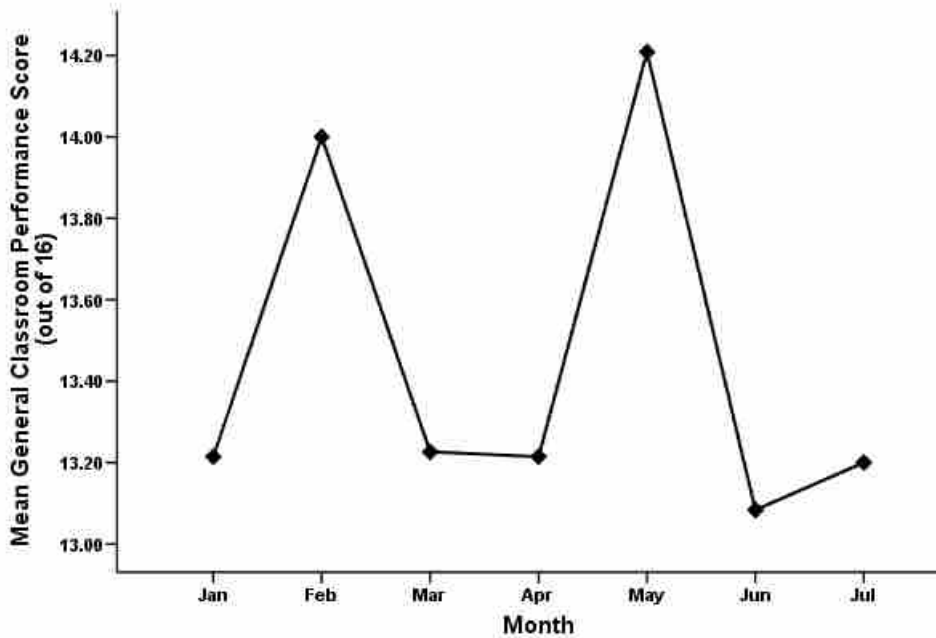


In addition, a one-way independent measures ANOVA was completed to determine if there was any difference in health and social skills learning between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in health and social skills learning scores, $F(1, 12) = 1.40, p = .260$, between dropouts ($M = 5.95, SD = 1.10$) and non-dropouts ($M = 6.50, SD = 0.55$).

General Classroom Performance Scale

To determine if there was any significant change in general classroom performance, a one-way repeated measures ANOVA was carried out among the ten participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was non-significant, $\chi^2(20) = 24.32, p = .277$, so sphericity was assumed. There was a marginally non-significant change in general classroom performance, $F(6, 54) = 2.25, p = .053$ between January ($M = 13.90, SD = 2.02$), February ($M = 14.35, SD = 1.43$), March ($M = 13.45, SD = 2.54$), April ($M = 14.00, SD = 1.78$), May ($M = 14.05, SD = 1.82$), June ($M = 13.00, SD = 2.05$), and July ($M = 13.20, SD = 2.01$) (see Figure 13 for a comparison of all fourteen participants at all evaluation periods for which data was available). Further trend analysis revealed no significant linear trend, $F(1, 9) = 3.61, p = .090$, quadratic trend, $F(1, 9) = 1.51, p = .250$, or cubic trend, $F(1, 9) = 0.00, p = .962$.

Figure 13. Mean scores on the general classroom performance assessment, measured on a 16-point scale, collapsed into one-month periods during seven of the eight months of class (no assessments were conducted in December 2006): January 2007 ($n = 14$), February 2007 ($n = 14$), March 2007 ($n = 14$), April 2007 ($n = 14$), May 2007 ($n = 12$), June 2007 ($n = 12$), and July 2007 ($n = 10$)



In addition, a one-way independent measures ANOVA was completed to determine if there was any difference in general classroom performance between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in general classroom performance scores, $F(1, 12) = 2.28, p = .157$, between dropouts ($M = 12.63, SD = 2.81$) and non-dropouts ($M = 14.29, SD = 0.78$).

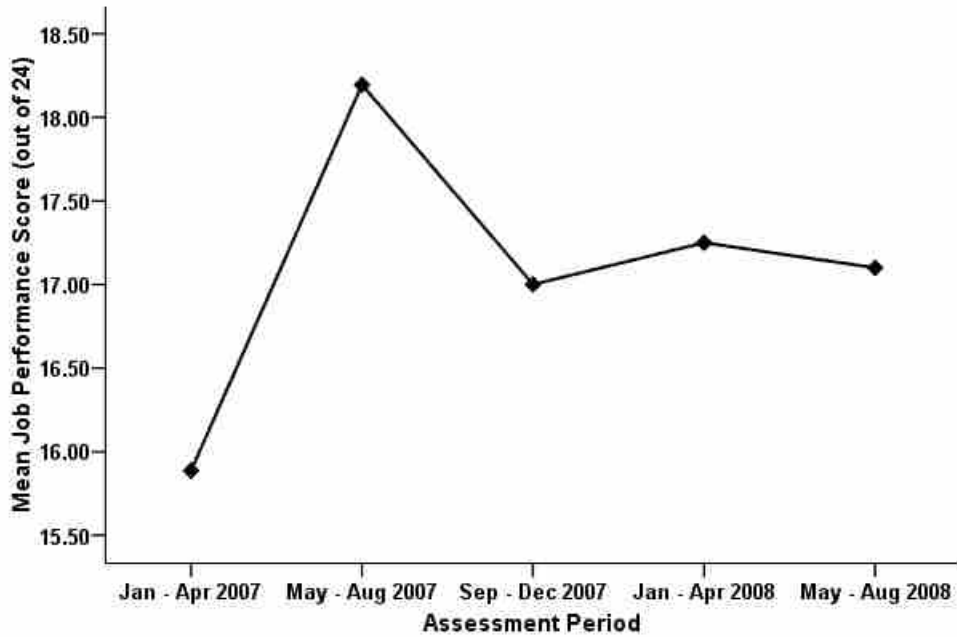
Job Performance

Job Performance Scale

To determine if there was any significant change in job performance, a one-way repeated measures ANOVA was carried out among the ten participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was significant, $\chi^2(9) = 19.47, p = .024$, so the Greenhouse-Geisser correction was used. There was no significant change in hotel job performance, $F(1, 15) = 2.45, p = .124$, across the 5 periods January to April 2007 ($M = 16.33, SD = 0.89$), May to

August 2007 ($M = 17.83, SD = 1.49$), September to December 2007 ($M = 17.15, SD = 0.34$), January to April 2008 ($M = 17.25, SD = 1.25$), and May to August 2008 ($M = 17.10, SD = 0.94$) (see Figure 14 for a comparison of all fourteen participants at all evaluation periods for which data was available). Trend analysis revealed no significant linear trend, $F(1, 9) = 0.54, p = .480$, or cubic trend, $F(1, 9) = 2.07, p = .184$; but there was a significant quadratic trend, $F(1, 9) = 6.43, p = .032$.

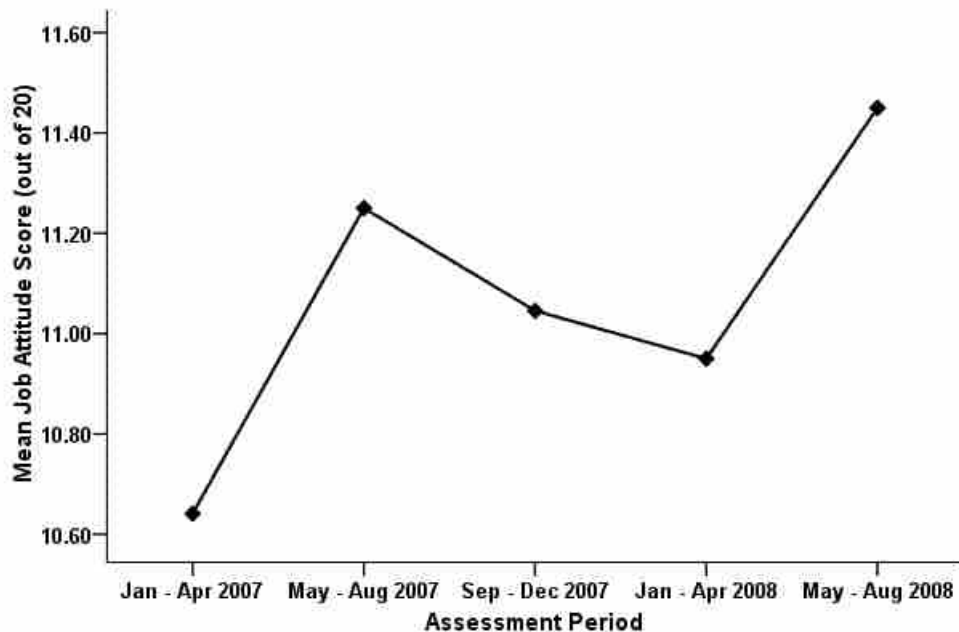
Figure 14. Mean scores on job performance assessment, using a 24-point scale, collapsed into two-month periods: January to April 2007 ($n = 14$), May to August 2007 ($n = 12$), September to December 2007 ($n = 11$), January to April 2008 ($n = 10$), and May to August 2008 ($n = 10$).



Job Attitude Scale

To determine if there was any significant change in assessment of participants' job attitude, a one-way repeated measures ANOVA was carried out among the ten participants for whom complete longitudinal data for this scale was available. Mauchly's test of sphericity was non-significant, $\chi^2(9) = 6.91, p = .655$, so sphericity was assumed. There was no significant change in assessed hotel job attitude, $F(4, 36) = 0.48, p = .751$, between January to April 2007 ($M = 10.91, SD = 0.92$), May to August 2007 ($M = 11.00, SD = 1.32$), September to December 2007 ($M = 11.05, SD = 0.86$), January to April 2008 ($M = 10.95, SD = 1.30$), and May to August 2008 ($M = 11.45, SD = 1.01$) (see Figure 15 for a comparison of all fourteen participants and evaluation periods for which data was available).

Figure 15. Mean scores on the job attitude assessment, measured on a 20-point scale, collapsed into two-month periods: January to April 2007 ($n = 14$), May to August 2007 ($n = 12$), September to December 2007 ($n = 11$), January to April 2008 ($n = 10$), and May to August 2008 ($n = 10$).



In addition, a one-way independent samples ANOVA was carried out to determine whether there was a significant effect of the hotel environment on job attitude, collapsed across time ($n = 14$). There was no significant effect of hotel, $F(2, 11) = 2.49, p = .128$, such that job attitude was judged similarly by supervisors at Sokha Hotel ($M = 10.73, SD = 0.58, n = 4$), Lin Ratanak Hotel ($M = 10.37, SD = 0.88, n = 5$), and Angkor Howard Hotel ($M = 11.36, SD = 0.59, n = 5$).

Finally, a one-way independent measures ANOVA was completed to determine if there was any difference in job attitude between participants who remained in the program ($n = 7$), and those who left before its end ($n = 7$). There was no significant difference in job attitude scores, $F(1, 12) = 0.63 = .442$, between dropouts ($M = 11.00, SD = .85$) and non-dropouts ($M = 10.66, SD = 0.74$).

Discussion

A wide variety of quantitative measures were analyzed to assess the effectiveness of the Hotel Apprenticeship Program (HAP) run by the NGO SiRCHESEI in partnership with three local Siem Reap hotels. Changes are examined and discussed, whenever results showed statistical significance. In addition, because the women in the program represent a unique and entire population (as opposed to a partial sample), any changes among the data are examined. Finally, quantitative measures are contextualized with qualitative measures taken during the program.

The women in the program displayed an increase in health-related knowledge and behaviour in two of three risk areas. First, there was an increase in knowledge about HIV/AIDS prevention, primarily between baseline and the four-month measure, but continuing throughout the program. There was also a dramatic decrease in alcohol consumption, both measured by litres of alcohol consumed per night; and nights of alcohol consumption per week. A perplexing increase in reported consumption of alcohol for the last drinking episode occurred in the last report at 21 months.

However, the primary effect of removing women from beer selling upon reducing alcohol consumption generally is supported. On a third health-related behaviour measure, however, there was no sign of overall change. Condom use, was assessed through i) reported condom use during last sexual encounter, ii) suggesting using a condom during last sexual encounter, and iii) condom negotiation success rate (condom suggested and condom used). There were no significant overall changes in these indicators throughout the program, and all three condom-related indicators showed the lowest rates at the final 21-month assessment (See also Figures 3, 4 and 5). Lack of condom use in a multi-partner environment is considered risky; however, stable monogamous family units may show decreased condom use, especially for family procreation.

In general, measures of job satisfaction and self-esteem displayed dramatic increases between baseline (beer selling) and in-program (hotel job), but little change throughout the program (see Figures 8, 9, 10), as they displayed “ceiling effect” patterns. The Job Satisfaction Scale (Figure 8) indicated a significant increase in satisfaction from beer selling job to hotel job, but no further significant change throughout the course of the program, remaining near maximum. Hotel job satisfaction was highest at the four-month evaluations, with six participants out of fourteen giving the hotel job a perfect score of 21 on the job satisfaction scale.

Both measures of self-esteem displayed similar patterns. The abbreviated Rosenberg self-esteem scale (see Figure 9) displayed a non-significant decrease during the course of the program. After leaving the beer industry, the highest scores were found at the four-month assessment, with seven participants out of fourteen scoring a perfect score of 16 on the abbreviated Rosenberg self-esteem scale. A measure of job-related self-esteem was also employed, and displayed a dramatic increase from beer selling job to hotel job (see Figure 10). Indeed, throughout assessments of the hotel job, only one score (out of 44 assessments) was not a perfect score of 4 on the job-related self-esteem scale.

However, in contrast to the measures above, the five assessments scales taken from the Hotel and School Performance Appraisals – Job Performance Scale, Job Attitude Scale, English Proficiency Learning Scale, Health and Social Skills Learning Scale, and General Classroom Performance Scale – did not provide such clear results. Of these five scales, only two (Health and Social Skills Learning and English Proficiency Learning) changed significantly throughout the program. While the change in the Health and Social Skills Learning Scale was significant, there was high variability over time, but no apparent pattern. In contrast, the English Proficiency Learning Scale did display a significant cubic and quadratic trend (also visible when scores are represented graphically, see Figure 11), implying a potential ‘mid-program slump,’ followed by a final accelerated improvement.

In addition, the scores for participants who left the program (‘dropouts’) and those of participants who remained with the program until the end in November 2008 (‘non-dropouts’) were compared for each scale, to determine if there was any significant predictor of remaining with the program. No significant difference was found in any scale between dropouts and non-dropouts.

The lack of significant results in either predicting program dropouts, or in evaluating performance in either the hotel or school portions of the program, may be due to the volatile and individualistic nature of all these measures; as well, at the hotels, there was variability amongst the managers supplying the ratings. To assess some of the additional complex, individualistic factors, not captured in the aggregate expression of a statistical mean, more in-depth, qualitative measures related to the program were also examined. In addition, qualitative analyses may provide explanatory insights into reported quantitative results.

One key to understanding the situation of the participants in the HAP may be an examination of their former situation as beer sellers. In discussions with both the English teacher and the program counselor, it was mentioned that the possibility of escaping beer selling was what most motivated the participants to succeed in a long, difficult program. During interviews in August, 2008, with all

participants, they indicated that as beer sellers, they had been forced to drink, had been touched inappropriately, had been physically attacked, and had been coerced into performing sexual acts. One participant said she was often frightened as a beer seller, especially when serving drunken tourists. In addition, participants felt excessive pressure from their employers to sell large quantities of beer, and although many were on fixed salaries, they felt that not doing so often resulted in salary penalties. Participants were also aware of the low social status of beer sellers. Because beer selling is a job that is available to women with no education, no connections, no ability to speak English, and who may sometimes be propositioned to sell sex, the women who sell beer are looked down upon by the community. Several participants reported feeling ashamed of their former jobs.

With few exceptions, participants framed their explanation of beer selling in dramatic contrast to hotel work. Hotel jobs are recognized by the wider community as stable, well-paying, and skilled. The regimentation of hotel work had originally been seen by program designers as a likely problem area for the beer sellers, who were used to a more non-structured job environment. However, it was in fact noted as a positive factor by several participants, who recognized that it ensured clear job descriptions, fair employee-employer relations, and safety for hotel employees. The relative safety of the hotel environment was noted by many participants. Participants felt confident that hotel patrons who were acting inappropriately towards employees or towards other patrons (as opposed to beer hall patrons acting similarly) would be dealt with immediately by security staff and management.

However, participants did note difficulties with structural factors of the hotels. Several participants noted difficulties with supervisors who had what they perceived to be unrealistic expectations and short tempers. But the structural factor most commonly noted by participants as frustrating was the difficulty changing jobs within the hotel. When the HAP was set up, it was expected that participants would be transferred between several different departments within the hotel, thereby learning a variety of skills. For this reason, little attention was paid to the specific

department in which they began training. However, certain jobs – such as cook, cashier, and jobs in the hotel spa – were sought after for a variety of reasons. One participant, who worked as a public area cleaner, said she wanted a more challenging job, because even a child could do hers. Others, who also worked in such jobs, were reluctant to classify themselves as better or worse than their fellow employees, stating everyone in their department was about the same. This was in sharp contrast to participants who worked in more skilled jobs. They were quick to assess their performance as compared to their co-workers – a finding that could have implications not only for self-esteem and job satisfaction, but also for the ability to stand out to management as a potential candidate for promotion. Other participants noted the applicability of skills in some jobs, such as cook or cashier, to future employment prospects, including working in the market either selling products or cooking. Finally, participants were aware that some hotel jobs (e.g. housekeeping, waiter, and spa jobs) include the possibility of tips, which could supplement their still-insufficient income.

However, hotel managers were ultimately reluctant to move participants once they had received training in one department. Such decisions were generally made more based on which departments needed staff, than actual employee preferences. Several participants – notably, all working at the Sokha Hotel, the only five-star hotel and the hotel originally expected to provide the best working environment – stated that, except in cases when a department was sorely lacking in personnel, no one ever got moved between departments. Even in cases when a move was theoretically possible, HAP participants' lack of English proved a serious barrier. Because of their lack of English at the beginning of the program, participants were often placed in departments where English would not be as important; such as public area cleaning and laundry (generally, the least skilled departments). In the end, though, after the eight-month apprenticeship stage of the program ended, and with it the daily English education, participants in areas where they could not practice English began to lose the language; further hampering their chances of changing to a better job within

the hotel. Remedial English classes, offered by SiRCHESEI as a late addition to the program, had low and sporadic attendance, because of participants' changeable and generally very busy work schedules.

Several times the English teacher wrote recommendations in School Evaluations that one-on-one tutoring be implemented to improve the English level of some students – especially students with little prior formal education. However, as one participant noted during her interview, eight-hour shifts (longer than they were used to, as beer sellers work only four to five hours per shift), in addition to family and other concerns external to the program, did not allow for the possibility of coming to the SiRCHESEI school for more training. Two participants – both praised in their in-class evaluations for studiousness and consistent completion of homework – were chastised at work for reading (presumably studying) during shift.

The qualitative findings in the interviews also lent support to several of the quantitative research findings. Participants in the HAP universally agreed that the way they saw themselves had changed, as compared to before the program. They cited such factors as job skills, English comprehension, health-related knowledge and behaviour, happiness, and respect from friends, family, and others in the community. Despite often wanting to switch departments, all participants (with one exception) stated they enjoyed hotel work. Qualitative findings also supported the overall worth of the program. All participants – including participants who left the program subsequent to the interviews – said they liked the program, often quite enthusiastically. Many elements were listed as the most worthwhile part of the program: English classes, health-related learning, job skills, hotel employment, and the staff of the program – particularly the program counselor.

Discussion of participants' plans following the end of the HAP also revealed generally high levels of self-confidence, optimism, and perceived self-agency. Several participants listed comprehensive future goals – and definite plans to achieve those goals. Desire to switch departments

within the hotel (discussed above) was frequently connected to future plans. A number of participants wished to work as cooks in the hotel, in order to be able to cook and sell food in the market later on in life; or wished to work as cashiers in the hotel, in order to be able to sell goods in the market later on in life. Selling in the market was, in fact, mentioned by virtually all participants as a viable job opportunity in the distant future. Selling in the market was described as more independent than hotel work, easier to do while taking care of young children, and less physically strenuous, and therefore a job that was easier to do later in life.

However, all participants who were interviewed (with the exception of one participant who was planning on leaving the HAP) planned to keep working in the hotel industry at the end of the program; and at least continuing for several years. It was expected in creating the program that participants would gain specific loyalties to the hotel where they were employed; but participants expressed much more pragmatic intentions. Participants said they would leave their hotels if another hotel offered them either increased wages or improved work, including promotions and a switch to a better department.

Discussion of future plans also revealed that participants had long-term plans in their personal lives, involving marriage and children. Indeed, during the course of the program, several participants gave birth to children, taking advantage of their hotels' maternity leave policies (offering three months of time off, with full salary) – not an option in their previous beer selling jobs. There is substantial evidence that the duration of the HAP was a time for 'settling down' in participants' personal lives. It is unknown if this was merely a function of the life-stage of the participants in the program (mean age was 24.93 years at the beginning of the program), or if there is a causal relationship with some of the primary consequences of the program; including increased self-esteem, job security, and financial security. However, this settling down may have an unexpected secondary consequence in the inconsistent pattern of condom use displayed by participants, discussed earlier.

Previous research (e.g. Schuster, 2006) has discovered that Cambodian relationships based on love and/or trust have the lowest rates of condom use. The increased number of married participants who were trying to become pregnant, not using condoms, and trusting that their husbands were monogamous and not spreading HIV/AIDS and sexually-transmitted infections, may partially account for the inconsistent use of condoms late in the program.

This may be problematic, because, as Schuster (2006) notes, many Cambodian men have extramarital sexual encounters. Approximately 20-25% of local men reported having paid sex during the preceding year (often without condoms). This has created a 'bridging pattern' of infection, from sex workers, to married men, through to their wives and future children (Schuster, 2006). This bridging pattern and the importance of condom use even during marital sex was mentioned in SiRCHESE health lectures in the early weeks of the program, but further emphasis on this point would be desirable – especially as the program continues and more participants enter serious relationships and plan families.

Some additional insight into the condom question was provided by another question on interviews, asking "If you were asked to teach a beer girl about health issues in her job and in her life, do you think you could do it? What would you tell them?" All participants said they would be able to talk to beer sellers. Several participants said they would simply tell the sellers to quit and find a better job - that it is impossible to be a healthy beer seller. Others said they would tell the beer sellers about the dangers of excessive alcohol consumption. Intriguingly, although general health promotion and HIV prevention were also mentioned quite frequently, only two participants (of nine) specifically mentioned condom use as an important area of education.

The interviews also provide a unique perspective on the relative importance of the hotel at which participants were placed. Though no significant differences were found in quantitative analysis between the hotels in job performance, job attitude, job satisfaction, or job-related self-esteem; other

indicators do suggest differences between the hotels. First, it cannot be ignored that all participants except one employed at Angkor Howard Hotel have dropped out of the HAP, compared to zero participants employed at Sokha Hotel, and three out of five participants employed at Lin Ratanak Hotel. SiRCHESEI members who had contact with hotel personnel described management at Angkor Howard as constantly under revision and at times dysfunctional. In addition, Angkor Howard had the lowest rate of trainee feedback through completion of Hotel Performance Appraisals – part of the contractual agreement between SiRCHESEI and the hotels.

The differences between the hotels were also clearly expressed in interviews with participants. Notably, participants at Sokha Hotel were the most enthusiastic about their hotel, despite the hotel's unwillingness to move employees between departments. Two participants mentioned the hotel's five-star status, suggesting it improved the work environment and the class of customer who came to the hotel. In contrast, the sole participant to indicate that they did not like the hotel where they worked was one of the two participants interviewed who worked at Angkor Howard. She mentioned the difficulty getting promoted, and also contract violations, such as the hotel not always providing the meal they were supposed to. This was also the sole participant who indicated that she wanted to change hotels at the end of the program. Notably, shortly after her interview, this participant too dropped out of the HAP.

Another source of qualitative data – in the form of comments included in the School and Hotel Performance Appraisals – may also provide insight into the ability of the quantitative indicators to assess performance. For School Performance Appraisals, it seems there is a relatively direct relationship between in-class achievement as measured quantitatively by the English Proficiency Learning scale and qualitatively by the English teacher's comments. Figure 16 below displays the English Proficiency Learning scores of three participants; one described by the English teacher as a

“top student,” one described as “slow to learn,” and one described as having “outstanding progress and development.” Quantitative and qualitative assessments strongly agree.

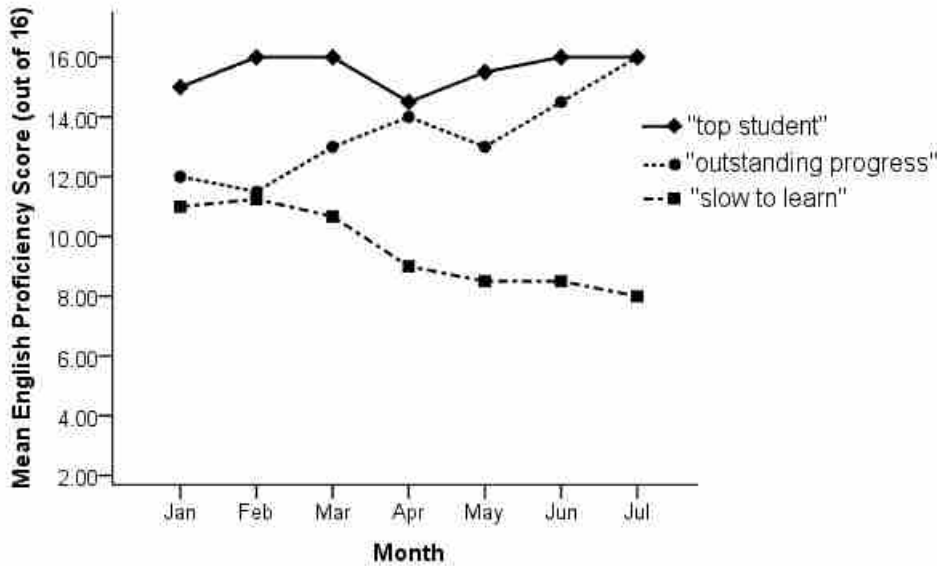


Figure 16. English Proficiency Learning scores of three participants, identified by their description by the English teacher in their School Performance Appraisals; demonstrating convergence of quantitative and qualitative data.

In addition, for both participants who left the HAP during the eight-month apprenticeship phase (when school evaluations were conducted on a regular basis), General Classroom Performance indicators do display a pattern considerably different from the class mean (see Figure 17, below). While both dropouts do not display identical patterns, it is notable that they display a pattern of results inconsistent month-to-month, and inconsistent when compared with the class mean. This is supplemented by comments by SiRCHESEI staff placed on the School Performance Appraisals, such as “Needs to catch up and study at home” and “Lets her conversation fall behind.” For future iterations of the HAP, close monitoring of the quantitative and qualitative assessments made on the School Performance Appraisals during the course of the program, can help uncover students who are at risk of dropping out. During the program, SiRCHESEI teachers, counselors and staff often worked with students and their families when faced by personal, health or work problems.

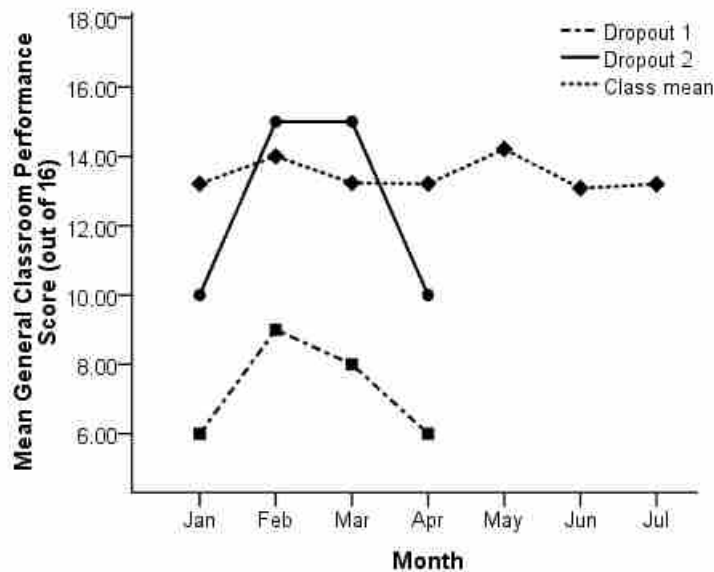


Figure 17. General Classroom Performance scores for the two participants who dropped out of the program during the eight-month apprenticeship phase of the HAP, compared against mean scores of all participants; demonstrating the erratic scores predicting future drop-out.

Unfortunately, the same cannot be said of the Hotel Performance Appraisals. The primary difficulty encountered with the Hotel Performance Appraisals was the lack of consistent data due to hotel managers and department heads not completing the questionnaires in a regular manner. During the eight months of the apprenticeship phase of the HAP, only 101 Hotel Performance Appraisals were filled out, out of an expected 200. In order to achieve usable data on this measure, performance data had to be compressed into four-month intervals; for future iterations of the HAP, consistent and prompt feedback is needed to pinpoint participants who might be in danger of leaving the program.

Indeed, it is unclear if the appraisals provide any clear description of the performance of employees. Examining comments included with the appraisals, there is remarkable neutrality in comments. Participants received similar comments from appraisal to appraisal, generally without

high praises or severe reprimands. No employee was singled out in any evaluation as particularly outstanding, or particularly poor. This is reflected quantitatively. Few participants received any scores of 1 ('Fair/Below Standard') or 4 ('Outstanding/Excellent'). On the Job Performance Scale, the mean score was 16.53 out of 24 ($SD = 1.36$), indicating an average score per question of 2.76 out of 4. On the Job Attitude Scale, the mean score was 10.82 out of 20, indicating an average score per question of 2.16 out of 4. It is possible that this reflects a problem with the Job Performance Appraisals. However, the mediocre assessments are consistent with participants' own assessments; they often discussed the difficulty of standing out to their supervisors as exceptionally proficient at their job. This factor may itself have perpetuated 'average' job performance. It is also possible that the design of the HAP produces non-exceptional, single-skill employees, as the participants, during the crucial job training period, must divide their time between job training and SiRCHESEI classes.

This 'average performance effect' suggests that the Hotel Performance Appraisals – though they are the primary form of assessment for the final sixteen months of the program – are not useful tools for uncovering employees who may be struggling, or may be in danger of dropping out of the program. This is reflected in the data, where participants who dropped out of the program showed no consistent patterns in the Job Performance or Job Attitude Scales that might indicate a problem (see Figure 18 below for example using five dropouts and the Job Performance Scale).

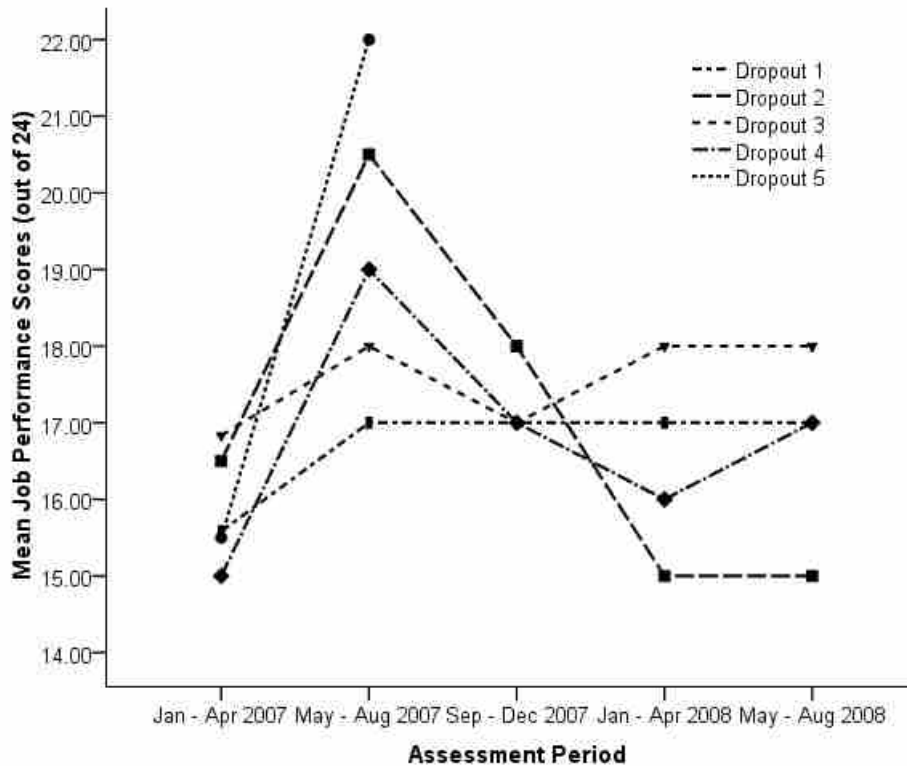


Figure 18. Job Performance scores of five participants who left the program, demonstrating the lack of pattern from Job Performance Appraisals that could predict future drop-out.

Additional difficulties with the hotel industry emerged as the program continued, especially related to salary. A preliminary assessment at the beginning of the program determined that, with normal pay increases, employees of three-, four-, and five-star hotels would all be making at least \$110 per month (previously determined to be a Cambodian living wage) by the end of two years employment. It was thus the understanding that, while SiRCHESE would initially subsidize HAP participants' salaries to \$110; by the end of the program, the hotels would be paying the entire salary, and perhaps more. However, this did not happen. Many participants were kept at trainee salary throughout the eight-month apprenticeship stage of the program, and given few salary increases following that. At the 21-month assessment, mean monthly salary for participants was \$56.67 ($SD = 3.19$), with a range of \$40 to \$65. By the end of the program, no participant was making more than \$70 per month - only \$11.70 more per month than the beer-selling mean. With SiRCHESE Fellowship

assistance ending in November 2008, salaries would thus drop severely from the living wage encountered for the past 2 years. To aid in the transition, SiRCHESEI has agreed to provide a transitional 'consulting fee' of \$25 monthly, for 5 months, paid to Cohort 1 for completing additional monthly evaluations, attending focus groups, etc.

In discussing NGO-corporate partnerships, Berger, Cunningham, and Drumwright (2004) emphasized the importance of finding the right 'fit' between NGO and corporation; and the HAP highlighted some of the incompatibilities between SiRCHESEI and the hotel industry. Three of the different types of 'fit' among those emphasized by Berger, Cunningham, and Drumwright (2004) are structural fit, evaluation fit, and mission fit. Structural fit, referring to the hierarchy of command within the organization, was violated, as instability within hotel industry management often led to confusion of who SiRCHESEI should communicate with, and whether new members of hotel management were even aware of the HAP participants they employed. Evaluation fit, referring to criteria considered important for program evaluation, was also different between the hotels and SiRCHESEI. SiRCHESEI, a research-based NGO, was clearly more interested in the empirical evaluation of the program on a week-by-week basis than would be required, or considered efficient, within a hotel. Most hotels already evaluated their staff every two months; but considered the rigor of SiRCHESEI's two-week evaluations excessive.

However, it was perhaps in mission fit where the widest gap was apparent. This was evident in the reluctance of the hotels to move HAP participants between departments; a move that would make the participants happier, and provide increased skill-sets, but would also temporarily reduce employee productivity. In addition, the lack of promotions or salary increases for HAP participants suggests that, in part, the program may have been seen by hotel owners, not just as an opportunity to help women in need (as SiRCHESEI saw it); but as a way to economize on salary budgets. Because of these common lacks of 'fit', Berger, Cunningham, and Drumwright (2004) suggest that efficient,

consistent communication between NGO and corporate partners is essential to ensuring a successful program in which both parties understand each other's structure, goals, and method.

Indeed, many of the difficulties described above speak to the need for a responsive, efficiently-communicating network - including SiRCHESEI staff, program counselors, hotel contacts, and the trainees themselves. If it is discovered participants are getting married, condom education should be altered to reflect the risks even during marital sex, as well as family planning strategies during the two years of the program. Whenever one of the teachers becomes aware of a student who is lagging behind and may soon drop out of the program, this needs to be communicated to all program staff and addressed immediately. Similarly, as the data does seem to have some predictive power in terms of program success, data collection and analysis needs to be completed consistently throughout the program, to discover and address difficulties early. Lewin (1946) and Chataway (1997) emphasize the importance of a 'feedback loop' that assesses and addresses problem areas of an intervention following every iteration of the program (a loop in which this thesis certainly plays a part). However, with a program lasting two years, with a considerable budget, and with profound effects on the lives of its participants, a quicker within-program feedback loop is clearly necessitated.

Ultimately, some issues which drove participants away from the program are beyond the control of SiRCHESEI and reflect wider structural issues. Some of these issues – such as problems at a hotel level – may be solved with increased communication and partnership with the hotels, but other issues lie at a deeper level. One participant, a high achiever in school and at work, left the program because her partner thought it inappropriate that she be working such long hours. Another participant had become increasingly stressed out during the program due to a land claim dispute (relatively common in Cambodia following the dissolution of private property rights during the reign of the Khmer Rouge); and finally had to leave the program to return home to help her family deal with the

ensuing legal battle. Though this participant remained positive about the HAP, even as she had to leave it, factors entirely out of the control of anyone associated with the program intervened.

However, despite such structural problems that intervene, certain problems inherent to the hotel industry, and organizational issues within the HAP, there is clear evidence of the program's effectiveness. Apart from condom use, other health-related knowledge and behaviour showed dramatic increases, as did self-esteem and job satisfaction measures. Furthermore, speaking with the participants in the program revealed their love for their work and for the program, their belief in the skills they had learned through the program, their enjoyment of the hotel industry, and their hope for the future. Participatory Action Research-based intervention programs always require alteration as the programs continue; but initial findings suggest that the essential model of the Hotel Apprenticeship Program is sound.

Areas for Future Investigation

This study has provided an initial framework on which future iterations of the Hotel Apprenticeship Program, or programs like it, can be assessed. While this study has examined Cohort 1 of SiRCHESE's program, its investigation ends roughly at the 21-month mark of the project, three months prior to completion. In addition, six of the seven participants who are completing the program have elected to remain in contact with SiRCHESE for five months of continued consulting and evaluating. This additional evaluation of their continued participation will provide insight into how the program actually affected their lives in the long term, and their expertise about the program will provide ideas for later assessments of, and improvements to, the program.

Furthermore, Cohort 2 is in the sixteenth month of the HAP, as of December 2008. Throughout the program, similar evaluations have been filled out by them and about them; and so an evaluation of that program, following the framework laid out in this study, is possible, and may refine (or contradict) the findings of this report. One Cohort 1 participant, in the course of her interview,

indicated she thought the program was more difficult for Cohort 1 students, because the program was refined and altered for Cohort 2, to fix the difficulties of Cohort 1. A comparison of the two cohorts of participants, along the dimensions listed above and perhaps along other dimensions, could provide evidence of the changing nature of the program.

In addition, it is believed a deeper analysis of the structure of the program is required, to determine if there are barriers to effective communication between the partners of the program. Several of the problems that arose during the program (e.g. hotels not completing evaluations on a regular basis), require consistent, effective communication and clear chains of command within the program, with additional compensation for hotel management shifts. Such an analysis need not be limited to the HAP, but be extended to encompass additional challenges and potential solutions concerning the functioning of the SiRCHESEI NGO, NGO structures in general, and Participatory Action Research used in international health research and interventions.

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