

Critical Issues

Sexual and Reproductive Health

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Sexual and Reproductive Health



Introduction

Facilitators who have not recently trained or worked in the area covered by this Resource Pack, should read carefully through the various Topics, Overheads, Exercises, Handouts and Readings before starting to plan their training activity. Please note when using these materials, that they are to be used in conjunction with stated policy (they do not replace it) and aim to stimulate learning and discussion.

KEY CONCEPTS

1. Sexual and reproductive health is an issue that concerns everyone.
2. The time when these issues start to affect young lives is at adolescence when young people are beginning to learn about their own sexuality and are having to make decisions about their sexual behaviour which may have life-long implications. Effective support and intervention before and during this period of their lives can have important and long lasting benefits.
3. Due to the unstable nature of their situation, refugee and displaced young people are more at risk of sexual and reproductive ill-health than settled young people. Programmes to address their needs should be a priority.
4. Sexual health problems for young people arise when they do not have control over their own sexual lives; when they are either ill-informed or ill-equipped to deal with the consequences of their sexual activities.
5. Working effectively with sexual and reproductive health issues involves working with young people and their communities to develop programmes which are culturally appropriate and address relevant gender issues and truly “speak” to the local communities.
6. Working with young people to address issues of their sexuality and reproductive health demands special skills, including the ability to centrally involve the young people themselves in the process of developing effective self-help strategies.
7. Understanding and applying key legal standards which relate directly to sexual and reproductive health rights of young people serve to support advocacy in this field, and can helpfully inform policy making and programme planning.
8. Effective sexual and reproductive health programmes require a multi-sectoral approach and strong co-ordination between and within agencies. Information, Education and Communication (IEC) programmes support this work and are

complementary in terms of the messages that they give and the action that they promote.

9. Successful IEC programmes share many of the same features: they include strong community participation, youth led activities, strategies to assist youth in learning to manage themselves and their behaviour with confidence, and the provision of a number of key life skills.
10. There are specific health and prevention messages that relate to individual key issues: Sexually Transmitted Infections (STIs) including HIV/AIDS, early or unplanned pregnancies, female genital mutilation (FGM), substance abuse, and nutrition. Sexual and gender-based violence (SGBV) is covered in the ARC resource pack on **Exploitation and Abuse**.

These Key Concepts appear in **Overhead 1.0**.

OVERVIEW AND DEFINITIONS

Concern with healthy and responsible sexuality has in the past decade grown in family planning programmes, as well as in other health and social activities, primarily for two reasons: the increase of adolescent sexuality, pregnancy and abortion, and the wide-spread growth in sexually transmitted infections, including the Human Immunodeficiency Virus (HIV) causing AIDS.

Annually, more than 333 million new cases of STIs are estimated to occur, making them one of the most common infectious diseases around the world, particularly in the 15-49 age group. Estimates suggest that more than half of the people living with HIV/AIDS were infected before they were 25 years of age.

Premarital sexual experience is becoming more common among young people in developing countries. As countries have become more urban and economically developed, the age at marriage has risen, and young people's sexual attitude and behaviour before marriage have been changing. For refugee or displaced young people, these issues are likely to affect them even more acutely than when they are living in settled situations.

Because adolescents typically begin sexual relations without contemplating the consequences and without accurate information and protection, many face serious and even dangerous consequences, including unwanted pregnancies, abortions, Sexually Transmitted Infections (STIs) and HIV/AIDS.

The economic and social consequences of adolescent sexuality can be enormous. Young, unmarried women who become pregnant are less likely to finish their education, face greater marital instability, and have fewer assets and lower incomes later in life than other women. Yet, often government policies or unnecessary barriers keep family planning and reproductive health services from adolescents. Meeting the reproductive health needs of young people requires not only providing services and education but also changing attitudes, overcoming opposition, building understanding, and educating adults about the problems facing young people.

In this resource pack, the term "young person" refers broadly to anyone within the 10-24 age range. Definitions of what a society considers a child, an adolescent or a young adult vary from culture to culture. Yet the need for reproductive health services begins at a young age. The term "adolescent girl" is used when

describing or comparing her situation with that of an older woman, as neither “young girl” or “young woman” effectively describe the age range in question.

The term “sexual and reproductive health” has been used in preference to simply “reproductive health” or “adolescent reproductive health” in recognition of the fact that young people’s reproductive health is determined by their sexual health and their sexual activities; and that issues of sexual behaviour and sexuality are central to the question of their reproductive health. Also refer to the **ARC Resource Pack on Child and Adolescent Development Topic 1**.

THE IMPORTANCE OF THE CONVENTION ON THE RIGHTS OF THE CHILD

The human rights of children are fully articulated in one treaty: the United Nations Convention on the Rights of the Child (CRC,1989), offering the highest standard of protection and assistance for children under any international instrument. The approach of the Convention is holistic, which means that the rights are indivisible and interrelated, and that all articles are equally important. The CRC is the most universally accepted human rights instrument - it has been ratified by every country in the world except two (the United States and Somalia). It provides the most comprehensive framework for the responsibilities of States Parties to all children within their borders: by ratifying the Convention, national governments have committed themselves to protecting and ensuring the rights of all children without discrimination, including the rights of refugee and displaced children and adolescents. The CRC defines a “child” as everyone under 18 years of age “unless under the law applicable to the child, majority is attained earlier”. The scheme of the CRC suggests that this exception should be interpreted as an empowering one, in other words that under 18 years can claim the benefits of adulthood if granted by national law while still able to claim the protection of the CRC.

Article 24 of the CRC on the right to health builds on and develops the right to life and to survival and development addressed in article 6 of the CRC. The principle of non-discrimination requires States Parties to recognise the right of all children to the “highest attainable standard of health “ as well as to “facilities for the treatment of illness and rehabilitation of health”. In addition, article 24, paragraph 2 provides a list of appropriate measures that States Parties must take in order to pursue full implementation of this right. The holistic nature of the Convention stresses the importance of the relation between the right to health, to an adequate standard of living (article 27) and the right to education (article 28). The need for full consideration of adolescents’ health issues is underlined in article 5 with respect to the child’s evolving capacities.

The CRC was the first international human rights treaty to explicitly recognise sexual violence and abuse, a major factor related to young person’s sexual and reproductive health.

STRUCTURE OF THIS RESOURCE PACK

Topic 1: Sexual Health and Young People. This topic defines what is meant by sexual and reproductive health, and investigates how sexual health problems might arise for young people. It looks at the issue of greater risks to the sexual and reproductive health of refugee and displaced young people.

Topic 2: Working with Young People: the Challenges and the Strengths. This topic looks specifically at the issues around working with young people in this context. It examines the challenges and cultural and gender issues that have to be addressed and it looks at the particular strengths that young people can bring to working with these issues.

Topic 3: Relevant Legal Standards and Programme Planning. This topic offers an overview of some of the more important legal instruments that might be used for advocacy at all levels and to inform programme planning. It also offers some suggestions for developing a broader focus to programming in order to address some of the sexual and reproductive needs and rights of young people.

Topic 4: Effective Sexual and Reproductive Health Promotion and Prevention. This topic looks at the importance of a multi-sectoral approach and of good co-ordination between and within agencies in developing and implementing programmes which address the sexual and reproductive health needs and rights of young people, and it discusses how effective Information, Education and Communication activities (IEC) can support these programmes.

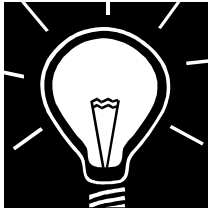
Topic 5: Specific Sexual and Reproductive Health Issues and Key Messages for Young People. In this topic, brief descriptions of the following issues are provided along with key preventive and protection messages for young people: STIs including HIV/AIDS, early or unplanned pregnancies, female genital mutilation, substance abuse, and nutrition.

Participatory exercises, case studies, overheads and handouts are provided. Facilitators are strongly recommended to develop regionally or country-specific materials such as case studies in order to make the training more relevant.

OTHER RESOURCE PACKS IN THIS SERIES

Facilitators are encouraged to look at this Resource Pack in the light of other ARC materials, in particular the **ARC Resource Pack on Child and Adolescent Development, Working with Children and Situation Analysis**. A serious issue impacting on the sexual and reproductive health of children and adolescents is sexual exploitation and abuse, and it is therefore recommended that the **ARC Resource Pack on Exploitation and Abuse** be referred to directly when working with this Resource Pack.

Sexual and Reproductive Health



Topic 1:

Sexual Health and Young People

KEY LEARNING POINTS

- ***Sexual and reproductive health concerns everyone.***
- ***Effective support and intervention for young people who are about to begin their sexual lives can have lasting and beneficial effects on many aspects of their lives.***
- ***Adolescence marks the beginning of a young person's journey into sexual development and sexuality. It can be an exciting, worrying and/or difficult time.***
- ***Good sexual health involves feeling good in relation to one's sexual behaviour in body, mind and spirit, as well as in the context of the social environment in which one lives.***
- ***Sexual health problems arise when young people do not have control over their sexual lives: they are either ill-informed or ill-equipped to deal with the consequences of sexual activity.***
- ***Due to the unstable nature of their situation, refugee and displaced young people are at increased risk of damaging their sexual and reproductive health than settled young people.***

SEXUAL AND REPRODUCTIVE HEALTH CONCERNS EVERYONE

Sexual Health

"...is the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love."

Reproductive Health

"...is a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

Cairo Programme of Action of the United Nations International Conference on Population and Development (ICPD), 1994, paragraph 7.2.

This definition is also presented in **Overhead 1.2.**

Sexual and reproductive health is a very personal issue and concerns everyone, young or old, male or female for a large part of their lives. This issue begins to affect people's lives at adolescence when they are aware that they are starting to change from being children and are growing towards adulthood. Because this is such a major life change, this growing awareness of sexuality can have an acute affect on the way that young people conduct themselves and their lives. It can be an exciting, stressful, frightening or difficult time.

It is increasingly recognised that support and intervention to ensure good sexual and reproductive health for young people can have a life-long beneficial effect: decisions or events relating to sexual behaviour and activity that occur between the ages of 10–24 can be a major factor in the direction that a young person's life will take. A sexually active 13-year-old girl, for example, regardless of whether her sexual activity is from an early marriage, child prostitution or curiosity, will probably never complete her education. She will be more at risk from other reproductive health problems and, following from that, she will be more likely to experience social and psychological problems.

Despite the economic, social, medical and educational advances of this century, today's young people are more at risk in terms of reproductive health than some of their predecessors. Increasing urbanisation, the breakdown of traditional social and economic structures, and the increased mobility of the world's population, means that young people are exposed to dangers to their health, mental health and reproductive health that did not exist in previous generations, or were limited to relatively few young people. The commercial sex industry can now operate on the Internet. Illicit and potentially harmful drugs are now manufactured almost world-wide. Violence in the form of urban street violence or in the form of conflict or war is a danger to many young people.

Dept of Child and Adolescent Health Development (2000), "Meeting an Urgent and Unmet Need: Making Reproductive Health Services Available and Accessible to Forcibly Displaced Young People." Geneva, World Health Organisation.

SEXUAL FEELINGS AND SEXUALITY

As a boy or a girl reaches puberty his/her body starts to change from being the body of a child to the body of an adult. Chemical changes in the body are also taking place. This is a period of growth and change through which it is not always easy to navigate a safe passage. At this time too, young people often begin to experience sexual feelings. They may feel tingling or warm feelings when they think about or touch another person. These feelings can run round their body like an electric current causing arousal and excitement. They may be able to think of nothing else. These feelings are a natural part of growing up. But, what young people do with these feelings is important. Although they may be sexually active, they are often ill-equipped and/or powerless to deal with the consequences of sex. Without access to information, contraception and equal rights, they are at high risk of contracting sexually transmitted infections (STIs), having unwanted pregnancies, spoiling whatever educational opportunities that they have, being

shunned, cast out of their families and a host of other consequences which will negatively affect their futures:

“I was not told anything about sex when I was growing up – my parents just said that I should not play with boys after I started my periods. When I fell in love, I just did what came naturally. I had no idea that I could get pregnant the first time or that he would walk out on me”.

Overhead 1.4 provides a list of characteristics of young people which may influence the ways in which they behave.

The provision of appropriate and effective support, information and guidance when young people are making personal choices can make a lasting and positive difference to their lives.

SEXUAL HEALTH

A young person enjoys sexual health when s/he feels good in relation to the area of her/his life to do with sex. S/he feels good in body, mind, and spirit, and s/he feels comfortable within her/his society about the way s/he is conducting this part of her/his life.

What does good sexual health mean? It should include being confident and able to:

- make decisions about their own bodies and how they will express their sexuality without anyone forcing or pressurising them;
- say “no” to sex until they are in a loving relationship and are happy to say “yes”;
- if they do have sex, protect themselves from unwanted pregnancy and diseases that are passed during sexual intercourse;
- enjoy pleasure from sex without harming others;
- enjoy their sexuality free from shame, guilt and fear;
- visit the health centre if they have a problem.

HOW DO SEXUAL HEALTH PROBLEMS ARISE?

Many sexual health problems arise because young people - both girls and boys - do not have control over their sexual lives. They are either ill-informed or ill-equipped to deal with the consequences of sexual activity that they have entered into voluntarily, or they have been forced or coerced into sexual activity by one or more people who are more powerful than they are.

A serious consequence of the above can be early marriage and childbearing. Women aged 15-19 have up to three times the maternal death rate as those aged 20-24. Postponing first births until the mother is at least 18 years of age is also an important factor in reducing child deaths.

A related issue may be consanguineous marriage - marriage where the husband and wife are related to each other at the level of second cousin or closer (often the result of cultural, social, religious and educational factors). The most common type is the cousin marriage. Women in consanguineous unions generally marry earlier

and are less likely to use modern contraceptive methods. Consanguinity is also a major factor for unsafe motherhood and childhood (complicated pregnancies, stillbirths, child and infant mortality, major risks of birth defects, malformation, etc.).

Sexual and gender-based violence poses a huge threat to young people particularly girls both in settled situations and in times of insecurity: rape is most commonly referred to in this category, but also included are sexual threats, exploitation, humiliation, assaults, incest, domestic violence, and involuntary prostitution. The Swedish Association for Sex Education reports that 2 million young girls are introduced into the sex market in Africa each year. Female genital mutilation (FGM) is another related issue. It is reported that in Africa up to 2 million girls, aged between 7 and 12, are genitally mutilated each year (Source: *Swedish Association for Sex Education 1997*). These issues, and suggestions for working with them, are dealt with in greater detail in **Topic 5**.

SEXUAL AND REPRODUCTIVE HEALTH FOR YOUNG PEOPLE AFFECTED BY ARMED CONFLICT

Young people affected by armed conflict, whether they are refugees or IDPs living in rural or urban settings, are likely to be more at risk of developing sexual or reproductive health problems than young people who have not been displaced: they may have, in addition, the burden of the trauma of exile and the uncertainties inherent to their future. They may have experienced or witnessed rape, torture or killings and may have lost their “role models” from their families and the community. They may also find themselves living in a new society where social norms are very different from those that they grew up with and with which they were beginning to come to terms. The separation from one’s homeland, one’s elders and one’s traditional culture may create a situation in which risky behaviour is less condemned, thus increasing the risk of unplanned or unwanted pregnancy, STIs, drug abuse, violence, etc. In terms of resettlement or repatriation, they might find themselves in another cultural or social situation which contradicts the norms that they have become used to. Guatemalan refugees returning from Mexico, for example, moved from a more progressive urban situation to a very traditional rural setting, formally their home. The young people who had picked up their social and sexual education in a city context found this move very hard.

Some or all of the following considerations may also affect young people’s situations:

- the disruption of educational systems which constitutes the loss of another source of information, protection and assistance;
- loss of income sources which reduces the ability to make free choices;
- women, and even children themselves, may be the sole carers for the total welfare of their families. Fulfilling this role often represents a great emotional and physical burden that is not compensated for by appropriate service provision. Young people in these family settings who, in some senses, appear to be capable of looking after themselves, are often left to their own devices;
- in refugee and displaced situations attention is often given to immediate life-saving measures and insufficient priority is given to reproductive health care.

(The information above is also presented as **Overhead 1.3**).

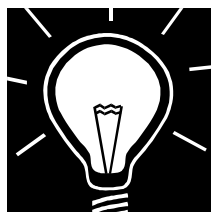
TRAINING MATERIALS FOR TOPIC 1

Overhead 1.1: Key Learning Points for Topic 1	Key Learning Points for Topic 1
Overhead 1.2: Definition of Reproductive Health	Definition
Overhead 1.3: Difficulties Faced by Refugee and Displaced Young People	Specific problems facing refugees and others that are likely to have an effect on their sexual and reproductive health
Overhead 1.4: Characteristics of Young People	Particular characteristics of young people that are likely to have an effect on their sexual and reproductive health
Exercise 1.1: What Did You Do When You Were an Adolescent?	A short exercise where participants reflect on their own adolescence
Exercise 1.2: What's Difficult about Being an Adolescent?	Discussion exercise which draws on participants' own experiences
Exercise 1.3: Refugee and Displaced Young People: The Risks	Exercise which develops understanding about the increased risks that refugee and displaced young people face

FURTHER SUGGESTIONS FOR TRAINING

Ask participants in groups to come up with a definition of what “sexual health” means for a young person. Ask them to share their definitions and, as a result, develop a definition that the whole group agrees with. Compare the group definition with the one in these Briefing Notes.

Sexual and Reproductive Health



Topic 2:

Working with Young People - The Challenges and Strengths

KEY LEARNING POINTS

- *There are important challenges associated with the development of effective sexual and reproductive health programmes for young people.*
- *Young people have particular strengths that can contribute significantly to the success of such programmes.*
- *A clear understanding and analysis of prevalent cultural and gender issues should inform any programme planning in this field.*
- *Young people should be involved in all stages of programme planning, implementation and evaluation.*
- *Parents, teachers, community and religious leaders should be consulted and briefed on the importance of sexual and reproductive health programmes for young people.*

THE CHALLENGES IN PRODUCING EFFECTIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE

Providing young people with effective sexual health education and reproductive health care opportunities will contribute significantly to their safety, to their general health, to their education, and to the development of their self-confidence and their self-esteem. (**Topic 4** deals in more detail with the development of such programmes).

However there are challenges to be met and addressed. Working with young people involves understanding their vulnerabilities and constraints as well as their strengths. For example:

- young people may live in cultures which discourage or prohibit them from discussing reproductive health issues or sexual practices, or from making decisions about their own sexual activities or reproductive health;
- they may be hesitant to talk about sex or reproductive health issues with older people, if they talk about them at all;
- those young people who have already established an “alternative” urban life style, such as commercial sex or drug use, may have difficulty in communicating with anyone except their peers.

Factors which present challenges to the provision of reproductive health services, particularly with respect to young people, were highlighted in the Beijing Conference, 1995:

- *inadequate levels of knowledge about human sexuality;*
- *inappropriate or poor-quality reproductive health information and services;*
- *the prevalence of high-risk sexual behaviour;*
- *discriminatory social practices;*
- *negative attitudes towards women and girls;*
- *the limited power many women and girls have over their sexual and reproductive lives.*

This list is also presented as **Overhead 2.2**.

But the special strengths that young people can bring to a situation can contribute significantly to countering all these challenges. Consider the following strengths.

- Young people are more flexible and often have an easier time adapting to a new situation than their parents.
- They may also learn more quickly how to “work” within new structures.
- They tend to be more open to new ideas than their older counterparts.
- When motivated, they have huge sources of energy and enthusiasm.
- They can be far better communicators with their peer groups than many adults, especially those who are perceived to be in authority.

This list is also presented as **Overhead 2.3**.

CULTURAL CONSIDERATIONS

In this area of work, perhaps more than many others, cultural considerations and sensitivities are critically important.

Practices that are condoned and encouraged in one culture are banned or punishable in another. Culture reflects the history and the tradition of the society in which a person lives. It describes what s/he thinks, learns and does as an individual, and what her/his society considers to be important, in terms of both religious and social values. Cultural practices may have good or bad effects on different people in the community.

Girls are often influenced by their society to believe that their bodies are shameful, that nice girls do not know about, talk about, or enjoy sex.

Boys too are influenced by prevalent thinking and attitudes in their society:

“We boys learned about sex from each other. We thought that we should start having sex early otherwise our organs would shrivel and our future wives would laugh at us. I did not want a girlfriend and I was worried about diseases, but I got drunk and tried to catch one”.

In terms of sexual and reproductive health issues, cultural considerations may manifest themselves in different ways:

- young people may have cultural differences from their parents and grandparents;
- refugee or displaced young people may additionally be moving into a culture where religious and social values and cultural practices differ from those that they were brought up with;
- those people who are charged with the responsibility of providing advice and support about reproductive and sexual health to young people may hold different cultural values to those young people.

A positive approach to working with cultural issues in this context was offered by Felix Houphouët-Boigny, former President of Côte d'Ivoire:

“We should see culture as a river leading us forward, not a stagnant pool where we stay in one place. Culture is a guide that enables us to progress, not a heavy weight that holds us back”.

GENDER CONSIDERATIONS

In many cultures, women are the property of fathers, brothers, husbands or the extended family. Fathers can exchange their young daughters with older husbands or traders, for cows or money. Husbands are entitled to have sex with their wives whenever they feel like it, regardless of the wife's feelings or health. Women or girls may be given nicknames for refusing sex. In the world of paid work, women are often forced to have sex in order to get or keep a job.

In situations where girls are more powerless than boys (through poverty, class, caste or lack of education), they are inevitably more likely to be the victims of sexual harassment or abuse. In situations where they are taught to be subservient and expected to behave passively, it becomes a much greater challenge for them to be able to say “no”, or to make the decisions that they want to about their bodies.

For refugee or displaced young people, these issues are likely to affect them even more acutely than when they are living in settled situations.

Effective and sustainable sexual and reproductive health programming must not only address the particular needs and interests of women and girls, but also those of men and boys. A gender sensitive approach, therefore, must ensure the equitable participation of women and girls, men and boys in such a way that all are able to contribute to, and benefit from, improved sexual and reproductive health.

HOW TO WORK EFFECTIVELY WITH ISSUES OF SEXUAL AND REPRODUCTIVE HEALTH

A clear understanding of the cultural values and complexities of a new working situation and analysis of the sexual and reproductive health issues that are pertinent to young people will form the foundation of any effective work in this field. The importance of involving the community leaders, family and young people themselves in this process as well as planning and implementation of sexual and

reproductive health programmes should not be under-estimated. An active effort to ensure that girls, women and mothers are represented in this process must be made.

It is also worth bearing the following points in mind. According to global surveys, young people everywhere feel that they are ruled by adults who tell them how to behave but then refuse to give them control over their own bodies and their own sexuality. Nor do they protect them from exploitation. While the religious leaders, the media and governments decry the fact the kids are having sex and “family values” are breaking down, they fail to protect these “kids” from the dangers of unwanted and unsafe sex. Adult attitudes to young people’s sexuality can be both condescending and contradictory:

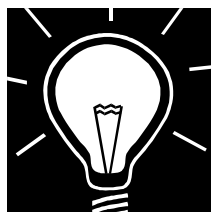
“You can’t feel me up when I am ten and then come back when I am nineteen and tell me not to have sex with my boyfriend”.

The aim of this Resource Pack is to encourage those working in the sensitive field of reproductive health to acknowledge both the importance and the challenges involved in providing effective programmes for young people which will ensure their sexual and reproductive health; to harness the special strengths and creativity of these young people; and to involve them at all stages of programme development.

TRAINING MATERIALS FOR TOPIC 2

Overhead 2.1: Key Learning Points for Topic 2	Key Learning Points for Topic 2
Overhead 2.2: Challenges in the Provision of Reproductive Health Services	Factors which present challenges to the provision of reproductive health services, particularly with respect to young people, highlighted in the Beijing Conference, 1995
Overhead 2.3: Potential Strengths in Young People	Positive strengths of young people
Exercise 2.1: Assessing the Strengths and Challenges when Working with Young People	A SWOC analysis exercise

Sexual and Reproductive Health



Topic 3:

Relevant Legal Standards and Programme Planning

KEY LEARNING POINTS

- *There are a number of legal instruments which relate to sexual and reproductive health issues. These can be used effectively for advocacy and promotion of the reproductive, and sexual, rights of young people.*
- *An understanding of sexual and reproductive rights issues as they relate to young people can serve to influence policy makers and programme planners to develop programmes which better address young people's needs.*

Working to improve the sexual and reproductive health and well-being of children and young people has to be tackled at all levels, from advocacy and influence with international bodies, to working to counsel individuals who are immediately vulnerable. As with all issues of this sensitive nature, working on only one level may result in minor changes and improvements, but without a clear understanding of the whole spectrum of the issues, these changes are not likely to be effective in the long term. In refugee situations, a lack of awareness in protecting and promoting sexual and reproductive health by service providers as well as the local community may result in a large increase in risky sexual activity and reproductive ill-health.

This topic is devoted to giving an overview of legal standards that could be used in promotion or advocacy for reproductive (and sexual) rights for young people, and providing pointers to ways in which policies and programmes might better serve the sexual and reproductive health needs and rights of young people.

ADVANCING REPRODUCTIVE HEALTH RIGHTS THROUGH LEGAL STANDARDS

There are a number of instruments that establish not only the right to health but also relate directly to reproductive health issues. These can be used effectively for advocacy and promotion of the reproductive, and sexual, rights of young people. In addition, staff working in a region should always be aware of the regional instruments and their provisions, such as the African Charter on Human and Peoples' Rights, the African Charter on the Rights and Welfare of the Child, the European Convention on Human Rights and the American Convention on Human Rights.

Reproductive health rights embrace certain human rights as recognised in various instruments and documents reflecting international consensus. It is important to recall that reproductive health rights may also be ensured by national laws.

The instruments presented in this topic differ in their nature and importance. Treaties, also called conventions or covenants, are formal legal texts to which States become parties. They are considered as “hard law”, because they create legal binding obligations. Other instruments, such as declarations, principles or rules, are non-binding on States, and are often referred to as “soft law”. The provisions they set out are often more detailed than those found in treaties, and can therefore complement hard law. These instruments are authoritative standards because States participated in their elaboration and they reflect international consensus, i.e. States did not object to the provisions they contain. An example of soft law is the Beijing Declaration and Platform of Action of the Fourth World Conference on Women of 1995. This topic also refers to a number of UNHCR guidelines which provide practical operational guidance to staff and are not legally binding.

The Right to Health

The right to health is directly linked to the inherent right to life of the child (CRC, article 6). The right to health is recognised by article 24 of the CRC for all children without any discrimination. Under Article 24.1, “State Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...”. Similarly, **the International Covenant on Economic, Social and Cultural Rights (ICESCR)** recognised the right of everyone to the enjoyment of the highest attainable standards of physical and mental health (article 12).

The CRC article 24.2 develops further the texts of the International Bill of Human Rights (UDHR, ICESCR and ICCPR) in establishing a right of access to health care services: “States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”. The article details a list of measures that States Parties must take to fully implement the right to health: this list is non-exclusive, i.e. other measures may be required to implement this right.

The UNHCR Refugee Children Guidelines on Protection and Care (page 62) state that refugee children should have access to the national health services of the host country. Appropriate health care must be available to all refugee children. **The UNHCR Guidelines on the Protection of the Refugee Women** state that access to health care services is important both for the woman’s own health and the health of the family. The guidelines note that access to health services also serve an important protection function.

Sexual and Reproductive Health Rights

Sexual and reproductive health are essential elements of the right to health. According to the Programme of Action of the Cairo International Conference on Population and Development (ICPD) Programme of Action of 1994 (paragraph 7.2) and the Beijing Fourth World Conference on Women of 1995, *reproductive health* is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive

system. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. *Sexual health* is the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love, and thus the notion of sexual health implies a positive approach to human sexuality.

The right to sexual and reproductive health includes various elements:

- **Reproductive choice:** all couples and individuals have the basic right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the respect for security of the person and physical integrity of the human body, and the right of couples and individuals to make decisions concerning reproduction free of discrimination, coercion and violence (Cairo ICPD, Programme of Action, paragraph. 7.2). Under article 34 of the CRC, States Parties undertake to protect the child from all forms of sexual exploitation and abuse, notably to prevent the inducement and coercion of a child to engage in any unlawful sexual activity.
- **Family planning:** measures must be taken in order to develop family planning education and services (CRC article 24.2(f), and Convention on the Elimination of All Forms of Discrimination Against Women of 1979 (CEDAW article 12.1).
- **Marriage:** men and women have the equal right to marry, with a free and full consent and to found a family according to the Universal Declaration on Human Rights (UDHR article 16.1), CEDAW article 16.1, and the Convention on Consent to Marriage, Minimum Age and Registration of Marriages (article 1.1). Marriage under the minimum age is specifically prohibited (article 2 of the Convention on Consent to Marriage, Minimum Age and Registration of Marriages). This right also includes special protection of the family as a fundamental unit of society (ICCPR, article 23.1).
- **Safe motherhood:** appropriate pre-natal and post-natal health care for mothers must be ensured by the States Parties (article 24.2(d) of the CRC). Health care for mothers is also emphasised in other human rights instruments, notably in the CEDAW under article 12.2 and in the ICESCR, article 25.2.
- **Reduction of infant and child mortality:** appropriate measures to reduce infant and child mortality must be taken (article 24.2(a) of the CRC and ICESCR article 12.2(a)). States Parties shall also place a special emphasis on the provision of primary and preventive health care i.e. among others, infections and STIs (CRC article 24.2(b) and (f))
- **Protection from HIV/AIDS:** the International Guidelines on HIV/AIDS and Human Rights adopted in collaboration of UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) in 1996 declare that States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups (Guideline No.8). The Guidelines also declare that States should enact legislation to provide for the regulation of HIV-related information so as to

ensure wide-spread availability of qualitative preventive measures and services and adequate HIV prevention and care information (guideline No. 6). UNHCR has set its own Policy and Guidelines regarding Refugee Protection and Assistance and AIDS, through IOM/FOM/21/20 of 1988, and an up-date issued through a policy statement made in 1998 (IOM/FOM/78/84).

- **Nutrition:** Special attention should be given to child nutrition (article 24.2(c) of the CRC), to women during pregnancy and lactation (CEDAW article 12.2), and to the girl child because of existing discrimination in her access to nutrition (Platform of Action of the Fourth World Conference on Women, Beijing, 1995, paragraph 93).
- **Education:** Access to education under article 24 of the CRC requires States Parties to develop preventive health care, guidance for parents and family planning education. Inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information can lead to early pregnancies, unsafe abortions, unhealthy sexual relations, and STIs, notably HIV/AIDS. Health education is also highlighted for safe motherhood and childhood (article 24.2(e) of the CRC): “States parties shall ensure that parents and children are informed and have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast feeding, and hygiene...”
- **Protection from Harmful Traditional Practices:** all effective and appropriate measures with the view to abolishing traditional practices prejudicial to the health of children should be taken by the States Parties (article 24.3 of the CRC). Practices which should be reviewed under the light of the Convention include: all forms of genital mutilations and circumcision; scarring, burning, branding, tattooing and piercing; harmful initiation ceremonies; deliberate discriminatory treatment of children involving violence and/or prejudicial to health, like preferential feeding and/or care of male children, or lack of care of disabled children; traditional harmful beliefs; and early marriages and dowries.

Other international instruments such as article 5 of CEDAW, the **Vienna Declaration** adopted in 1993 by the World Conference on Human Rights, the **Cairo ICPD Programme of Action** of 1994, the **Beijing Declaration and Platform of Action** of 1995 and **UNHCR Policy on Traditional Harmful Practices** detailed in IOM/FOM 83/97 call for the suppression of harmful traditional practices prejudicial to the health of the child.

- **Abortion:** international human rights do not explicitly address the right to have an abortion. The right to health, however, includes the right to treatment of complications resulting from unsafe abortion. Whether a refugee woman may undergo a legal abortion will depend on the national laws of the host country. Abortion of a pregnancy that results from rape is legal in some countries where abortion of any other pregnancy is not.

(The above legal instruments on sexual and reproductive health are presented in **Handout 3.1**)

The **Reproductive Health in Refugee Situations Inter-agency Field Manual** takes as a principle that “reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees,

particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees, while also conforming with universally recognised international human rights”.

The Importance of Recent International Conferences for Reproductive Health Rights of Young People

The reproductive rights of young people remains a controversial subject. For many societies, adolescents’ sexuality is a sensitive, if not controversial, issue. Nevertheless, recent international conferences brought increased attention to the subject of sexual and reproductive health needs and concerns of young people.

The main objective of the Cairo ICPD of 1994 was to emphasise the direct links between reproductive health and human rights, while placing the concerns of women and the girl child at the centre of the Conference theme. The following year, the Beijing Fourth World Conference on Women called for the evaluation of policies and programmes from a gender perspective and highlighted the special needs of adolescent girls to access health and nutrition services.

The consensus documents agreed at the ICPD and at the Beijing Conference explicitly recognise that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health which includes the right to reproductive health.

Both Conferences stressed the importance of men’s shared responsibilities and active involvement in sexual and reproductive health, including in family planning, motherhood, child health, prevention of STIs including HIV and prevention of unwanted/high risk pregnancies (Beijing Platform of Action, paragraph 93, ICPD paragraph 4.26 and 4.27).

Moreover, the Report of the ICPD (A/CONF.171/13/Add.1) stated that youth should be actively involved in planning, implementation and evaluation of programmes. This is especially relevant with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other STIs. Access to, as well as confidentiality and privacy of, these services must be ensured with the support and guidance of parents and in line with the CRC. In addition, there is need for educational programmes in favour of life planning skills, healthy lifestyles and the active discouragement of substance abuse.

The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community-supported policies and programmes in the area of sexual and reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

HOW POLICIES AND PROGRAMMES CAN BEST RESPOND TO THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE IN REFUGEE AND DISPLACED SITUATIONS

Policies and programmes that aim to reduce levels of adolescents' marriage and childbearing need to address the underlying social, cultural and economic factors that contribute to these patterns. While the principal focus should remain on addressing the health consequences of adolescents' sexuality and reproduction and target problems such as lack of knowledge about reproduction and contraception and access to services, programmes should extend their focus to address longer term variables including:

- physical autonomy;
- schooling;
- skill-building opportunities;
- the development of self-esteem;
- access to income and other resources;
- social status of girls in comparison to male peers.

It is only through expanded opportunities and the development of social and marketable skills that young women will be able to make full use of their potential in a variety of roles. The following pointers and suggestions for action can be considered in terms of advocacy and programme development.

Encourage family and community support for delayed marriage and childbearing.

- Mass media campaigns and other efforts that address the importance of investing in girls' education and health must be strengthened. These efforts need to target issues such as early marriage and childbearing, as well as heavy domestic responsibilities, which limit opportunities for young girls.
- Government may wish to consider providing support and/or incentives to families and communities in making progress toward these goals.

Expand girls' access to higher quality education and training

- Educational and training opportunities should be expanded for young women and adapted to reflect their physical and social needs. Initiatives need to be tailored to the communities they intend to serve, and may involve separate (but equal) classes for boys and girls, creating educational alternatives for pregnant girls and adolescent mothers, and developing gender-sensitive curricula.

Expand income-generating opportunities for adolescent girls and women

- Expanding income-generating opportunities for adolescent girls and women will improve their ability to provide for their own needs as well as that of their families, and will empower them to contribute more equally in household, community, and possibly national level decision making.

A study of the garment manufacturing industry in Bangladesh suggests that providing opportunities for young women to work for income outside of the

home can lead to significant social change. In 1996, almost one million women worked in Bangladesh's garment sector; 70% of these women were between 15 and 19 years of age. Study results show that garment workers marry later than women of similar social class who do not work and that many workers are able to save a substantial amount of money by the time they do marry.

Enable adolescent girls and boys to take responsibility for and protect their sexual and reproductive health

Legal, regulatory, cultural and social-economic barriers to sexual and reproductive health information and services for young people must be removed. Sex education, or family life education, has been shown to result in higher levels of abstinence, later initiation of sexual activity, greater use of contraception and fewer sexual partners. Governments should adopt national strategies to ensure that all young people are accurately informed about sexuality and reproductive health.

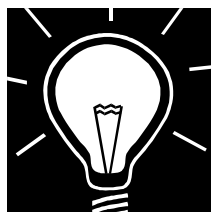
- All young people - married and unmarried - should have access to sensitive, respectful and confidential reproductive health counselling and services. These services should emphasise the prevention of unwanted pregnancy, unsafe abortion and STIs. Programmes also need to help equip young people with life skills that enable them to make informed decisions about sexuality and to negotiate abstinence or safe sex. Research and programme planning should focus on the roles and responsibilities of men in the prevention of early and unwanted pregnancy.
- Services should be designed specifically to meet the needs of young people, which may vary according to age, sex, marital status, level of sexual activity, religion, ethnicity, culture, school status, geographic location, socio-economic status, and vulnerability to sexual coercion or abuse.
- To identify and address obstacles to young people' use of services and appropriate steps for making services more "youth-friendly", young people should be involved in the planning, implementation and evaluation of health programmes.

TRAINING MATERIALS FOR TOPIC 3

Overhead 3.1: Key Learning Points for Topic 3	Key Learning Points for Topic 3
Overhead 3.2: Critical Actions to Improve Reproductive Health Rights	Three key strategies for improving reproductive health rights.
Exercise 3.1: Related Reproductive Health Rights and Their Effectiveness	Exercise offers an opportunity to gain a better understanding of relevant legal instruments
Exercise 3.2: Developing Policies and Programmes which will Contribute to Reducing Levels of Adolescents' Child-Bearing and Marriage	Exercise provides a forum for thinking about improvements to policies and programmes
Handout 3.1: A Summary of Reproductive Health Rights	A summary of the main legal instruments that make reference to reproductive health.

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Sexual and Reproductive Health



Topic 4:

Effective Sexual and Reproductive Health Promotion & Prevention

KEY LEARNING POINTS

- *Sexual and reproductive health programmes require a multi-sectoral approach in order to be effective.*
- *Co-ordination, both between and within implementing agencies, with respect to this work is essential.*
- *Information, Education and Communication (IEC programmes) can provide useful and appropriate information, counselling and advocacy as well as developing community participation and individual commitment to change.*
- *Successful IEC programmes often share similar features (see below).*
- *There are a number of important principles to adhere to when working with young people.*

A MULTI-SECTORAL APPROACH

There are a number of key issues to consider when setting up or improving sexual and reproductive health programmes for young people. Firstly, issues around this subject cross many sectors. The sexual and reproductive health of young people will influence how they access the services and opportunities that might be available to them and, vice versa, their access to educational opportunities, health and nutrition services, opportunities to earn a living, social and cultural opportunities, and protection services will have a bearing on their sexual and reproductive health. A young female refugee who is continually being forced to have sex with an older member of the family, for example, will probably not be in a position to access any of these services. Similarly, all sectors working in a given area, should contain within their programmes strategies for targeting and including young people who are likely to be at risk.

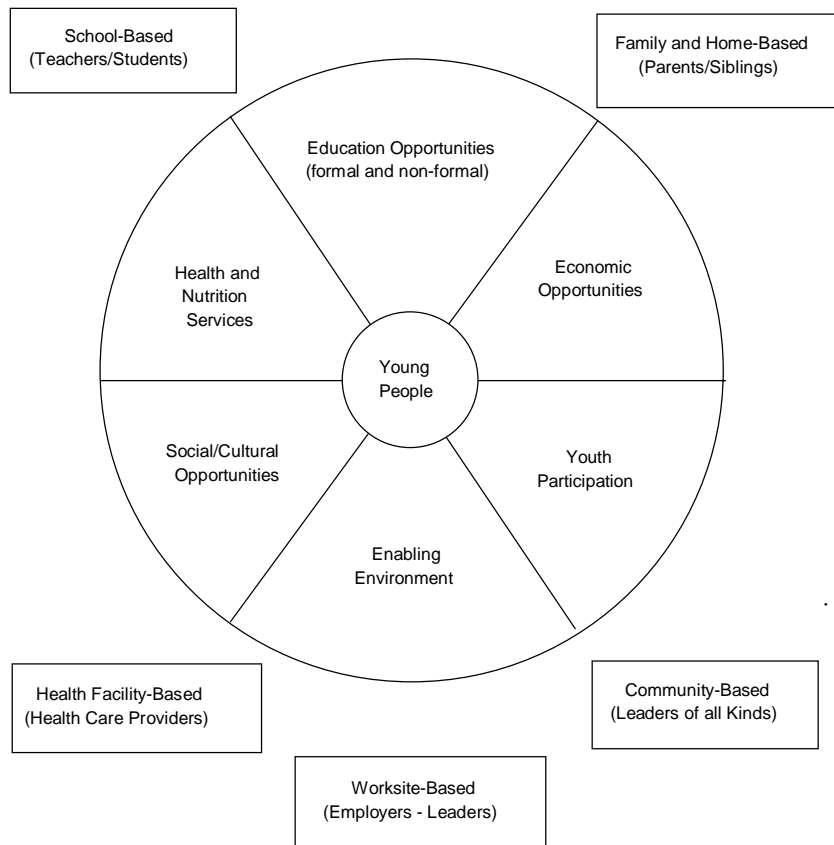
Co-ordination of various types is needed: between sectors (health, community services, protection), between implementing agencies (government, NGOs, UN agencies) and between levels of service provision (doctor, midwife, TBA (traditional birth attendant), health assistant). In a refugee context, it is recommended that **a single individual is identified** to assume the overall organisation and supervision of sexual and reproductive health activities.

Co-ordination between implementing agencies requires that, although each agency has its own expertise and range of qualified staff, there should be a

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standardisation of approach across all agencies involved. Even while each one may not provide a full range of services, co-ordination between them should ensure that the final service provision is complementary and comprehensive in nature.

The following diagram has been prepared by UNHCR, and suggests a strategic framework across sectors for working with young people to lead productive and safe sexual and reproductive lives.



Strategic Framework for Enabling Refugee Young People to Lead Productive and Safe Sexual and Reproductive Lives:
The What and the Where/Who

This diagram is also presented as **Overhead 4.2**.

Participants on ARC training courses on this topic, could be encouraged to consider how, within their own sector, they might be able to improve services to meet the needs of young people more effectively.

INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Lack of knowledge and understanding about human sexuality and inappropriate, inadequate or inaccessible information are factors which contribute to young people being more likely to damage their health and chances in life as a result of engaging in risky sexual behaviour.

Young people, as well as more mature women and men, should understand how their bodies work and how they can maintain good reproductive health. Scientifically validated knowledge, which is clear and presented in an appropriate way, should be shared in order to promote access to free and informed choice and counter the side-effects of harmful practices.

“Problems we identified together included an over-emphasis on the bio-medical aspects of the (HIV/AIDS) epidemic, which left many young people thinking of HIV/AIDS as a battle between white blood cells and a spiky invader instead of something of relevance to their own everyday lives”. (Winskell Kate, (1999), Scenarios from the Sahel Replication Guide. New York, UNDP).

IEC activities are an essential means of sharing this knowledge. Such activities range from “one-to-one” conversations between service providers and refugees, to highly developed formal campaigns.

There are also effective IEC strategies for promoting community participation and individual commitment to making changes in environments where young people have been forcibly displaced which, in turn, can also feed into the development and change of the services which are being provided.

FEATURES OF A SUCCESSFUL IEC PROGRAMME

A recent UNAIDS review found that effective HIV/AIDS prevention programmes for young people share certain features:

- they have as specific aims, both delayed first intercourse, and protected intercourse;
- they encourage the learning of life skills (and the same skills that also build self-confidence and avoid unwanted pregnancy, sexual abuse and substance abuse);
- they discuss clearly the results of unprotected sex and the way to avoid it; they help young people “personalise” the risk through role playing;
- they reinforce group values against unsafe behaviour both at school and in the community.

These features are obviously relevant to all areas of sexual and reproductive health.

UNAIDS also lists the following important life skills for young people in relation to HIV/AIDS (most of which are relevant to all areas of sexual and reproductive health):

- how to make sound decisions about relationships and sexual intercourse, and stand up for those decisions;
- how to deal with the pressures of unwanted sex or drugs;
- how to recognise a situation which might be risky or dangerous;
- how and where to ask for help or support;
- when ready to have sexual relationships, how to negotiate protected sex or other forms of safer sex;

- how to show compassion or solidarity towards people with HIV/AIDS;
- how to care for people with AIDS in the family or the community.

More detailed information about setting up IEC programmes are presented as **Handout 4.1** and details about specific messages to address different sexual and reproductive health issues appear in **Topic 5**.

PRINCIPLES FOR WORKING WITH YOUNG PEOPLE

In working with young people in any capacity, certain principles should be adhered to. In the context of setting up sexual and reproductive health programmes, they are particularly pertinent.

- Community participation at all stages is essential to ensure the acceptability, appropriateness and sustainability of sexual and reproductive health projects, and is a concrete strategy for empowering refugee and displaced young people to have a greater degree of control over their own lives and the services which are provided to them. This means the active participation and support from parents, teachers, religious and community leaders, health care providers, as well as young people themselves.

Handout 4.4 provides more information on the importance of community participation.

- Additionally, young people must be involved in the actual design, implementation and evaluation of sexual and reproductive health programmes. They are the ones who understand the problems and fears that they and their peers are facing, and they are better equipped to identify successful strategies for addressing these issues.
- Programmes should also identify and encourage peer leadership and communication. Peers are usually perceived as the more trustworthy sources of information than adults: from a young person's point of view, "heavy-handedness, brainwashing and moralising" will not stop the young from engaging in sexual activity.

Exercise 4.3 provides more information and a chart that indicates ways in which peers can work as educators.

- Linkages between health, protection and community services are necessary, not only for prevention of problems (see above) but also to ensure that young people get the appropriate treatment for problems which might surface through one service but require additional assistance from another (e.g. sexual violence, unsafe abortion etc.).
- Young people have a strong need for privacy. It is usually problems that bring them to a service provider and these are often problems that may cause them to feel ashamed, embarrassed or confused. Though space may be at a premium in a camp setting, it is important for providers to try to create the most private space possible in which to talk to young people.
- Service providers need to maintain confidentiality in their dealings with young people and to be honest and open with them when there may be a need to break this confidentiality.

- In many cultures, the sex of the service provider is important and preference should be given to a provider of the same sex.

LINKS TO SERVICE PROVISION AND FOLLOW UP

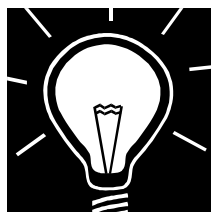
For IEC of any kind to be effective, there must be a clear and coherent link to the services provided. Young people must be able to act on the advice that is contained with the IEC messages and materials. It would be pointless, for example, for all young people to be encouraged to use condoms and then for them to find that other service providers do not condone the provision of condoms to young girls under the age of fifteen, or that there is a shortage in the supply of condoms.

“Reproductive Health in Refugee Situations: An Inter-Agency Field Manual” (1999. Geneva, UNHCR) is a recommended reading in any work connected with these issues. In particular, Chapter 2 “Minimum Initial Service Package” describes a set of activities which should be implemented in a co-ordinated manner during the early phase of a refugee situation (which may or may not be an emergency). This chapter is included at the end of this Resource Pack as **Reading 4.1**.

TRAINING MATERIALS FOR TOPIC 4

Overhead 4.1 Key Learning Points for Topic 4	Key Learning Points for Topic 4
Overhead 4.2: Strategic Framework for Enabling Young People to Lead Productive and Safe Sexual and Reproductive Lives	Strategic Framework for Enabling Young People to Lead Productive and Safe Sexual and Reproductive Lives.
Exercise 4.1: Promoting Reproductive Health Rights for Refugee and Displaced Young People	Exercise designed to further thinking about the development of relevant programmes.
Exercise 4.2: The Importance of Community Participation	Exercise which underlines the importance of community participation and provides an opportunity to consider who to involve.
Exercise 4.3: Working with Peer Groups	Exercise develops understanding of the different ways in which participants might work with peer groups.
Exercise 4.4: Let's get Creative!	An opportunity to develop key messages in a culturally sensitive way.
Handout 4.1: Setting up Information and Communication Programmes	Guidelines for setting up information and communication programmes.
Handout 4.2: The Importance of Community Participation	Guidance on positively harnessing the participation of opinion leaders.
Reading 4.1: Minimum Initial Service Package	Reproductive Health in Refugee Situations: An Inter-Agency Field Manual
Reading 4.2: The International Rescue Committee's Reproductive Health Programme	Extract taken from: How To Guide: Reproductive Health in Refugee Situations, IRC N'zerekore, Guinea, February 1998

Sexual and Reproductive Health



Topic 5: Specific Issues and Key Messages for Young People

KEY LEARNING POINTS for this Topic are covered under each sub-section.

In addition to general messages that relate to the promotion of good sexual and reproductive health, there are specific and important health messages that relate to particular sexual health issues that should be communicated to young people.

This topic provides information and suggested messages for young people about some of the key sexual and reproductive health issues that they are likely to have to deal with. They are covered under the following sub-sections. Key learning points for each are also found under these sub-sections:

- 5.1: Sexually Transmitted Infections, including HIV/AIDS
- 5.2: Early/Unplanned Pregnancies
- 5.3: Unsafe Abortions
- 5.4: Female Genital Mutilations (FGM)
- 5.5: Substance Abuse
- 5.6: Nutrition

Although sexual and gender-based violence is not referred to in this Topic it constitutes one of the major reproductive health issues for young people. It is covered comprehensively in the ARC Resource Pack on **Exploitation and Abuse**.

5.1 SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS

Key Learning Points

- ***Young people in general lack knowledge about sexuality and some of the negative consequences of sexual intercourse.***
- ***Adolescent girls are more susceptible to STIs, including HIV, than older women.***

Sexually transmitted infections (STIs) are diseases that can be transmitted from one person to another by sexual contact. STIs can cause pain, and some cause infertility and death if not treated. Some common curable STIs are gonorrhoea, trichomoniasis, chlamydia infection, and syphilis.

AIDS refers to Acquired Immune Deficiency Syndrome. AIDS is caused by the Human Immunodeficiency Virus (HIV). HIV can be transmitted by sexual contact, by blood (through unsafe practices such as unclean syringes, the giving of

untested blood in transfusions etc.) and from a pregnant woman to her child during pregnancy, childbirth, or, occasionally, by breastfeeding. As of 2000, AIDS has no definite cure. However, treatments have improved the quality and length of life for people with HIV/AIDS, and there is a vast amount of research going into the development of new treatments including anti-retroviral drugs.

UNHCR has set its own Policy and Guidelines regarding Refugee Protection and Assistance and AIDS, through IOM/FOM/21/20 of 1988, and an up-date issued through a policy statement made in 1998 (IOM/FOM/78/84). Also IOM/FOM/47/48 of 1999 provides information on Post Exposure Preventive (PEP) Treatment Starter Kits.

Each year there are more than 333 million new cases of curable STIs. STIs are more common than malaria in many parts of the world. Daily, more than 8,500 children become infected with HIV. During 1998 alone, more than 3 million children and young people became infected (Source: HIV Development Programme, UNDP).

Young people in general lack knowledge about STIs and their prevention. They face substantial barriers to sexual and reproductive health services that may not be open or known to them. This includes the provision - or lack of it - of contraception and advice on contraception that could help them reduce their exposure to STIs and unplanned pregnancy. There may also be a lack of skilled health care providers who understand the issues that relate particularly to young people.

Young people may also lack skills to negotiate no sex or safe sex. When an adolescent girl's sexual partner is older, which is often the case, there may be an even greater imbalance of power in the relationship that further reduces her ability to negotiate safe sexual activity.

Adolescent girls are physiologically more susceptible to STIs than older women. The cervix and vagina of an adolescent is different from that of an older woman and makes her more vulnerable to contracting STIs when exposed. Increased likelihood of tearing the vagina during sex further augments this risk. Many adolescent girls do not recognise the symptoms of an STI or do not know where to seek treatment. Additionally, many STIs in women are asymptomatic, making it difficult for them to know when they may have an STI.

If left untreated, STIs can lead to pelvic inflammatory disease, ectopic pregnancy (abnormal or misplaced pregnancy) and infertility, and if present during pregnancy, can lead to health problems for both the child and the mother.

More information about HIV/AIDS is presented in **Handout 5.1**.

Key Messages for Young People on Sexually Transmitted Infections

- Sexual behaviour is a personal issue, it may be difficult to convince persons at risk to come forward.
- STI prevention interventions should be sustainable in order to achieve positive results.
- Talking about sex can be uncomfortable and may be taboo in many societies. It is important to understand cultural interpretations and to work with

community leaders, family and young people to develop appropriate approaches.

- Advice on control and prevention of STIs in young people must include referral for treatment.
- Education on the prevention of STIs and HIV/AIDS must include dangers of high risk behaviour and raise awareness of low risk behaviour (non-penetrative sex, use of condoms, avoidance of drug abuse).
- If one has an STI, both partners to seek treatment and complete the course of treatment.
- Messages on the prevention of STIs should take into consideration that young people may be questioning themselves and their sexual orientation, and this should be dealt with in a friendly way without creating a sense of guilt.

Reading 5.1 provides an extract taken from a UNAIDS document entitled Learning and Teaching about AIDS in School, October 1997.

5.2 EARLY OR UNPLANNED PREGNANCIES

Key Learning Points

- ***Education levels strongly influence adolescent child-bearing.***
- ***There are significant health risks attached to early pregnancies.***
- ***There are significant social and economic risks attached to early child-bearing.***

Adolescent girls in traditional societies are often bound by cultural norms that equate marriage and motherhood with female status and worth. Even the youngest brides and grooms often face enormous pressure to prove their fertility soon after marriage through the birth of a child. In other cases, cultural traditions encourage young women to prove their fertility before marriage.

In some refugee and returnee situations, land/living space is allocated on the basis of numbers of families. This situation can result in adolescent girls being pushed into early child-bearing and/or marriage in order to secure more living space, or to replace the losses that the family has experienced due to conflict or war.

Health Risks of Adolescents' Sexual Activity and Childbearing

Although adolescent girls are mature enough to have sexual intercourse, their young bodies are not necessarily sufficiently developed to be able to carry a pregnancy safely through nine months to the birth of the child. Both the mother and the child are more at risk than they would be if pregnancy was delayed for some years.

Children born to adolescent mothers often experience higher risks of death during the first five years of life.

Social and Economic Risks of Early Childbearing

While the health consequences of adolescent childbearing in developing countries are relatively well known, there is much less information on the economic and

social consequences. Despite the lack of data, the following premises are generally accepted:

- **Early/unplanned pregnancy and childbearing limit educational opportunity and achievement.**
Adolescent girls are often expelled from school if they become pregnant, and few ever return. A national study in Botswana showed that one in seven girls who dropped out of school did so because of pregnancy and only one in five pregnant dropouts returned to school. In Kenya, 10,000 girls leave school each year due to pregnancy.
- **Early pregnancy compromises a woman's ability to support herself and her children financially.**
The responsibility of caring for a young child, as well as lack of education, can limit a woman's access to income-generating opportunities.
- **A young woman's opportunities are severely constrained when she becomes a mother and as such her quality of life can be threatened.**
Limited access to education and income-generating opportunities, in conjunction with traditional societal norms, serve to perpetuate the devaluation of girls and women. A young woman's ability to negotiate and safeguard her own needs and those of her children, both within a relationship and within society at large may be jeopardised.
- **In some situations the stigma of being an unmarried parent can result in rejection by the family and/or the community.**

(This information is also presented as **Overhead 5.2**).

Key information and skills for young people about early/unplanned pregnancies include:

- an understanding of the consequences of early and unplanned pregnancy;
- decision making, communication, negotiating skills required to resist pressure to have sex;
- information on how to access STI/HIV prevention;
- information on available health and social services;
- the importance of seeking pre-natal services when pregnant.

5.3 UNSAFE ABORTIONS

Key Learning Point

- ***There are many reasons why adolescent girls may resort to abortion.***

An unsafe abortion is an abortion that has not been carried out in a safe environment by a health professional. Unsafe abortions include taking of poisons or other potentially harmful substances; or inserting twigs or sharp objects into the womb. Deaths from complications resulting from unsafe abortion account for a significant percentage of all maternal deaths, although accurate data are difficult to obtain.

Adolescent girls are often the victims of rape, one of the serious consequences of which is unwanted pregnancy. As many women and girls find little support and limited options in dealing with this problem, many resort to unsafe abortions. As mentioned at the beginning of this topic, sexual and gender-based violence, including rape, is one of the major sexual and reproductive health issues for young people and is covered in-depth in the **ARC Resource Pack on Exploitation and Abuse**.

Young people often state the following reasons for resorting to abortion:

- the girl is determined not to bring shame on her family. In many communities pregnancy before marriage is greeted with disdain and as evidence of poor parenting, a judgement with which many mothers and fathers cannot live;
- the girl may be a victim of rape or incest and does not want to prolong her agony by carrying the pregnancy to term;
- the girl has been let down by her boyfriend who had previously promised marriage upon demonstration of fertility;
- if in school, the girl wants to continue with her education and resorts to abortion for fear of getting expelled from school if discovered.

Key preventive information

- Provide a safe and supportive environment.
- Advise to seek help from a health facility.
- Discourage substance abuse (e.g. drugs, alcohol) as these often lead to risk taking behaviour.
- Provide appropriate sexual and reproductive health messages to young people.
- Involve the communities (young people included) in discussions of the issues related to unwanted pregnancy, abortion and its consequences.
- Involve the community in the prevention of unwanted pregnancy and abortion and in helping young people to cope with these situations when they arise.

5.4 FEMALE GENITAL MUTILATION

Key Learning Points

- ***Refugees for whom female genital mutilation was a custom in the country of origin tend to continue the practice when in exile.***
- ***Extreme risks accompany the practice of female genital mutilation; repercussions are likely to continue throughout a woman's entire life.***
- ***It is vital to understand reasons for the practice of female genital mutilation before embarking on information campaigns.***

Sexual and reproductive health programmes should encompass strategies to discourage female genital mutilation, emphasising the link between the practice and poor reproductive and sexual health and general health in women and girls. It is vital to understand the reasons for the practice before embarking on information

campaigns. Efforts by health workers for the elimination of female genital mutilation can be greatly enhanced by enlisting the support of responsible community members for its elimination.

Elaborate guidance on Harmful Traditional Practices is contained in the UNHCR IOM/FOM 83/97 entitled "UNHCR Policy on Harmful Traditional Practices". It not only sets out UNHCR's policy on HTPs, but also provides suggestions for their eradication. It should be read in conjunction with UNHCR's existing policies and guidelines in respect to refugee children and refugee women.

Definitions and Classification of Female Genital Mutilation **Handout 5.2** provides definition, classification and description of FGM from the WHO: "Female Genital Mutilation", Information Kit, 1994. **Overhead 5.3** summarises the definitions and classifications.

Prevention and Response in Refugee Settings

Elements of a WHO-recommended strategy include:

- establishing contact with government representatives, professionals and NGOs in the host country who are concerned with discouraging female genital mutilation;
- including information and education on the harmful effects of female genital mutilation, particularly in programmes for women and children, such as family planning, immunisation and the control of diarrhoeal diseases;
- enlisting the participation of men, so that as women's attitudes begin to change they find support among brothers, fathers, friends and partners;
- targeting young people who are often in the vanguard of creating new social norms;
- identifying alternative income sources for practitioners of female genital mutilation for whom it provides a livelihood, including promotion of alternative puberty rites (e.g. giving of gifts) which promote traditional values.

5.5 SUBSTANCE ABUSE

Key Learning Point

- ***When people misuse substances like alcohol and drugs, they lose control over the way they behave. They don't make sensible and informed decisions.***

The issue of substance abuse should be covered in programmes which focus on sexual, and reproductive health, as it obviously relates to a young person's ability to make informed decisions about their behaviour. Substance abuse is a major factor often linked to unwanted/unplanned pregnancies and associate consequences. The issue of substance abuse is covered briefly in the **ARC Resource Pack on Education Topic 6**. Further readings are suggested at the end of this Resource Pack.

5.6 NUTRITION

Key Learning Point

- ***It is especially important that adolescent girls are sufficiently well nourished.***

All young people benefit from good nutrition. For young people, when they are changing and growing at a very fast rate, good nutrition is especially important. Additionally, for adolescent girls, it is during this period that their bones are growing and forming. Under-nourished girls may develop very narrow pelvises so that child-bearing will become difficult or dangerous for themselves or for their children.

Adolescent girls who are either pregnant or breast-feeding need to eat well.

Appropriate information about nutrition, exercise and rest should be included in a sexual and reproductive health programme.

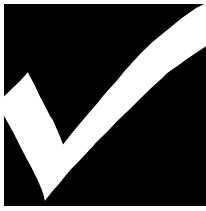
TRAINING MATERIALS FOR TOPIC 5

Overhead 5.1: Key Learning Points for Topic 5	Key Learning Points for Topic 5
Overhead 5.2: Social and Economic Risks of Early Child-Bearing.	Four main risks associated with early child-bearing.
Overhead 5.3: Definitions and Classification of Female Genital Mutilation	WHO classification of the main types of FGM.
Exercise 5.1: Case Study – Unsafe Abortions	Exercise facilitating discussion of issues around unsafe abortions
Exercise 5.2: STIs/HIV/AIDS: Features of a Successful Education Programme	Exercise provides key information and provokes discussion about education issues
Exercise 5.3: Early/unplanned Pregnancies; Group work	Develops understanding of dangers of early pregnancies and considers key preventive information
Handout 5.1: What are HIV and AIDS?	Provides some basic information on HIV and AIDS
Handout 5.2: What is Female Genital Mutilation?	Extract from WHO Information kit on FGM, 1994.
Reading 5.1: Learning and Teaching about AIDS at School	Extract from UNAIDS Technical Update, October 1997

FURTHER SUGGESTIONS FOR TRAINING

Facilitators may like to use video materials as a stimulus for some of the more sensitive topics. There is a list of videos in the section on **Further Readings, Videos and Websites.**

Sexual and Reproductive Health



Sample Programmes

Different participants are likely to have different learning needs and priorities. We have divided participants into three broad groups: senior managers, sector co-ordinators and field staff.

Senior managers are those people who have key responsibility for an NGO's operations in a country or region or a UNHCR Section. They will have overall responsibility for strategy and resource allocation within the organisation's policy framework. Senior managers' needs are likely to be best served through briefings.

Sector co-ordinators comprise those people who have responsibility for a particular aspect of their agency's work in a country or region or who have a responsibility for a particular function within an operation, such as for example UNHCR programme, protection or community services officers. Sector co-ordinators are those responsible for translating policy into practice and ensuring that programme budgets reflect the necessary resources to support good practice.

Field staff are those people working in the field who are responsible for implementing the programme activities. They often have considerable front-line experience. Field staff may value the opportunity to develop and practise new skills as well as develop their knowledge and understanding.

Training programmes should be designed with the responsibilities and learning needs of these different groups in mind. If possible, participants from different groups should be trained separately but if this is not possible exercises and input should be selected which will meet the needs of all groups. It may be possible to use different small group exercises to address the needs of each type of participant in a mixed group workshop.

Two types of programme are included in this Resource Pack. The first describes a half day awareness-raising workshop. The programme makes detailed reference to materials from the Resource Pack and describes how a facilitator might use these materials to conduct a session lasting three hours.

The second example is for a full day workshop. It is written in the form of a Session Plan that covers:

- the overall aim of the training session;
- specific learning objectives;
- a description of what will be covered and the sequence to be followed;
- the timing for each part of the session;
- who will take responsibility for the different parts of the programme;

- what inputs and exercises will be used;
- what materials (e.g. handouts, overheads, briefing papers, index cards) will be required;
- what equipment (e.g. flipchart, overhead projector, blackboard, video) is needed.

The purpose and development of session plans are described in detail in the **ARC Facilitator's Toolkit**.

Both programmes are intended as guidance examples only. It is very important that the facilitator should think carefully about the group of participants with whom he or she will be working and devise a programme that takes into account:

- the role and responsibilities of the participants;
- the learning needs of the participants;
- their existing level of knowledge;
- their interest in the subject;
- their willingness to share experience and admit to gaps in their knowledge / skills;
- current / local issues and priorities for the participants;
- the amount of time they have available;
- their position in their organisation.

Any training programme should be devised, if possible, in consultation with the intended participants. If it is not possible to consult with all participants (for example, by sending out an application form including questions about their expectations for the training), the facilitator should try to speak to a sample of participants before making final decisions about the programme.

The facilitator should also consider:

- the range of Topics to be covered;
- the order in which Topics should be addressed;
- how to encourage the sharing of experience and information between participants;
- who will carry out the training;
- what methods will be most appropriate for the participants.

More detail on the process of training can be found in the **ARC Facilitator's Toolkit**.

Remember to build in a workshop evaluation - you will find ideas for this in the **ARC Facilitator's Toolkit**.

DETAILED PROGRAMME FOR A HALF DAY AWARENESS WORKSHOP

This programme comprising two sessions of just under two hours each is designed to provide participants with an overall awareness of the subject and an introduction to some of the key issues.

LEARNING OBJECTIVES

By the end of this workshop, participants will be able to:

- understand what it means for a young person to enjoy sexual and reproductive health;
- appreciate why young people in general are at risk of damaging their sexual and reproductive health; and why refugee and displaced young people are at much greater risk in this respect;
- identify and build on the strengths of young people, so that they can be fully involved in all aspects of project planning and implementation;
- explain what key features might characterise a successful sexual and reproductive health programme;
- understand which articles from the CRC and other legal instruments protect the sexual and reproductive health rights of young people; and appreciate how they might be used in advocacy and informing policy and planning.

PREPARATION

The facilitator should prepare an information pack for the participants which may include:

- copies of the relevant Handouts and Briefing Notes;
- a copy of the Reading List and relevant Readings;
- copies of relevant materials from the region / country / locality (e.g. research papers, monitoring reports).

If possible, this pack should be sent to participants in advance.

The facilitator should gather any locally relevant information on the Topics to be addressed in the training and identify individuals with specific expertise who could act as resource persons. All participants can be asked to bring along relevant material to display / share with others.

The facilitator should study the notes for each Exercise carefully to ensure that all the necessary materials are prepared in advance.

Introduction

10 mins	Introduce the agreed aims of the session on Sexual and Reproductive Health on a prepared flipchart. Using Sexual and Reproductive Health Overhead 1.0: Key Concepts , introduce the relevant Key Concepts.	Flipchart summarising aims of session. Overhead 1.0
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Sexual Health and Young People

20 mins	Provide a briefing on this subject, based on the Briefing Notes for Topic 1 and Sexual and Reproductive Health Overheads 1.3 and 1.4 covering the following: What does it mean to be sexually healthy? Why this might be difficult for a young person to achieve. Why might refugee and displaced young people be at greater risk of sexual and reproductive ill-health	Overhead 1.3 Overhead 1.4
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Working with Young People – The Strengths and the Challenges

60 mins	Introduction, using Briefing Notes for Topic 2 and Sexual and Reproductive Health Overheads 2.2 and 2.3 . Introduce and facilitate Sexual and Reproductive Health Exercise 2.1 .	Overheads 2.2, 2.3. Exercise 2.1
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Suggested 15 minute break

Relevant Legal Standards and Implications for Advocacy, Policy Making and Planning

30 mins	Using Briefing Notes from Topic 3 and Sexual and Reproductive Health Handout 3.1 and Overhead 3.2 , provide a brief overview of relevant	Overhead 3.2 and 3.3
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60 mins	legal instruments. Discussion. Questions and answers. Invite participants to consider ways in which these legal instruments might be used in advocacy and in policy making. Introduce and facilitate Sexual and Reproductive Health Exercise 3.2.	Exercise 3.2
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The Components of a Sexual and Reproductive Health Programme

30 mins	Briefing using the Briefing Notes for Topic 4 and Sexual and Reproductive Health Overhead 4.2 , ensuring that the following headings are covered: The importance of a multi-sectoral approach IEC Programmes Features of a successful IEC programme Principles for working with young people	Overhead 4.2
45 mins	Introduce and facilitate Sexual and Reproductive Health Exercise 4.1	Exercise 4.1

Summary and Evaluation

5 mins	Remind participants about the aims of this session on Sexual and Reproductive Health by referring to the aims flipchart. Review the topics covered using Sexual and Reproductive Health Overhead 1.0: Key Concepts	Aims flipchart. Overhead 1.0
5 mins	Ask participants to identify three action points they intend to follow up.	
5 mins	Conduct a brief evaluation using customised forms from the ARC Facilitator's Toolkit.	Evaluation forms.

TRAINING PLAN FOR A DAY WORKSHOP ON SEXUAL AND REPRODUCTIVE HEALTH AND SITUATION ANALYSIS

This programme has been written as a training plan to demonstrate how materials from more than one Resource Pack can be combined to create a workshop which is customised to the needs of a particular group of participants. It is intended as an example only.

Overall Aim

To raise the awareness of participants about the issue of sexual and reproductive health and to demonstrate how a thorough and appropriate situation analysis can contribute to the development of a sound programme.

Learning Objectives

By the end of this workshop, participants will be able to:

- Understand what it means for a young person to enjoy good sexual health;
- Appreciate why the sexual and reproductive health of young people is often at risk and to appreciate the particular risks faced by refugee and displaced young people;
- Appreciate the importance of conducting a child centred situation analysis as a first step in setting up a sexual and reproductive health programme;
- Use this analysis to develop methods of planning programmes;
- Identify and build on the strengths of young people so that they can be fully involved in the planning, implementation and evaluation processes;
- Describe which components are necessary for a sexual and reproductive health programme;
- Decide how they might best promote sexual and reproductive health for refugee and displaced young people;
- Focus on particular sexual health issues and understand the key messages that should be given to young people who are experiencing these problems;
- List relevant legal instruments that protect the sexual and reproductive health rights of young people and understand how they might apply them to advocacy, policy making or programme planning.

ARC (Action for the Rights of Children)

Timing	Content	Methods	Materials	Resources & Equipment	Responsibility
30 minutes	Welcome and introductions Sharing and agreeing of objectives	Short participatory exercise where participants can get to know each other Sharing and refining of objectives	<ul style="list-style-type: none"> As required in introductory activity 	Flipchart and pens.	
15 minutes	Introduction to the topic	Short input by facilitator.	<ul style="list-style-type: none"> Overhead 1.0: Key Concepts. 	Overhead projector. Flipchart and pens.	
30 minutes	Sexual and reproductive health, and why some young people are at risk	Short input by facilitator (based on Briefing Notes for Topic 1). Plenary discussion.	<ul style="list-style-type: none"> Briefing Notes for Topic 1. 	Flipchart and pens.	
30 minutes	Importance of a child-centred situation analysis in order to understand the needs of refugee and displaced young people	Short input by facilitator (based on information from Topic 3 and 4 of ARC Resource Pack on Situation Analysis). Question and answers.	<ul style="list-style-type: none"> Briefing Notes Situation Analysis Topic 3. Briefing Notes Situation Analysis Topic 4. 	Overhead projector. Flipchart and pens.	
Suggested Break					
60 minutes	Planning on the basis of the needs of young people	Introduce and facilitate Situation Analysis Exercise 4.1. Plenary discussion.	<ul style="list-style-type: none"> Situation Analysis Exercise 4.1. 	Flipchart and pens.	
Suggested Break					

ARC (Action for the Rights of Children)

60 minutes	Working with young people: the challenges and the strengths	Introduce and facilitate Sexual and Reproductive Health Exercise 2.1.	<ul style="list-style-type: none"> • Exercise 2.1. 	Flipchart and pens.	
45 minutes	The components of a sexual and reproductive health programme	Briefing based on the information from Topic 4.	<ul style="list-style-type: none"> • Overhead 4.2. 	Overhead projector Flipchart and pens.	
Suggested Break					
60 minutes	Sexual and reproductive health: Specific issues and key messages	Briefing on one or more specific issues that are relevant to the needs/interests of the participants (based on the information provided in Topic 5).	<ul style="list-style-type: none"> • Relevant exercise from the training materials from Topic 5. 	Flipchart and pens.	
25 minutes	Summary, action-planning and workshop evaluation	Short input by facilitator. Small group action-planning exercise. Evaluation exercise.	<ul style="list-style-type: none"> • Evaluation form. 	Overhead projector Flipchart and pens.	

Sexual and Reproductive Health



Overheads

1.0	Key Concepts
1.1	Key Learning Points for Topic 1
1.2	Definition of Reproductive Health
1.3	Difficulties Faced by Refugee and Displaced Young People
1.4	Characteristics of Young People
2.1	Key Learning Points for Topic 2
2.2	Challenges to the Provision of Sexual and Reproductive Health Services
2.3	Potential Strengths in Young People
3.1	Key Learning Points for Topic 3
3.2	Critical Actions to Improve Reproductive Health Rights
4.1	Key Learning Points for Topic 4
4.2	Strategic Framework for Enabling Refugee Young People to Lead Productive and Safe Sexual and Reproductive Lives
5.1	Specific SRH Problems Covered in Topic 5
5.2	Social and Economic Risks of Early Child-bearing
5.3	Definitions and Classification of Female Genital Mutilation

Sexual and Reproductive Health – Overhead 1.0

Key Concepts

1. SRH is an issue that concerns everyone.
2. Effective support and intervention during adolescence can have important and long lasting benefits.
3. Refugee and displaced young people are more at risk than settled young people.
4. Sexual health problems in young people arise when they are either ill-informed or ill-equipped to deal with the consequences of their sexual activities.
5. Working effectively with SRH issues involves working with communities and young people.
6. Centrally involve the young people themselves in the process of developing effective self-help strategies.
7. Human rights instruments serve to support advocacy in this field.
8. Effective SRH programmes require a multi-sectoral approach and strong co-ordination between and within agencies.
9. Successful IEC programmes share many common features.
10. There are specific health and prevention messages which relate to individual key issues.

Sexual and Reproductive Health – Overhead 1.1

Key Learning Points for Topic 1

- Sexual and reproductive health concerns everyone.
- Effective support and intervention for young people who are about to begin their sexual lives can have lasting and beneficial effects on many aspects of their lives.
- Adolescence marks the beginning of a young person's journey into sexual development and sexuality. It can be an exciting, worrying and/or difficult time.
- Good sexual health involves feeling good in relation to one's sexual behaviour in body, mind and, spirit as well as in the context of the social environment in which one lives.
- Sexual health problems arise when young people do not have control over their sexual lives: they are either ill-informed or ill-equipped to deal with the consequences of sexual activity.
- Due to the unstable nature of their situation, refugee and displaced young people are at increased risk of damaging their sexual and reproductive health than settled young people.

Sexual and Reproductive Health – Overhead 1.2

Definition of Sexual and Reproductive Health

Sexual health is the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.

Reproductive health is a state of complete, physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.¹

¹Cairo Programme of Action of the United Nations International Conference on Population and Development (ICPD) 1994, para.7.2.

Sexual and Reproductive Health – Overhead 1.3

Difficulties Faced by Refugee and Displaced Young People

Could include:

- the burden of the trauma of exile;
- the uncertainties inherent in their futures;
- trauma arising from experience or witness of rape, torture or killings;
- the breakdown of pre-existing family support networks means that young men and women lose their traditional sources of information, assistance and protection;
- disruption of educational systems which constitute the loss of another source of information, protection and assistance;
- disruption of accepted and understood norms can have a profound effect on young people;
- loss of income sources to refugees reduces their ability to make free choices;
- women, and even children, may be the sole carers for their families. This represents a great emotional and physical burden;
- insufficient priority may be given to reproductive health care.

Sexual and Reproductive Health – Overhead 1.4

Characteristics of Young People

- Rapid physical growth and development
- Physical, social and psychological maturity, but not all at the same time
- Trying out experiences for the first time
- A frequent lack of knowledge and skills to make healthy choices
- Patterns of thinking in which immediate needs tend to have priority over long-term implications
- The start of behaviours that may become life-time habits that may result in diseases many years later.

Sexual and Reproductive Health – Overhead 2.1

Key Learning Points for Topic 2

- There are important challenges associated with the development of effective sexual and reproductive health programmes for young people.
- Young people have particular strengths which can contribute significantly to the success of such programmes.
- A clear understanding and analysis of prevalent cultural and gender issues should inform any programme planning in this field.
- Young people should be involved in all stages of programme planning, implementation and evaluation.
- Parents, teachers, community and religious leaders should be consulted and briefed on the importance of sexual and reproductive health programmes for young people.

Sexual and Reproductive Health – Overhead 2.2

Challenges to the Provision of Sexual and Reproductive Health Services

Factors which present challenges to the provision of reproductive health services, particularly with respect to young people, highlighted in the Beijing Conference, 1995:

- *inadequate levels of knowledge about human sexuality;*
- *inappropriate or poor-quality reproductive health information and services;*
- *the prevalence of high-risk sexual behaviour;*
- *discriminatory social practices;*
- *negative attitudes towards women and girls;*
- *the limited power many women and girls have over their sexual and reproductive lives.*

Sexual and Reproductive Health – Overhead 2.3

Potential Strengths in Young People

- Young people are more flexible and often have an easier time adapting to a new situation than their parents.
- They may also learn quickly how to “work” within new structures”.
- They tend to be more open to new ideas than their older counterparts.
- When motivated, they have huge sources of energy and enthusiasm.
- They can be far better communicators with their peer groups than many adults, especially those who are perceived to be in authority.

Key Learning Points for Topic 3

- There are a number of legal instruments which relate directly to sexual and reproductive health issues. These can be used effectively for advocacy and promotion of the reproductive, and sexual, rights of young people.
- An understanding of sexual and reproductive rights issues as they relate to young people can serve to influence policy makers and programme planners to develop programmes which better address young people's needs.

Sexual and Reproductive Health – Overhead 3.2

Critical Actions to Improve Reproductive Health Rights

Three critical actions needed now to improve reproductive health rights are:

- reforming laws that contribute to maternal mortality: e.g. laws that require women seeking health services to obtain the authorisation of their husbands, and laws that inhibit access to safe reproductive health services;
- implementing laws that protect women's health interest e.g. laws that prohibit child marriages, female genital mutilation and rape and sexual abuse;
- applying human rights in national constitutions and international conventions to advance safe motherhood e.g. by requiring states to take effective preventive and curative measures to reduce mortality and to treat women with respect and dignity.

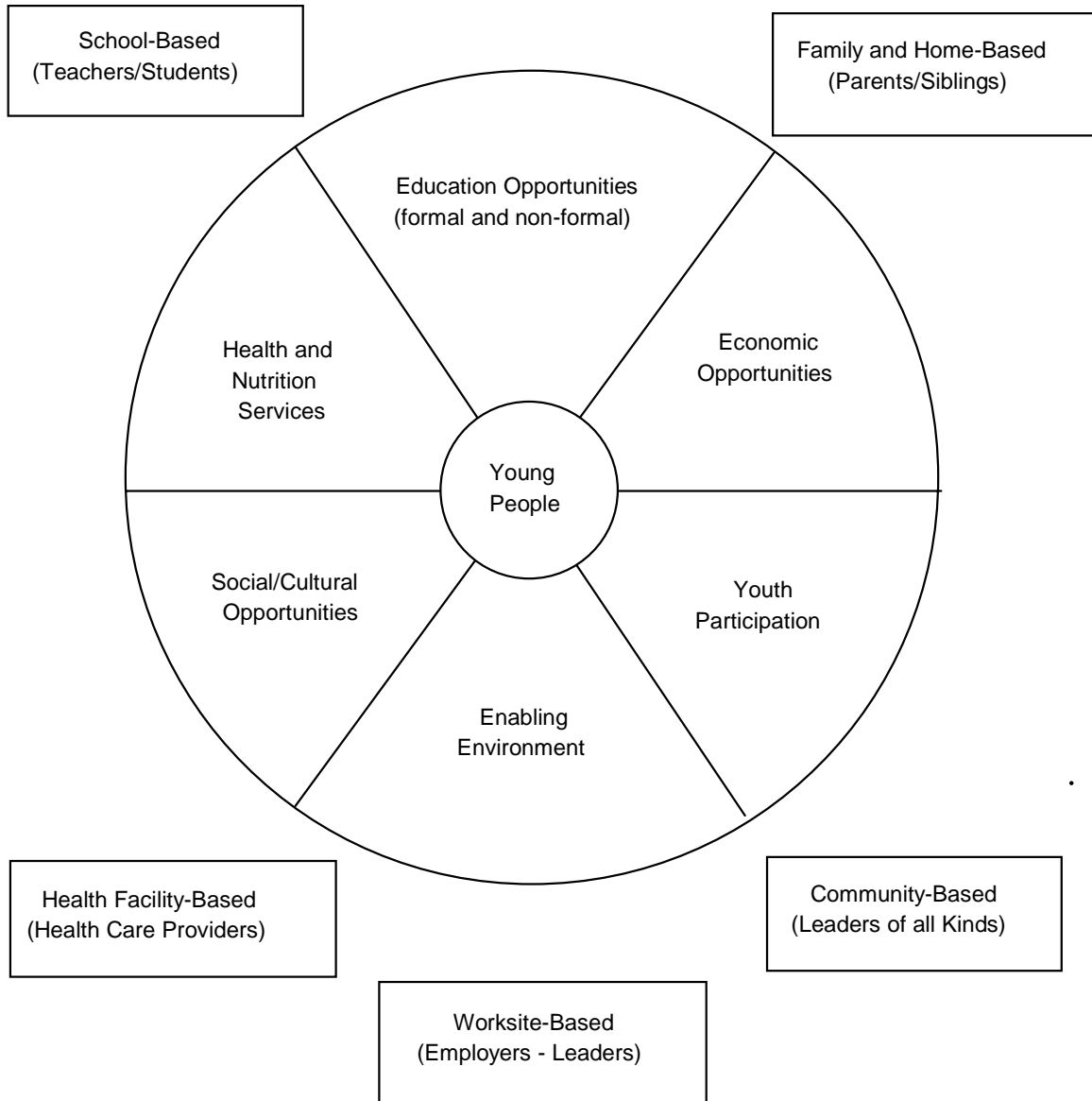
Sexual and Reproductive Health – Overhead 4.1

Key Learning Points for Topic 4

- Sexual and reproductive health require a multi-sectoral approach in order to be effective.
- Co-ordination both between and within implementing agencies with respect to this work is also essential.
- Information, Education and Communication (IEC programmes) can provide useful and appropriate information, counselling and advocacy as well as developing community participation and individual commitment to change.
- Successful IEC programmes often share similar features (see below).
- There are a number of important principles to adhere to when working with young people.

Sexual and Reproductive Health – Overhead 4.2

Strategic Framework for Refugee Young People



Strategic Framework for Enabling Refugee
People to Lead Productive and Safe Sexual and
Reproductive Lives:
The What and the Where/Who

Sexual and Reproductive Health – Overhead 5.1

Specific SRH Issues Covered in Topic 5

**5.1: SEXUALLY TRANSMITTED
INFECTIONS, INCLUDING HIV/
AIDS**

**5.2: EARLY/UNPLANNED
PREGNANCIES**

5.3: UNSAFE ABORTIONS

5.4: FEMALE GENITAL MUTILATION

5.5 SUBSTANCE ABUSE

5.6: NUTRITION

Sexual and Reproductive Health – Overhead 5.2

Social and Economic Risks of Early Child-Bearing

- Early pregnancy and childbearing limit educational opportunity and achievement.
- Early pregnancy compromises a woman's ability to support herself and her children financially.
- A young woman's opportunities are severely constrained when she becomes a mother and as such her quality of life is threatened.
- In some situations, the stigma of being an unmarried parent can result in rejection by the family and/or the community.

Sexual and Reproductive Health – Overhead 5.3

Definitions and Classification of Female Genital Mutilation

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

WHO CLASSIFICATION

Type I: Excision of the prepuce with or without excision of part or all of the clitoris.

Type II: Excision of the clitoris together with partial or total excision of the labia minora.

Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

TYPE IV: UNCLASSIFIED

- pricking, piercing or incision of the clitoris and/or labia
- stretching of the clitoris and/or labia
- introcision
- scraping (angurya cuts) or cutting (gishiri cuts) of the vagina or surrounding tissue
- introduction of corrosive substances or herbs into the vagina
- any other procedure that falls under the definition of female genital mutilation given above.

Sexual and Reproductive Health



Exercises

1.1	What Did You Do When You Were an Adolescent?	Sector Co-ordinators, Field Staff.
1.2	What's Difficult about Being an Adolescent?	Senior Managers, Sector Co-ordinators, Field Staff.
1.3	Refugee and Displaced Young People: the Risks	Senior Managers, Sector Co-ordinators, Field Staff.
2.1	Assessing the Strengths and Challenges when Working with Young People	Sector Co-ordinators, Field Staff.
3.1	Related Reproductive Health Rights and their Effectiveness	Senior Managers, Sector Co-ordinators, Field Staff.
3.2	Policies and Programmes which Contribute to Reducing Adolescent Marriage and Child-bearing	Senior Managers, Sector Co-ordinator.
4.1	Promoting Reproductive Health Rights for Refugee and displaced Young people	Sector Co-ordinators, Field Staff.
4.2	The Importance of Community Participation	Sector Co-ordinators, Field Staff.
4.3	Working with Peer Groups - Youth to Youth	Sector Co-ordinators, Field Staff.
4.4	Let's Get Creative!	Field Staff.
5.1	Case Study: Unsafe Abortions	Sector Co-ordinators, Field Staff.
5.2	STIs/HIV/AIDS: Features of a Successful Education Programme	Senior Managers, Sector Co-ordinators, Field Staff.
5.3	Early/Unplanned Pregnancies	Senior Managers, Sector Co-ordinators, Field Staff.

Sexual and Reproductive Health



Exercise 1.1:

What did you do when you were an adolescent?

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVE

By the end of this exercise, participants will be able to:

- acknowledge that indulging in risky behaviour as young people is common to all.

TIMEFRAME

10 minutes

METHOD

Ask participants to think of how they were when they were young people; and to focus on one incident during this period of their own lives where they took a risk (the riskier the examples, the better for the purpose of this exercise). Having focussed on the incident, ask participants to think of the reasons why they did this and to share these reasons with a partner (NB. it is not necessary to share *what* they did).

NOTE: This method may not be appropriate in certain cultural situations where admission of doing “risky things” by certain groups in the society would not be acceptable. If this is the case, the facilitator should adjust the exercise by inviting participants to think of someone they know who took risks when they were young people and what their reasons for doing so might have been.

Plenary: ask participants to share the reasons that they gave. Likely examples:

I wanted to see what it was like
Everyone else was doing it
For the hell of it - it looked fun
My friend persuaded me.

Short discussion.

RESOURCES

Flipchart paper and marker pens.

Sexual and Reproductive Health



Exercise 1.2:

What's Difficult About Being an Adolescent?

TARGET GROUP

Senior Managers, Sector Co-ordinators, Field Staff.

OBJECTIVE

By the end of this exercise, participants will be able to:

- identify those aspects of adolescence which increase the risks of being abused or engaging in risky behaviour.

TIMEFRAME

20 minutes

METHOD

Participants work in pairs. Using their own experience and/or their experience of their own children and/or their working situation participants to address the question:

“What is difficult about being an adolescent?”

Plenary: facilitator highlights main responses on flip chart and presents **Overhead 1.3.**

RESOURCES

Flipchart paper and marker pens.

Overhead 1.3.

Sexual and Reproductive Health



Exercise 1.3:

Refugee and displaced Young People - The Risks

TARGET GROUP

Senior Managers, Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- describe the scope of risks taken by young people and the possible consequences of these risks;
- apply an understanding of these risks in terms of adolescent refugee populations.

TIMEFRAME

45 minutes

METHOD

Divide participants into small groups. Give each group flip chart paper and pens. Ask them to elect a scribe.

Ask participants to brainstorm (in their small groups) risky behaviour that young people are likely to get involved in.

Having completed this task, participants (still working in small groups) draw up a list of possible consequences for each “risky behaviour” listed. For example:

Risky behaviour: unprotected sex

Possible consequences:

- too early/unplanned pregnancy;
- too early childbirth: potential ill-health or death of mother and/or child;
- unsafe abortion: possible ill-health/death;
- STI; HIV/AIDS: ill health, short and/or long term; possible death; passing condition to others.

Plenary: Facilitator will have prepared on flip chart the following points to highlight situations that refugees might find themselves in:

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- Poverty and dire need for better shelter
- Lack of organised activities
- Breakdown of social structures
- Loss or death of family, relatives and friends
- Loss of traditional role models
- Differing norms of accepted social behaviour
- Peer group pressure.

Lead discussion on how each of these factors may further influence the vulnerability of adolescent refugees.

RESOURCES

Flipchart paper and marker pens.

Sexual and Reproductive Health



Exercise 2.1: (Facilitator's notes)

Assessing the Strengths and the Challenges when Working with Young People

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVE

By the end of this exercise, participants will be able to:

- describe the challenges and the strengths they face in producing effective sexual and reproductive health programmes for young people.

TIMEFRAME

45 - 60 minutes

METHOD

Provide a brief introduction of the key challenges that should be addressed when working with young people on sexual and reproductive health issues (using information from Briefing Notes for Topic 2). Point out that working with young people requires special skills and understanding of their strengths and skills, and also understanding the stresses that they face in their lives.

Divide participants into small groups. Ask them to develop a SWOC analysis which describes the strengths, weaknesses, opportunities, and constraints the participants have experienced in working with young people to improve their sexual and reproductive health.

A description of how to run a SWOC analysis appears in the ARC Facilitator's Toolkit. On the following page, there is a pro-forma that can be used for this exercise.

Plenary: Include in the plenary some discussion about how to build on this analysis.

Sexual and Reproductive Health



Exercise 2.1: (Participants' Notes)

Assessing the Strengths and the Challenges when Working with Young People

SWOC Analysis - Working with Young People.

<p><i>Strengths</i></p>	<p><i>Weaknesses</i></p>
<p><i>Opportunities</i></p>	<p><i>Constraints</i></p>

Sexual and Reproductive Health



Exercise 3.1:

Related Reproductive Health Rights and Their Effectiveness

TARGET GROUP

Senior Managers, Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- describe the legal instruments which could be used to enhance the reproductive health and well-being of children and young people;
- explain ways in which these legal instruments can be used to greatest effect.

TIMEFRAME

45 - 60 minutes

METHOD

Using the participants' own knowledge and experience, brainstorm legal instruments that are pertinent to reproductive health and well-being of young people.

Organise information onto the flip chart.

Using information in **Briefing Notes for Topic 3**, include other instruments that participants are not necessarily familiar with.

Ask participants to work in groups of three to identify the three most crucial instruments (in their own experience) and to consider ways in which they would/could use them (or have used them) to influence other NGOs, governments, other policy makers.

Plenary: summary/presentation from each group.

Use **Overhead 3.2: Critical Actions to Improve Reproductive Health Rights** to stimulate further discussion.

RESOURCES

Flipchart paper and marker pens.

Overhead 3.2.

Handout 3.1.

Sexual and Reproductive Health



Exercise 3.2: (Facilitator's notes)

Policies and Programmes Which Contribute to Reducing Adolescents' Marriage and Childbearing.

TARGET GROUP

Senior Managers; Sector Co-ordinators.

OBJECTIVE

By the end of this exercise, participants will be able to:

- identify or develop policies and programmes that would effectively reduce levels of adolescents' marriage and child-bearing in their own areas of work/influence.

TIMEFRAME

45 - 60 minutes

METHOD

Group participants as far as possible into working teams.

Introduce the tasks for each group.

In terms of reproductive health in your area/sphere of influence:

1. Consider first the policies that are in place and then the main features of programmes that are up and running;
2. Identify the strengths of those policies and programmes, and then consider where they are lacking or weak.
3. Identify other policies and features of programmes which are not presently in existence in your area but which would enhance the reproductive health and well-being of children and young people.

Plenary: having shared these ideas in a plenary session, distribute and discuss the suggestions on the **Checklist** which follows this exercise.

RESOURCES

Flipchart paper and marker pens

A copy of the following **Checklist** for each participant.

Checklist:

WHAT CAN BE DONE

Governments, donors, NGOs and service providers need to make changes at the programme level by:

- Ensuring that all providers of care have the medical supplies, technical skills, information and interpersonal communication skills necessary for offering high quality care.
- Ensuring that all couples and individuals have access to good quality, client-oriented and confidential family planning information and services that offer a wide choice of modern contraceptive methods, including emergency contraception where appropriate. Family Planning counselling should be supportive and responsive to clients' needs to ensure confidence and continuity. Services must be based on the goal of enabling women and men to achieve their reproductive intentions while protecting themselves against STIs. Family planning should be part of a comprehensive sexual and reproductive health programme.
- Informing women and their families through a variety of communication channels about family planning including emergency contraception; the importance of prevention and early treatment of STIs and where STI services are available; when and where a pregnancy may be legally terminated; and other reproductive health issues.
- Ensuring that all young people receive high quality, comprehensive sexual and reproductive health education that offers information on decision-making skills, and gender relations with respect to sexuality, reproduction, contraception and STIs including HIV.
- Providing confidential reproductive health counselling and services to all sexually active people, including young people and unmarried women.
- Offering reliable information and compassionate counselling to all women with an unwanted pregnancy.
- Making high quality, safe abortion services available to the fullest extent allowed by law and ensuring that services are accessible and affordable.
- Ensuring that all women have access to quality services for the management of abortion-related complications, and that post-abortion family planning information and services are offered.

Policy-makers need to encourage broader changes within communities and at the national level to:

- ensure gender-sensitive policy-making;
- address regulatory, social, economic and cultural factors that limit women's control over their sexuality and reproduction;
- take action to stop all forms of sexual violence and to reduce power inequalities between men and women;

ARC (Action for the Rights of Children)

- identify specific actions needed to address the problem of unwanted pregnancy among young people, and to modify attitudes that stigmatise and blame young girls who get pregnant;
- foster in men attitudes that promote caring, responsible and equitable action in sexual relations, contraception, pregnancy and child care;
- work to change the power imbalances between women and men and the deep-rooted gender inequalities that foster the neglect of women's health, constrain their choices, and ultimately threaten their lives.

Sexual and Reproductive Health



Exercise 4.1: (Facilitator's notes)

Promoting Reproductive Health Rights for Young people in Refugee Situations.

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVE

By the end of this exercise, participants will be able to:

- generate practical ideas for the development of programmes in local refugee situations.

TIMEFRAME

45 minutes

METHOD

Participants to work in small groups (preferably in working teams).

Ask them to make a list of ways in which they could promote reproductive health for refugee children and young people in their own working situations.

Having made their lists, ask groups to rank their ideas in terms of how effective they consider them to be.

Plenary: summarise these ideas on flip chart.

Distribute copies of **Checklist** that follows this exercise.

Participants may also like to have copies of **Reading 4.2: International Rescue Committee Reproductive Health Education Programmes**. Although this programme is bedded within a formal education situation, many of the components are transferable to less formal situations

RESOURCES

Flipchart paper and marker pens.

Checklist.

Reading 4.2.

Checklist:

ADDRESSING THE REPRODUCTIVE HEALTH NEEDS OF ADOLESCENT REFUGEES

The following are recommendations on how to address specific reproductive health needs of young people.

- Young people need basic information about **sexuality and reproduction**. In many refugee settlements, formal education stops after primary school. Creative ways must be sought to provide information. Any organised activity for young people (sports, video showings, handicraft clubs) may serve as an opportunity for providing important health information to participants.
- Young people should be informed about STIs and unwanted pregnancy and appropriate advice and supplies should be made available to them.
- Adolescent **girls who do not attend school** and who are destined to marry immediately after the start of menstruation may be particularly difficult to reach. It may be culturally acceptable for them to be visited at home by a TBA (traditional birth attendant) who discusses health education matters focusing on preparation for parenthood.
- A rape experience can be the reason for an adolescent's first encounter with health services. Both boys and girls are likely to be victims of **sexual violence**. Not only does this have implications for treatment services, but great effort should be made to find means to provide adequate protection for young people.
- Among young people who are pregnant, it is important to emphasise **good antenatal care** as they are more prone to pregnancy and delivery complications.
- Messages on the prevention of STIs should take into consideration that young people may be questioning themselves and their sexual orientation, and this should be dealt with in a friendly way without creating a sense of guilt.
- Psychological trauma resulting from refugee experiences may create **resistance to seeking services** related to sexual health. To the extent to which it is possible, young people should be given additional encouragement to seek counselling services.

Sexual and Reproductive Health



Exercise 4.2: (Facilitator's notes)

The Importance of Community Participation

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- explain the critical importance of ensuring community participation at all stages of a reproductive health programme;
- identify key people in their own working situations.

TIMEFRAME

45 minutes

METHOD

Organise participants to work as far as possible in working teams (individual groups should not have more than 5 participants).

Introduce the subject.

Distribute copies of Participants' Notes for this exercise.

Ask the participants to discuss the following questions in the context of their own working situations:

- Within the community where you work, who are the opinion leaders?
- Who do you consider to be the key resource people in this community?
- In what ways might they contribute to organisation, development and success of a reproductive health programme within their community?

Ask the participants to use the pro - forma provided in the Participants' Notes

RESOURCES

Flipchart paper and marker pens.

Participants' Notes **Exercise 4.2.**

Sexual and Reproductive Health



Exercise 4.2: (Participants' notes)

The Importance of Community Participation

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, you will be able to:

- explain the critical importance of ensuring community participation at all stages of a reproductive health programme;
- identify key people in your own working situation.

TIMEFRAME

45 minutes

METHOD

In your groups, read the following and then consider the questions at the end of the extract:

The Importance of Community Participation

In any given community there is always a social structure. Within this social structure, there exist opinion leaders who have some influence on the community at large. They are key to information affecting the community and they can hinder or support initiatives affecting them. It is important to recognise them to secure their willingness to participate and ensure access to the community. These people can provide information about:

- problems existing in the camps
- opinion leaders whose ideas are respected
- entry process into the community
- cultural dimensions of the community in the camps
- informal services that are used by young people for their reproductive health concerns
- available resources in terms of human resources especially in formulation of culturally acceptable messages.

The young people themselves:

A child or adolescent in a refugee camp is not merely a source of problems but a great potential resource if given the support and opportunity. Most young people do not want to be different from others. They do not like attracting attention to themselves by asking for help or getting involved if not asked to do so. For example, they may try to induce a pregnancy or abortion by asking for help from a friend or self-treatment for an STI. It is therefore important to involve them in:

- Planning
- Implementing
- Evaluating

This can ensure relevance, commitment and cultural specificity of any activity related to reproductive health that affects them. Although young people must be given a greater degree of control over the services provided to them, it is important to realise as well that young people cannot do what is needed alone. They need to do it in partnership with those planning activities for them.

Other organisations

Initiatives targeting the child and the adolescent must be comprehensive. Various other organisations working in refugee camps can contribute to adolescent and children activities, giving their own specialised assistance wherever possible.

- Within the community that you work, who are the opinion leaders?
- Who do you consider to be the key resource people in this community?
- In what ways might they contribute to organisation, development and success of a reproductive health programme within their community?

Present the answers to these questions on the chart on the following page.

<p>Key opinion leaders within the community that you work:</p>	<p>How to work with them to develop an RH programme:</p>
<p>Key resource persons within the community that you work:</p>	<p>How they can support the development of an RH programme :</p>

Sexual and Reproductive Health



Exercise 4.3: (Facilitator's notes)

Working with Peer Groups – Youth to Youth

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- describe the different ways in which peer groups can be used within Reproductive Health programmes for children and young people;
- apply this understanding to the local situation.

TIMEFRAME

45 - 60 minutes

METHOD

Divide participants into groups of four or five people.

Distribute copies of Participants' Notes for this exercise.

Ask participants to share their own experiences of working with peer groups and then to consider ways in which they might use peer groups in their own working situations. Participants may wish to develop a chart similar to the one that they will be studying in the **Participants' Notes Exercise 4.3**.

Short plenary.

RESOURCES

Flip chart paper and marker pens.

Participants' Notes Exercise 4.3.

Sexual and Reproductive Health



Exercise 4.3: (Participants' notes -1)

Working with Peer Groups – Youth to Youth

EXAMPLE OF AN ADOLESCENT INTERVENTION

Peer Approach to Counselling by Teens (PACT) – Botswana

Results: Major outcome has been action taken by the health and social authorities to ensure that all young people have access to services for counselling, STI diagnosis and treatment, and condom supply for HIV/STI prevention and family planning

Interventions used: skills, counselling and information

Target population: 13-19 year olds in and out of schools. The programme is now trying to reach parents, communities, and youth who are out of school.

The purpose of this programme is to enable the youth to make healthy decisions about their own sexuality, to avoid unwanted pregnancy and infection by HIV/STI, and specifically to enhance their own confidence and self esteem. The aim is to build understanding and support for peer approach to counselling by teens (PACT) among the education and health authorities, the schools, parents, and the community.

10 peer educators are selected and trained in each school.

Methods used by peer educators to reach other youth include: drama; songs; discussion groups; poster contests; public debates; and information booths in fairs and church events.

This programme is an excellent example of direct involvement of the target group. The success of the action is dependent on the action of the youth themselves. The motivation of these youth is evident not only in their readiness to work during school holidays, but also in their other initiatives. Peer educators are directly involved in designing and implementing the educational activities of the programme and have played an active role in the development of peer educator curricula, guides, and the brochures. Peer educator activities have not only influenced their peers in school, but have also influenced families and community members.

Sexual and Reproductive Health



Exercise 4.3: (Participants' notes - 2)

Working with Peer Groups - Youth to Youth

	Peer communication	Peer education	Peer counselling
Objectives	Information building, some attitude change	Information and skills building; attitude change; and social support	Information and skills building, attitude change, problem solving and social support
Coverage	High coverage	Medium coverage	Low coverage
Intensity	Low intensity	Medium/ high	High intensity
Focus	Community and large groups	Community and small groups	Individuals
Examples	Drama, leaflet distribution, condom distribution	Peer-led group education activities	School, health facility or community based peer counsellors
Role of peers	Communicators recruited continuously on a voluntary and motivational basis. They have limited roles. Their commitment is usually for brief or sporadic periods	Educators are selected based on specific criteria. 20-30 educators at a time are usually recruited. They have specific tasks to perform. They are committed for short periods (6-8 months)	Counsellors are carefully selected. In many cases they are paid. They form a highly skilled task. They are highly committed over a long period of time
Training	Short briefings or motivational sessions are sufficient	Short intensive training workshops and refresher courses	Long duration and intensive training

Sexual and Reproductive Health



Exercise 4.4: (Facilitator's notes)

Let's get Creative!

TARGET GROUP

Field Staff.

OBJECTIVE

By the end of this exercise, participants will be able to:

- describe the main characteristics of a culturally sensitive IEC message.

TIMEFRAME

60 -90 minutes depending on numbers of participants.

METHOD

Divide participants into small groups.

Introduce the topic.

Distribute copies of Participants' Notes for this exercise and allow 45 minutes for groups to prepare their presentations. Each group then presents their message.

Alternatively, this task could be given to participants before a break, e.g. at the end of the morning session, or in the evening if the workshop is continuing the next day.

Sexual and Reproductive Health



Exercise 4.4: (Participants' notes)

Let's Get Creative!

TARGET GROUP

Field Staff.

OBJECTIVE

By the end of this exercise, you will be able to:

- describe the main characteristics of a culturally sensitive IEC message.

TIMEFRAME

60 -90 minutes depending on numbers of participants.

METHOD

Read the following extract, taken from "Reproductive Health in Refugee Situations - An Inter-Agency Field Manual":

- **Develop IEC messages.** A good message is short, accurate and relevant. It should be disseminated in the language of the Target Groups and should use vocabulary appropriate for that audience. The message tone may be humorous, didactic, authoritative, rational or emotionally appealing. It may be intended as a one-time appeal or as a repetitive reinforcement. It is often necessary to develop several versions of a message depending on the audience to whom it is directed. For example, differing information about contraceptive services will be relevant to women with three or four children already, or young people who are just beginning to be sexually active. Their needs and priorities will differ, so the IEC materials used with each group must also differ. Remember to find out if materials already exist in the host country or country of origin.
- **Determine suitable methods and channels of communication.** Once the audience is identified and researched and the key messages have been chosen, it is time to decide which media and combinations of information channels will reach the target group. Different channels do different jobs and each has its own strengths and weaknesses, depending on the role it will take in the communication programme. The choice of messages and media will be influenced by many factors: cost; literacy levels; artistic style within the community; familiarity with, and extent of penetration of, a particular medium for both service providers and user; and availability.

The development and refinement of messages and the choice of the communication channel or medium are inseparable. Very different messages will be developed for different media, for example, radio, poster or flip charts, as the nature of the medium affects what messages can be successfully used. The skills of those using the materials must also be considered. It may well be necessary to provide training to those staff who are expected to use the materials. For example, it is one thing to place a single picture or poster on a clinic wall which people may or may not look at; it is quite different to use a series of pictures in the form of a flip chart as an educational tool in a group setting.

BASED ON THE GUIDELINES ABOVE

- develop a message which will help adolescent girls protect and inform themselves about early or unwanted pregnancies;
- agree your Target Groups;
- decide upon your channel of communication (bearing in mind the constraints of the workshop situation);
- work together to “produce” this message using your chosen channel of communication.

When this task is completed, each group will present their message to the whole group for comment and feedback.

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Exercise 5.1: (Facilitator's notes)

Case study: Unsafe Abortions

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- explain why adolescent girls might resort to unsafe abortions;
- develop key messages and information that would protect and inform young people on the dangers of unsafe abortions;
- assess different approaches to dealing with young people who may resort to unsafe abortions.

TIMEFRAME

45 minutes

METHOD

Divide participants into small groups where, as far as possible, the members of each group have similar working roles and responsibilities.

Distribute copies of Participants' Notes **Exercise 5.1** and ask participants to work through the exercise.

Plenary session using flip chart to summarise key messages that the individual groups have developed.

RESOURCES

Participants' Notes Exercise 5.1

Flip chart paper.

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Exercise 5.1: (Participants' notes)

Case Study: Unsafe Abortions

TARGET GROUP

Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, you will be able to:

- explain why adolescent girls might resort to unsafe abortions;
- develop key messages and information that would protect and inform young people on the dangers of unsafe abortions;
- assess different approaches to dealing with young people who may resort to unsafe abortions.

TIMEFRAME

45 minutes

METHOD

You will be working in small groups. Read the following case study and discuss answers to the questions that follow.

You are a field worker in a refugee camp. One day when you are doing your usual activities in the camp, a young female refugee approaches you and asks if you can help her. She tells you that she is very sad and doesn't know what to do. She explains that two months ago she was raped by a gang of young men. You talk at length with her, and she tells you that she has recently taken some medicine that she bought from the local traditional healer. She hoped that this would result in an abortion but she is now feeling very sick and is in some pain.

In your group, discuss:

- In your own experience, how often does this sort of event occur?
- In what other situations might an adolescent girl seek to have an abortion?
- What key messages and information would protect and/or inform young female young people about the dangers of unsafe abortions?
- What would you do for this girl in this situation?

There will be a short plenary where key messages from each group will be shared.

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Exercise 5.2: (Facilitator's notes)

STIs and HIV/AIDS: Features of a Successful Education Programme

TARGET GROUP

Senior Managers, Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- explain key basic information about STIs, including HIV/AIDS;
- identify which features are essential in developing an effective education programme about STIs and HIV/AIDS for children and young people.

TIMEFRAME

60 minutes

METHOD

Divide participants into groups of 3 or 4 people. Using the **Briefing Notes for Topic 5, Section 5.1**, introduce the topic of STIs and HIV/AIDS and key messages for children and young people about these conditions.

Introduce the exercise by asking the participants to consider what features would be present in an effective education programme about STIs and HIV/AIDS. Point out that "Effective programmes are those that have a positive influence on behaviour as regards sex, drug use and non-discrimination - and not simply increased knowledge and changed the attitudes of students" (from "Learning and Teaching about AIDS at School", UNAIDS Technical Update October 1997).

Allow 30 minutes for the exercise.

Plenary session.

Distribute the **Checklist** which follows this exercise.

RESOURCES

Flipchart paper and marker pens.

Participants' Notes Exercise 5.2.

Checklist:

Extract adapted from “Learning and Teaching about AIDS at School”. UNAIDS Technical Update, October 1997.

Effective programmes are those that have had a positive influence on behaviour as regards sex, drug use and non-discrimination - and not simply increased knowledge and changed the attitudes of students. It has been shown that effective programmes do all the following things:

- focus on life skills - particularly relating to decision-making, negotiation and communication - with the double aim of delaying the first sexual intercourse and encouraging protected intercourse;
- concentrating on personalised risk through appropriate role playing and discussions;
- discuss clearly the possible results of unprotected sex - and always in equally clear terms the way to avoid such an outcome;
- explain where to turn for help and support among peers, school staff, community members and outside facilities;
- stress that skills useful for self protection from STIs and HIV also help build self confidence and avoid unwanted pregnancy, sexual abuse and the abuse of drugs (including tobacco and alcohol);
- reinforce values, norms and peer group support for practising and sustaining safe behaviour and resisting unsafe behaviour.

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Exercise 5.3:

Early/Unplanned Pregnancies

TARGET GROUP

Senior Managers, Sector Co-ordinators, Field Staff.

OBJECTIVES

By the end of this exercise, participants will be able to:

- explain the dangers of early pregnancies for children and young people;
- develop a set of key preventive messages for children and young people about early/unplanned pregnancies.

TIMEFRAME

45 - 60 minutes

METHOD

Provide a brief introduction to the topic using **Briefing Notes for Topic 5**.

Divide participants into groups of three/four.

Establish that the goal of the exercise is to develop key messages for children and young people about preventing early pregnancies; and that in order to develop these messages the participants must be clear about both the physical and the social consequences of early pregnancies.

Invite the participants to share their knowledge and experience of the subject in their groups under the following headings:

- Pregnancy Related and Obstetric Complications
- Maternal Mortality
- Infant and Child Mortality
- Social and Economic Risks

Plenary session to collate and summarise this information (refer to Briefing Notes).

In the same groups, ask participants to develop key preventive information/messages for children and young people on a flip chart.

Final plenary where individual group work is shared by the whole group.

RESOURCES

Flipchart paper and marker pens.

Overhead 5.2.

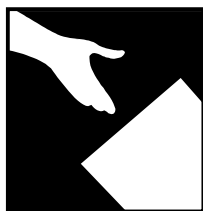
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Handouts

3.1	A Summary of Reproductive Health Rights
4.1	Setting Up Information and Communication Programmes
4.2	The Importance of Community Participation
5.1	What are HIV and AIDS?
5.2	What is Female Genital Mutilation?

Sexual and Reproductive Health



Handout 3.1:

A Summary of Reproductive Health Rights

UNIVERSAL INSTRUMENTS

The Right to Health and Health Care Services

Convention on the Rights of the Child (CRC) of 1989, Article 6.1

States Parties recognise that every child has the inherent right to life.

Article 24

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;
- (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- (f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Universal Declaration on Human Rights (UDHR) of 1948, Article 25.1

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care.

International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Reproductive and Sexual Health Definition

Cairo ICPD, Programme of Action of 1994, Paragraph 7.1

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system. Sexual health is the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love, and thus the notion of sexual health implies a positive approach to human sexuality...

Reproductive Choice

Cairo ICPD, Programme of Action of 1994, Paragraph 7.2

The cornerstone of [sexual and reproductive health] rests on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, [and the right to the enjoyment of the highest attainable standard of sexual and reproductive health]. It also includes respect for [human body as expressed in human rights documents, and the right of couples and individuals to make decisions concerning reproduction free of discrimination, coercion and violence.

Convention on the Rights of the Child (CRC) of 1989, Article 34 (a)

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- (a) the inducement or coercion of a child to engage in any unlawful sexual activity;...

Family Planning

Convention on the Rights of the Child (CRC) of 1989, Article 24.2 (f)

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, Article 12.1

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Marriage

Universal Declaration on Human Rights (UDHR) of 1948, Article 16 1

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

Convention on the Elimination of All Forms Of Discrimination Against Women (CEDAW) of 1979, Article 16 (1)

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

- (a) The same right to enter into marriage;
- (b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;...

Convention on Consent to Marriage, Minimum Age and Registration of Marriages of 1962, Article 1

1. No marriage shall be legally entered into without the full and free consent of both parties, such consent to be expressed by them in person after due publicity and in the presence of the authority competent to solemnise the marriage and of witnesses, as prescribed by law.

Article 2

States Parties to the present Convention shall take legislative action to specify a minimum age for marriage. No marriage shall be legally entered into by any person under this age, except where a competent authority has granted a dispensation as to age, for serious reasons, in the interest of the intending spouses.

The Right to Family Protection

International Covenant on Civil and Political Rights (ICCPR) of 1966, Article 23.1

The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Safe Motherhood

Convention on the Rights of the Child (CRC) of 1989, Article 24.2 (d)

International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, Article 25.2

Motherhood and childhood are entitled to special care and assistance.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, Article 12.2

Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Reduction of Child and Infant Mortality

Convention on the Rights of the Child (CRC) of 1989, Article 24.2 (a)

International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, Article 12.2 (a)

Protection from HIV/AIDS

The International Guidelines on HIV/AIDS and Human Rights, 1996

Guideline No. 6

States should enact legislation to provide for the regulation of ...HIV-related information so as to ensure wide-spread availability of qualitative preventive measures and services and adequate HIV prevention and care information...

Guideline No. 8

States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Nutrition

Convention on the Rights of the Child (CRC) of 1989, Article 24.2.(c)

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, Article 12.2

Platform of Action, Beijing Conference, 1995

Paragraph 93

Discrimination against girls, often resulting from son preference, in access to nutrition and health-care services endangers their current and future health and well-being.

Education

Convention on the Rights of the Child (CRC) of 1989, Article 24.2 (e)

Protection from Harmful Traditional Practices

Convention on the Rights of the Child (CRC) of 1989, Article 24.3

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979, Article 5 (a)

States Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based

on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;..

REGIONAL INSTRUMENTS

African Charter on Human and Peoples' Rights of 1981, OAU

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 18.1

1. The family shall be the natural unit and basis of society. It shall be protected by the State which shall take care of its physical health and moral.

African Charter on the Rights and Welfare of the Child of 1990, OAU

Article 14: Health and Health Services

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
 - (a) to reduce infant and child mortality rate;
 - (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) to ensure the provision of adequate nutrition and safe drinking water;
 - (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
 - (e) to ensure appropriate health care for expectant and nursing mothers;
 - (f) to develop preventive health care and family life education and provision of service;
 - (g) to integrate basic health service programmes in national development plans;
 - (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;
 - (i) to ensure the meaningful participation of non-governmental organisations, local communities and the beneficiary population in the planning and management of a basic service programme for children;
 - (j) to support through technical and financial means, the mobilisation of local community resources in the development of primary health care for children.

European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950

Article 8 – Right to Respect for Private and Family Life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

Article 12 – Right to Marry

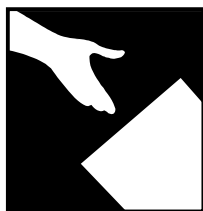
Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

American Convention on Human Rights, Pact of San Jose of 1969

Article 17. Rights of the Family

1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the state.
2. The right of men and women of marriageable age to marry and to raise a family shall be recognised, if they meet the conditions required by domestic laws, insofar as such conditions do not affect the principle of non-discrimination established in this Convention.
3. No marriage shall be entered into without the free and full consent of the intending spouses.

Sexual and Reproductive Health



Handout 4.1:

Setting Up Information and Communication Programmes

The first, and crucial, step involves undertaking a needs assessment.

Optimally, a person with experience of adolescent reproductive health service provision and refugee situations should participate in the needs assessment and the planning of the programmes. Young people should be identified, as quickly as possible, to participate in the design of programmes, and eventually take a leadership role. Information should be gathered regarding:

- cultural norms related to sexual relationships and rites of passage into adulthood;
- current adolescent norms/practices/perceptions/attitudes related to sex;
- typical patterns of adult authority over adolescents' behaviour within the camp;
- description of services available to young people (and applicable restrictions) and the degree to which this availability is understood by young people and adults in the camp;
- perceptions of camp staff/service providers related to providing RH services to young people;
- young peoples' perceptions of their RH needs.

This information can be gathered through camp records, interviews and focus group discussions and possibly through survey techniques, PRA etc.

However, it is usually necessary to use more formal methods in undertaking a thorough needs assessment. Focus groups, individual interview of Knowledge, Attitude, Behaviour and Practice (KABP) surveys can be valuable ways to gather information and help with the development of materials or messages to support an IEC intervention. Only after there is an accurate picture of the refugee community's knowledge, attitude and behaviours surrounding reproductive health can you determine what programme and messages might be best suited to its needs.

IEC activities and materials should be based on relevant research conducted through use of quantitative (how many) and qualitative (why and how) methods. Research and discussions should be seen as an integral and ongoing part of IEC planning and implementation.

QUANTITATIVE:

- Use available incidence or prevalence of targeted problems.

- Knowledge, Attitude, Behaviour and Practice (KABP) Surveys use a series of close- and open-ended questions to determine what people in a community know, think, believe or do in relation to their reproductive health. Findings are presented in the form of percentages of people who think or do a certain thing. These surveys require many respondents that are randomly selected from throughout the community. Interviewers are needed to implement the survey and they need to be trained. Generally considered an expensive and time-consuming method.

QUALITATIVE

- **Individual interviews** allow the researcher to get deeper insight into a person's thoughts and feelings. Using an interview guide, interviewer and respondent talk at length about respondent's feelings in relation to a specific service or issue.
- **Focus groups** are in-depth discussions, usually of 1 to 2 hours in length, with a small group of people. Members of the Focus Group should have something in common (age, sex, experience) in the expectation that this will make it easier for them to talk together. They are representatives of the target group in that they are deliberately chosen. The intention is to make sure different groups within the community are represented within the Focus Group, or that several Focus Groups are held with members drawn from various sectors within the community. Discussions are led by a facilitator who follows a prepared guide which allows the facilitator to probe into the thoughts and feelings of group members. Usually considered cost-effective, as many people are involved in expressing their opinions at a single point in time. Findings are presented in the form of comments, or extracts from interviews, which illustrate how people think about their behaviour, or why they engage in a particular activity.

The information gathered through your needs assessment provides the framework for the development of a suitable IEC activity. Any materials and activities must always be culturally sensitive and appropriate. If the materials produced in the country of origin or host country are available then these could be used. These are the major steps you should follow when designing a project:

- **Set the goal.** This is a broad statement of what you want to accomplish.
- **Set the objectives.** These will contribute to achieving the goal.
- **Develop the activities.** These will make up the IEC programme which, after successful implementation, will achieve your objectives and contribute to the goal.
- **Establish an evaluation plan.** This will include indicators of success that determine the level of achievement of the objectives. The more focused the objectives are, the easier it is to establish indicators.
- When the indicators are established, the evaluation and monitoring of the project is straightforward.
- **Develop IEC messages.** A good message is short, accurate and relevant. It should be disseminated in the language of the Target Groups and should use

vocabulary appropriate for that audience. The message tone may be humorous, didactic, authoritative, rational or emotionally appealing. It may be intended as a one-time appeal or as a repetitive reinforcement. It is often necessary to develop several versions of a message depending on the audience to whom it is directed. For example, differing information about contraceptive services will be relevant to women with three or four children already, or young people who are just beginning to be sexually active. Their needs and priorities will differ, so the IEC materials used with each group must also differ. Remember to find out if materials already exist in the host country or country of origin.

- **Pre-testing**, often repeated, is an essential part of developing messages. It is through pre-testing that you will ensure that people understand the message as intended.
- **Determine suitable methods and channels of communication.** Once the audience is identified and researched and the key messages have been chosen, it is time to decide which media and combinations of information channels will reach the target group. Different channels do different jobs and each has its own strengths and weaknesses, depending on the role it will take in the communication programme. The choice of messages and media will be influenced by many factors: cost; literacy levels; artistic style within the community; familiarity with, and extent of penetration of, a particular medium for both service providers and user; and availability.

The development and refinement of messages and the choice of the communication channel or medium are inseparable. Very different messages will be developed for different media, for example radio, poster or flip charts, as the nature of the medium affects what messages can be successfully used. The skills of those using the materials must also be considered. It may well be necessary to provide training to those staff who are expected to use the materials. For example, it is one thing to place a single picture or poster on a clinic wall which people may or may not look at; it is quite different to use a series of pictures in the form of a clip chart as an educational tool in a group setting.

- **Evaluate.** An impact evaluation will be necessary to measure the effectiveness of the materials being used and distributed. Evaluations can be conducted using interviews, group discussions, or observation.

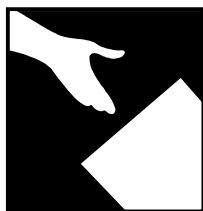
OTHER INDIVIDUALS AND COMMUNITY GROUPS

Beyond the communication with service users, it is necessary to open a dialogue with influential individuals and groups within the community. Such individuals and groups will need to be identified as early as possible. The nature and intention of service provision should be explained to them and their concerns and priorities discovered. Never assume that all refugees (even those that “come from” the same place) are alike. Some pointers for identifying such individuals and groups follow:

- **familiarise yourself with the community** with the help of someone who lives in the environment of the refugees and who provides them with some service, advice or protection;

- **identify individuals who are most important** in the social structure of the community you are working with. They can be existing formal leaders (elected or appointed), but, more often than not, are informal leaders;
- **identify individuals who have some influence within the community** - people whose opinions are respected. They will make suggestions on how to approach people and work effectively with them;
- **provide these individuals with very clear information** about what your intentions are and what you plan to do. Be specific about what they will gain from participating and allowing you access to the community;
- **provide them with input about your plans** before you proceed, and secure their willingness to participate.

Sexual and Reproductive Health



Handout 4.2:

The Importance of Community Participation

In any given community there is always a social structure. Within this social structure, there exist opinion leaders who have some influence on the community at large. They are key to information affecting the community and they can hinder or support initiatives affecting them. It is important to recognise them, to secure their willingness to participate and ensure access to the community. These people can provide information about:

- problems existing in the camps;
- opinion leaders whose ideas are respected;
- entry process into the community;
- cultural dimensions of the community in the camps;
- informal services that are used by young people for their reproductive health concerns;
- available resources in terms of human resources especially in formulation of culturally acceptable messages.

The young people themselves:

A young person in a refugee camp is not merely a source of problems, but a great potential resource if given the support and opportunity necessary. Most young people do not want to be different from others. They do not like attracting attention to themselves by asking for help or getting involved if not asked to do so. For example, they may try to induce a pregnancy or abortion by asking for help from a friend or self-treatment for an STI. It is therefore important to involve them in:

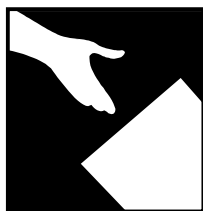
- planning
- implementing
- evaluating.

This can ensure relevance, commitment and cultural specificity of any activity related to reproductive health that affects them. Although young people must be given a greater degree of control over the services provided to them, it is important to realise as well that young people cannot do what is needed alone. They need to do it in partnership with those planning activities for them.

Other organisations

Initiatives targeting young people. Various other organisations working in refugee camps can contribute to adolescent and children activities, giving their own specialised assistance wherever possible.

Sexual and Reproductive Health



Handout 5.1:

What are HIV and AIDS?

HIV is the virus that causes AIDS. AIDS reduces the body's ability to fight other diseases. People with HIV/AIDS get sick very easily with certain diseases, such as pneumonia, tuberculosis, and diarrhoea. Most people with AIDS die from diseases that their bodies can no longer fight.

A PERSON WHO DOES NOT LOOK SICK CAN STILL PASS HIV TO OTHERS

A person may have HIV for years before any symptoms appear.

Other STIs increase a person's chances of getting HIV or transmitting it to others. People with STIs need to seek treatment and, if possible, to be tested for HIV and counselled.

HOW IS HIV CARRIED AND TRANSMITTED?

HIV is carried in body fluids. The most important are:

- semen,
- blood,
- vaginal fluid.

HIV can be transmitted through:

- vaginal sexual intercourse,
- anal intercourse,
- sharing intravenous hypodermic needles with an infected person,
- transfusions of infected blood,
- other activities that allow semen, blood, or vaginal fluid to enter the mouth, anus, or vagina or to touch an open cut or sore.
- the virus may be transmitted during pregnancy, childbirth or breastfeeding. In the absence of preventive measures, where no drugs are administered and the baby is predominantly breastfed for about 24 months by its HIV-positive mother, the risk of infection is generally around 30-35%. The risk of HIV transmission through breastfeeding depends of its duration and could be up to 20 % (if the mother breastfeeds for more than 24 months and/or has a very high viral load and/or is in a very advanced stage of AIDS). Where it's safe and feasible, replacement feeding should be recommended but for HIV- positive women who do not have an alternative to breastfeeding, it is recommended to

use exclusive breastfeeding during the first months of life. It is essential to stop the exclusive breastfeeding rapidly when introducing weaning food.

HIV is **not** transmitted by kissing, shaking hands, or sharing food, clothing, or toilets.

HOW CAN HIV/AIDS BE PREVENTED?

HIV/AIDS can be prevented in the same way that other STIs are prevented. Follow the ABCDs

- A** **A**bstain from sex if not protected.
- B** **B**e informed on how to protect yourself.
- C** **C**onsult someone you trust on the risks involved.
- D** **D**o not use a hypodermic needle that has not been sterilised or soaked in bleach.

Sexual and Reproductive Health



Handout 5.2:

What is Female Genital Mutilation?

DEFINITION, CLASSIFICATION AND DESCRIPTION (WHO)

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

WHO CLASSIFICATION

Type I: Excision of the prepuce with or without excision of part or all of the clitoris.

Type II: Excision of the clitoris together with partial or total excision of the labia minora.

Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV: Unclassified

- pricking, piercing or incision of the clitoris and/or labia
- stretching of the clitoris and/or labia
- introcision
- scraping (angurya cuts) or cutting (gishiri cuts) of the vagina or surrounding tissue
- introduction of corrosive substances or herbs into the vagina
- any other procedure that falls under the definition of female genital mutilation given above.

PHYSICAL CONSEQUENCES

Female genital mutilation causes grave damage to girls and women and frequently results in serious health consequences. The effects on health depend on the extent of cutting, the skills of the operator, the cleanliness of the tools and the environment, and the physical condition of the girl or woman concerned. Some of the effects are immediate while others only become apparent years later. Girls and women undergoing the more severe forms of mutilation are particularly likely to suffer serious and long-lasting complications. Documentation and studies are available on the physical short-term and long-term complications described below, but there has been little study of the sexual or psychological effects or the frequency with which complications occur. The mortality of girls and women

undergoing genital mutilation is unknown as few records are kept and deaths due to the practice are rarely reported.

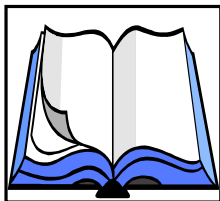
Female genital mutilation is wide-spread among refugee women from the cultures in which it is practised. It is practised in 41 countries, including many from which refugees originate, even when it is illegal in those countries. While it is not required by any religion, it is a practice rooted in traditions related to gender and power inequalities entrenched in the political, social, cultural and economic structures of the societies in which it is practised. Many women believe that genital mutilation is necessary for their health and to make them acceptable to their community. They are unaware that these mutilations are not practised in most of the world.

The operations are largely carried out by village women and TBAs (traditional birth attendants), usually on girls between four and ten years of age or younger, or, in some areas, on young people. Anaesthetics and antiseptics are not generally used. Refugees for whom female genital mutilation was a custom in their country of origin tend to continue it while in exile.

Extreme risks accompany the practice, particularly with infibulation. The repercussions continue throughout a woman's entire life, and may have major consequences for her reproductive health and well-being and the health of her children. Health workers in refugee situations are seldom knowledgeable about the physical, psychological and social consequences of female genital mutilation, nor are they always sensitive to the cultural beliefs that support the practice.

Therefore it is vital that field staff should discover whether female genital mutilation is practised within a refugee population and who is responsible for undertaking the procedure.

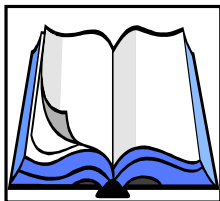
Sexual and Reproductive Health



Readings

Reading 4.1	Chapter 2, Reproductive Health in Refugee Situations: An Inter-agency Field Manual
Reading 4.2	The International Rescue Committee's Reproductive Health Programme
Reading 5.1	Learning and Teaching about AIDS at School

Sexual and Reproductive Health



Readings 4.1:

Chapter 2, Reproductive Health in Refugee Situations: An Inter-agency Field Manual

Extract taken from: **Reproductive Health in Refugee Situations: An Inter-agency Field Manual (1999). Geneva, UNHCR.**

2

CHAPTER TWO

Minimum Initial Service Package (MISP)

This Chapter describes a series of actions needed to respond to the reproductive health (RH) needs of populations in the early phase of a refugee situation (which may or may not be an emergency). The Minimum Initial Service Package (MISP) can be implemented without any new needs assessment since documented evidence already justifies its use. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff.

Special Note: the reader must refer to the relevant chapters in the Manual to properly implement the MISP.

Contents:

- Objectives of the MISP
- Components of the MISP
 - Identify an organisation(s) and individual(s) to facilitate the co-ordination and implementation of the MISP
 - Prevent and Manage the Consequences of Sexual Violence
 - Reduce HIV Transmission
 - Prevent excess neonatal and maternal morbidity and mortality
 - Plan for the provision of comprehensive RH services, integrated into Primary Health Care, as soon as possible
- Broad Terms of Reference for a RH Co-ordinator/Focal Point
- Material Resources
- Monitoring and Surveillance

Minimum Initial Service Package (MISP)

The major killers in refugee emergencies – diarrhoea, measles, acute respiratory infections (ARI), malnutrition and malaria, where prevalent – are well documented. Resources should not be diverted from dealing with these problems. However, there are some aspects of re-productive health that also must be addressed in this initial phase to reduce mortality and morbidity, particularly among women.

Please remember that the components of MISP form a minimum requirement. The expectation is that the comprehensive services as outlined in the rest of this Field Manual will be provided as soon as the situation allows.

OBJECTIVES OF THE MISP

IDENTIFY an organisation(s) and individual(s) to facilitate the co-ordination and implementation of the MISP;

PREVENT and manage the consequences of sexual violence;

REDUCE HIV transmission by

- Enforcing respect for universal precautions against HIV/AIDS, and
- Guaranteeing the availability of free condoms;

PREVENT excess neonatal and maternal morbidity and mortality by

- Providing clean delivery kits for use by mothers or birth attend-ants to promote clean home deliveries,
- Providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility, and
- Initiate the establishment of a referral system to manage obstetric emergencies; and

PLAN for the provision of comprehensive RH services, integrated into Primary Health Care (PHC), as the situation permits.

COMPONENTS OF THE MISP

Identify An Organisation(S) And Individual(S) To Facilitate The Co-ordination And Implementation Of The MISP

A qualified and experienced person should be identified to co-ordinate RH activities at the start of the emergency response. The overall leading agency should be responsible for the designation of such a person, and the person appointed should work under the supervision of the overall Health Co-ordinator.

RH focal points should be designated within each camp, and within each implementing agency. These health professionals, experienced in reproductive health, should be in post for a minimum of six months, as it is likely to take this long to establish comprehensive RH services.

All relief organisations should, in accordance with their mandates, and within the framework of emergency preparedness and response, train and sensitise their

staff on RH issues and gender awareness. (See Terms of Reference for the RH Co-ordinator at the end of this chapter.)

Prevent and Manage the Consequences of Sexual Violence

Sexual violence is strongly associated with situations of forced population movement. In this context, it is vital that all actors in the emergency response are aware of this issue and preventive measures are put in place. The UNHCR Guidelines for Prevention and Response to Sexual Violence against Refugees (1995) should be adhered to in the emergency response. Measures for assisting refugees who have experienced sexual violence, including rape, must also be established in the early phase of an emergency.

Women who have experienced sexual violence should be referred to the health services as soon as possible after the incident. Protection staff should also be involved in providing protection and legal support to survivors of sexual violence.

Key actions to be taken during the emergency to reduce the risk of sexual violence and respond to survivors are:

- design and locate refugee camps, in consultation with refugees, to enhance physical security
- ensure the presence of female protection and health staff and interpreters
- include the issues of sexual violence in the health co-ordination meetings
- ensure refugees are informed of the availability of services for survivors of sexual violence
- provide a medical response to survivors of sexual violence, including emergency contraception, as appropriate
- identify individual or groups who may be particularly at risk to sexual violence (single female heads-of-households, unaccompanied minors, etc.) and address their protection and assistance needs.

See Chapter Four for further information on elements of prevention and response to sexual violence.

Reduce HIV Transmission

Enforce Respect for Universal Precautions against HIV/AIDS

Universal precautions against the transmission of HIV/AIDS within the health care setting must be emphasised during the first meeting of Health Co-ordinators. Under the pressure of an emergency situation, it is possible that field staff are tempted to take short cuts in procedures which can jeopardise the safety of patients and staff. It is essential that universal precautions be respected. (See Chapter Five for details on universal precautions.)

Guarantee the Availability of Free Condoms

Availability of condoms should be ensured from the beginning so that they can be provided to anyone who requests them. Sufficient supplies should be ordered immediately. (See Annex 3, Chapter Five, Prevention and Care of Sexually Transmitted Diseases including HIV and AIDS for calculating condom supplies.) As well as providing condoms on request, field staff should make sure that

refugees are aware that condoms are available and where they can be obtained. Condoms should be made available in health facilities especially when treating cases of STDs. Other distribution points should be established so that those requesting condoms can obtain them in privacy.

Prevent Excess Neonatal and Maternal Morbidity and Mortality

Provide Clean Delivery Kits for Use by Mothers or Birth Attendants to Promote Clean Home Deliveries

A refugee population will include women who are in the later stages of pregnancy, and who will therefore deliver within the initial phase. Simple delivery kits for home use should be made available for women in the late stages of pregnancy. These are very simple kits that the women themselves or traditional birth attendants (TBAs) can use. They can be made up on site and include: one sheet of plastic, two pieces of string, one clean razor blade and one bar of soap. UNFPA also supplies this kit.

A formula, based upon the Crude Birth Rate (CBR), is used to calculate the supplies and services required. With a CBR of three to five per cent per year, there would be some 75-125 births in a three-month period in a population of 10,000. From this, a calculation can be made as to how many kits should be ordered.

Provide Midwife Delivery Kits (UNICEF or equivalent) to Facilitate Clean and Safe Deliveries at the Health Facility

In the early phase of an emergency, births will often take place outside the health facility without the assistance of trained health personnel. Approximately 15 per cent of births will involve some complications. Complicated births should be referred to the health centre. The supplementary unit of the New Emergency Health Kit 98 (NEHK-98) has all the materials needed to ensure safe and clean normal deliveries. Many obstetric emergencies can be managed with the equipment, supplies and drugs contained in the NEHK-98. Obstetric complications that cannot be managed at the health centre should be stabilised before transfer to the referral hospital.

Initiate the Establishment of a Referral System to Manage Obstetric Emergencies

Approximately three to seven per cent of deliveries will require Caesarean section. Additional obstetric emergencies may need to be referred to a hospital that is capable of performing comprehensive essential emergency obstetric care. (Refer to Chapters Three and Seven for information on pregnancy and delivery complications.)

As soon as the situation permits, a referral system that manages obstetric complications must be available for use by the refugee population 24 hours a day. Where feasible, a host-country referral facility should be used and supported to meet the needs of refugees. If this is not feasible because of distance or the inability of the host-country facility to meet the increased demand, then an appropriate refugee-specific referral facility should be provided. In either case, it will be necessary to co-ordinate with host-country authorities concerning the policies, procedures and practices to be followed within the referral facility. The protocols of the host country should be followed, although some variation may

have to be negotiated. Be sure that there is sufficient transport, qualified staff and materials to cope with the extra demands.

Plan for the Provision of Comprehensive RH Services, Integrated Into Primary Health Care, as Soon as Possible

It is essential to plan for the integration of RH activities into primary health care during the initial phase. If not, the provision of these services may be delayed unnecessarily. When planning, it is important to include the following activities:

- The collection of background information on maternal, infant and child mortality, available HIV/STD prevalence and contraceptive prevalence rates (CPR). This information can be obtained from the refugees' country of origin from such sources as WHO, UNFPA, the World Bank and Demographic and Health Survey (DHS). Gathering this information could be the responsibility of the Headquarters of the implementing agencies who may have ready access to these data.
- The identification of suitable sites for the future delivery of comprehensive RH services (as described in the remainder of this Field Manual). It is important to address the following factors when selecting suitable sites:
 - security both at the point of use and while moving between home and the service delivery point
 - accessibility for all potential users
 - privacy and confidentiality during consultations
 - easy access to water and sanitation facilities
 - appropriate space
 - aseptic conditions
- An assessment of the capacity of staff to undertake comprehensive RH services should be made and plans put in place to train/retrain staff. Equipment and supplies for comprehensive RH services should be ordered. This will allow comprehensive services to begin as soon as the situation stabilises.

Broad Terms of Reference for a RH Co-ordinator/Focal Point

Under the auspices of the overall health co-ordination framework, the RH Co-ordinator/Focal Point should

- be the focal point for RH services and provide technical advice and assistance on reproductive health to refugees and all organisations working in health and other sectors as needed.
- liaise with national and regional authorities of the host country when planning and implementing RH activities in refugee camps and among the surrounding population, where appropriate.
- liaise with other sectors (protection, community services, camp management, education, etc.) to ensure a multi-sectoral approach to reproductive health.
- create/adapt and introduce standardised strategies for reproductive health which are fully integrated within PHC.

- initiate and co-ordinate various audience-specific training sessions on reproductive health (for audiences such as health workers, community services officers, the refugee population, security personnel, etc.).
- introduce standardised protocols for selected areas (such as syndromic case management of STDs, referral of obstetric emergencies, medical response to survivors of sexual violence, counselling and family planning services, etc.).
- develop/adapt and introduce simple forms for monitoring RH activities during the emergency phase that can become more comprehensive once the programme is consolidated.
- report regularly to the health co-ordination team.

MATERIAL RESOURCES

New Emergency Health Kit–98 (NEHK-98)

The revised NEHK-98 (for 10,000 people for three months) contains the following supplies to implement the MISP:

- materials for universal precautions for infection control
- equipment, supplies and drugs for deliveries at health centres
- equipment, supplies and drugs for some obstetric emergencies
- equipment, supplies and drugs for post-rape management

A booklet-describing the NEHK-98 and how it can be ordered is available from WHO.

Reproductive Health Kit

A RH Kit for Emergency Situations has been developed by UNFPA, in co-operation with others, for use in refugee situations. It complements the NEHK-98 and should be ordered as needed to launch the MISP and support the referral system. The RH Kit is made up of 12 sub-kits, which can be ordered separately. Materials and supplies in sub-kits 3 and 6 are already available in the NEHK-98. To order RH sub-kits from UNFPA, contact the UNFPA Country Director in the country of asylum, the UNFPA Emergency Relief Office in Geneva or the UNFPA Procurement Office in New York. The RH Kit is targeted for use in the initial acute phase of the emergency. Once the situation stabilises, procurement of RH materials and supplies should be done along with other health programme supply and drug ordering.

A booklet describing the RH Kit and how it can be ordered is available from UNFPA. (See Appendix Four for contact addresses.)

What is in the UNFPA RH Kit

- For use at primary health care/health centre level: 10,000 population for three months.
 - 0 Training and Administration
 - 1 Condoms
 - 2 Clean delivery sets
 - 3 Post-rape management

- 4 Oral and injectable contraceptives
- 5 STD Drugs
- For use at health centre or referral level: 30,000 population for three months
 - 6 Professional midwifery delivery kit
 - 7 IUD insertion
 - 8 Management of the complications of unsafe abortion
 - 9 Suture of cervical and vaginal tears
 - 10 Vacuum extraction
- For use at the referral level: 150,000 population for three months
 - 11 A – Referral-Level Surgical (reusable equipment)
 - 11 B – Referral-Level Surgical (consumable items and drugs)
 - 12 Transfusion (HIV testing for blood transfusion)

MONITORING AND SURVEILLANCE

During the early phase of the emergency, a limited amount of data should be collected to assess the implementation of the MISP. Information on mortality and morbidity by age and sex should be routinely collected during the early phase of an emergency. Refer to Chapter Nine for more information on these indicators. Consider selecting MISP indicators from the following list.

MISP Indicators

- ***Incidence of sexual violence***

Monitor the number of cases of sexual violence reported to health services, protection and security officers.
- ***Supplies for universal precautions***

Monitor the availability of supplies for universal precautions, such as gloves, protective clothing and disposal of sharp objects.
- ***Estimate of condom coverage***

Calculate the number of condoms available for distribution to the population.
- ***Estimate of coverage of clean delivery kits***

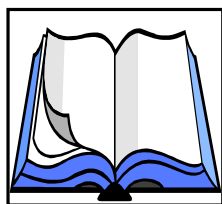
Calculate the number of clean delivery kits available to cover the estimated births in a given period of time.

CHECKLIST FOR THE RH MISP

- **Collect or estimate basic demographic information**
 - Total population
 - Number of women of reproductive age
 - Number of men of reproductive age
 - Crude birth rate

- Age-specific mortality rate
- Sex-specific mortality rate
- Number of pregnant women
- Number of lactating women
- **Prevent and manage the consequences of sexual and gender-based violence**
 - Systems to prevent sexual violence are in place
 - Health service able to manage cases of sexual violence
 - Staff trained (retrained) in prevention and response systems for cases of sexual violence
- **Prevent HIV transmission**
 - Materials in place for adequate practice of universal precautions
 - Condoms procured and distributed
 - Health workers trained/retrained in practice of universal precautions
- **Prevent excess neonatal and maternal morbidity and mortality**
 - Clean delivery kits available and distributed
 - UNICEF midwife kits (or equivalent) available at the health centre
 - Staff competency assessed and retraining undertaken
 - Referral system for obstetric emergencies functioning
- **Plan for the provision of comprehensive RH services**
 - Basic information collected (mortality, HIV prevalence, CPR)
 - Sites identified for future delivery of comprehensive RH services
- **Identify an organisation(s) and individual(s) to facilitate the MISP**
 - Overall RH Co-ordinator in place and functioning under the health co-ordination team
 - RH focal points in camps and implementing agencies in place
 - Staff trained and sensitised on technical, cultural, ethical, religious and legal aspects of RH and gender awareness
 - Materials for the implementation of the MISP available and used

Sexual and Reproductive Health



Reading 4.2:

The International Rescue Committee's Reproductive Health Programme

EXTRACT TAKEN FROM: HOW TO GUIDE: REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS, REPRODUCTIVE HEALTH EDUCATION FOR ADOLESCENTS, IRC N'ZEREKORE, GUINEA, FEBRUARY 1998

HOW IS IRC'S EDUCATION PROGRAMME IN GUINEA ORGANISED?

Since 1991, the International Rescue Committee in Guinea has provided education to Liberian and Sierra Leonean refugees through a formal school system. The programme started with 12,000 students at the end of 1990 and reached a high of 66,000 students in 1997. As of January 1998, the project continues to support 163 schools that are attended by about 60,000 students.

Refugee schools in Guinea are started on a self-help basis. A refugee community must contact IRC and show that there are at least 90 children available to attend the school. Once it has met this criterion, the community receives cement to build the foundation of the school and constructs the school up to the top of the doorways using mud bricks. When the construction has reached this point, IRC completes the school building.

The school receives continued support from IRC in various ways. The teachers and principals are paid by IRC and receive teacher training through the programme. Schools receive tables, benches, curricula, books, teaching aids, resource materials, and operating funds. Additionally, schools get assistance with the construction of latrines and wells.

The IRC/Guinea programme is planned, implemented, and supervised by the following departments: school administration, training, health, construction, vocational education, and administration/logistics. To maintain better control over activities in the field, an office (with staff from each department) is located in each of the four project regions (N'zerekore, Macenta, Gueckedou, and Forecariah).

WHAT ARE THE COMPONENTS OF THE IRC HEALTH EDUCATION PROGRAMME?

The IRC Health Education Department was started in 1994 to improve the health of refugee students through preventive health education. The health education programme covers a range of health topics such as nutrition, sanitation, preventable childhood diseases, and reproductive health. The projects implemented by the department include:

- formal health education classes
- health education seminars

- health clubs
- Young Women's Social Clubs
- reproductive health peer educator projects
- counselling projects

WHY WAS REPRODUCTIVE HEALTH EDUCATION INTEGRATED INTO THE FORMAL EDUCATION SYSTEM?

Discussions with adolescent students within the first year of the health education programme revealed that they wanted to learn more about how their bodies work, and preventing unwanted pregnancies, and STIs. Programme staff also identified the need for education about unplanned pregnancy and abortions, based on anecdotal information about the frequency in which they occurred.

WHAT ARE THE GOALS AND OBJECTIVES OF THE IRC REPRODUCTIVE HEALTH EDUCATION PROGRAMME?

The primary goal of the programme is to improve the sexual health and well-being of adolescent students and members of the surrounding refugee communities by increasing their knowledge of reproductive health problems and prevention and by promoting the use of condoms.

The objectives of the reproductive health education programme are:

- to increase knowledge about puberty, reproduction, contraception, STIs/AIDS and its' prevention among the estimated 14,500 5th-12th grade students
- to increase the use of condoms among approximately 14,500 adolescent students
- to build capacity and provide support for activities designed to increase the knowledge of 4,000 adolescent female students through workshops on reproduction, contraception, gender awareness, gender violence, and self-esteem
- to facilitate the delivery of reproductive health messages among students and teachers and the transfer of such messages from students to refugee community members through song and drama.

HOW IS REPRODUCTIVE HEALTH INTEGRATED INTO THE IRC HEALTH EDUCATION PROGRAMME?

The Health Education Department has made an effort to include reproductive health education in all aspects of its programme. This process is described below.

- **Health education classes** are held for two hours a week for pre-school through 6th grade students. The 4th-6th grade health education curriculum includes sections on human reproduction, puberty, menstruation, contraception, STIs, and AIDS. The health teachers for these grades have received training on these topics as well as the effective use of the curricula. Their schools have also been provided with adequate resource materials, books and visual aids to support their work.

- **Health Specialists and School Health Counsellors conduct education seminars on health talks** on a quarterly basis for 5th-12th grade students. A typical health talk lasts 1.5 hours, and is presented to each class separately. The health talks are intended to focus on topics that junior and senior high school students do not learn in their regular coursework. Reproductive health topics have been a major focus since students consistently request more information about these issues. Previous health talks have included topics on: human reproductive systems, condom use, HIV/AIDS prevention, STIs prevention, and contraception.
- **Health Clubs** are voluntary after-school clubs. They can be set up at schools of any grade level and any interested student is welcome to join. A health teacher often volunteers to sponsor the club and usually attends meetings to help motivate the members. Each club elects officers. Where School Health Counsellors visit schools, counsellors work closely with club members to develop and implement health-related activities. Counsellors also play an instrumental role in helping form new clubs. Health clubs implement a variety of activities including songs and dramas, clean-up campaigns, gardening, building urinals, and creating posters. Reproductive health related activities centre around songs and dramas. Health clubs have also played an important role in presenting special programmes on World AIDS Day to educate other students about HIV/AIDS and AIDS prevention. There are currently health clubs in about half (78) of IRC schools with membership ranging from 15 to over 60 students.
- **Young Women's Social Clubs (YWSCs)** are also voluntary after-school clubs. Membership is limited to female students at least 15 years old. As a result, YWSCs are generally based in junior and senior high schools. YWSCs were created to provide peer support and promote the health and well-being of club members, fellow female students, and community members through education, discussion, recreation, and other activities designed to increase awareness of women's issues. There are 25 YWSCs in IRC schools and membership ranges from about 15 to 20 students. Each club has a female sponsor, usually a health teacher, School Health Counsellor, or nurse from the refugee community, who attends the club's meetings and serves as a resource person. The club members meet on a regular basis to discuss reproductive health and women's issues.

Topics groups have covered include:

- Menstruation
- Reproduction
- Rape
- Contraception
- Abortion
- STIs/AIDS prevention
- Equality of women and men
- Importance of girls' education

- **Women's careers**

The clubs receive reference books, pamphlets, and posters on reproductive health, gender issues, and self-esteem often used to guide their discussions. A few members from each club also received training on gender awareness and self-esteem. These members are expected to develop activities to transfer the information they learned at the workshop to other members of the club and to other community members.

- **Peer educators** were recruited by the Health Education Department in all junior and senior high schools in 1997. Two to four individuals (depending on the size of the school) were invited to attend a three-day workshop where they learned about reproduction, contraception, condom use, STI/AIDS prevention, and communication skills. Half of the peer educators trained were female and half were male. Since returning to their schools their role has been to:
 - provide one-on-one reproductive health education to fellow students upon request
 - hold group educational activities including dramas, songs, health talks, and games, and
 - sell condoms to students, teachers, and community members.

Peer educators keep half of the proceeds of each condom sale and return the other half to IRC to purchase additional condom supplies. Each peer educator is also provided with a wooden penis used to demonstrate proper condom use. Late in 1997, the programme was extended to upper elementary level schools and a workshop for a second batch of peer educators was held. After the second workshop, there were 140 trained peer educators in 51 IRC schools.

- **The counselling programme** offers young people with special reproductive health problems or issues the assistance of a trained adult. Counsellors are available approximately once a week for counselling sessions at each of the schools they visit. Students can obtain a referral for family planning or STI services or talk to counsellors about problems with family, partners, sexual harassment, or rape. Counsellors are also available to talk to teachers when requested.

WHEN AND WHY WERE DIFFERENT ELEMENTS OF THE PROGRAMME ADDED?

The current IRC adolescent reproductive health education programme reflects an evolution over a period of three years. Different elements of the programme were added as the need arose. In 1994, the programme consisted of the health education curriculum and health talks. The most basic element of the health education programme are the classes provided to pre-school-6th grade students. Health talks were added to provide older students (especially those in 7th-12th grades) with health education no longer offered in their curriculum and to cover topics not included in their science curriculum. The idea of student-run health clubs was initiated in 1995 to give the students a chance to put the health education information they were learning into practice and to spread the messages beyond the school population.

In 1996, the condom distribution project and Young Women's Social Clubs were piloted. The condom distribution project was initiated in response to a need among adolescent students for access to methods for preventing unwanted pregnancy and STIs. The YWSCs were set up as means of collecting data to field test a refugee reproductive health needs assessment guide. Subsequently, they took on a life of their own and became discussion groups for women only. The pilot condom distribution project was not successful because students were embarrassed to buy condoms from teachers. As a result, the condom project was transformed into the peer educator programme in 1997, and an education component was included.

In 1997, the counselling programme was also added. A need for counselling services had been identified as early as 1995, when teachers and school administrators noted problems with students who had trouble concentrating on their studies and with ex-combatants who acted out in class. In addition, Health Specialists had remarked on the large number of unplanned pregnancies and attempted abortions. However, the counselling programme was not implemented until 1997 due to insufficient funding.

HOW DO THE DIFFERENT PARTS OF THE PROGRAMME WORK TOGETHER?

IRC's adolescent reproductive health programme is made up of a number of different initiatives. Although each initiative fills its own niche, there is overlap in some areas.

This service mix ensures maximum coverage of approximately 14,500 adolescent students despite the small number of health education programme staff.

- **Reproductive health sections** of the 4th-6th grade health education curriculum provide students with basic knowledge or reproductive health within a classroom setting.
- **Health talks** serve as sex education classes for older students who are no longer receiving formal health education classes.
- **Peer education** component offers students a chance to get information on pregnancy and STI/HIV prevention or to purchase condoms from people their own age.
- **Counsellors** help students with a range of issues including those related to reproductive health.
- **Young Women's Social Clubs** provide a comfortable forum for young women to meet and talk about reproductive health issues. These clubs also give young refugee women a source of recreation and peer support.
- **Health clubs** reach the general student population and the refugee community with messages that focus on STI and AIDS prevention.

The reproductive health education programme benefits the students who are directly involved by providing information and resources. Their involvement also provides a sense of belonging, special status among their peers, and an opportunity to take control of their lives. Through students' own efforts, the programme also reaches out to IRC teachers and refugee community members.

WHAT IS THE ORGANISATIONAL STRUCTURE OF IRC'S HEALTH EDUCATION DEPARTMENT?

The staff of the Health Education Department is comprised of a Health Education Manager, three Health Specialists, and 18 School Health Counsellors. The Health Education Manager is responsible for planning and co-ordinating the implementation of all aspects of the health education programme. Her responsibilities include:

- supervising Health Specialists and counsellors
- designing new programme initiatives
- developing new programme materials
- planning and implementing training programmes and workshops for students, teachers, and counsellors
- purchasing appropriate education materials
- co-ordinating activities with other IRC departments and other NGOs
- writing proposals and reports to funders
- developing and monitoring the departmental budget
- monitoring and evaluating health programme activities.

One of the major tasks of the three regional Health Specialists is to supervise the School Health Counsellors. Health Specialists also conduct health talks in the schools with 5th grade and above that are not covered by the counsellors. They are responsible for helping to develop training materials and for serving as facilitators during training workshops for students, teachers, and counsellors. In addition, Health Specialists assist with the periodic revision of the health education curriculum and monitor health teachers' use of the curriculum on a regular basis. They also ensure that supplies (including condoms, books, posters, etc.) are distributed appropriately. Finally, they help carry out needs assessments and the evaluation of programme activities.

There are six School Health Counsellors located in each of the three large project regions (N'zerekore, Macenta, and Gueckedou). The counsellors are based in refugee camps and communities, and provided with bicycles for transport. Each counsellor is assigned to visit 3-6 schools as outlined in his or her weekly schedule. Counsellors are responsible for:

- providing first aid for students and teachers during school hours
- providing students with individual counselling sessions on a range of issues
- conducting health talks for students in 5th-12th grades
- advising club leadership, motivating members, facilitating sponsorship and serving as a resource to health clubs and Young Women's Social Clubs
- monitoring condom sales and promoting condom use
- acting as resource person for health teachers

- co-ordinating school health activities that promote refugee health with the activities of other NGOs.

Although there are only 18 counsellors in the IRC system, approximately half of the schools (about 80) are receiving their services.

In addition to the staff described above, there are more than 280 teachers conducting formal health education classes in IRC's elementary schools. All teachers, including health teachers, are hired, deployed, and supervised by the School Administration Department. To ensure the quality of health instruction, the Health Education Department has requested that the number of health teachers per school should be as small as possible. As a result, in larger schools (those going up to at least 5th or 6th grade) it is possible for one teacher to get enough work hours per week by rotating through all grade levels to teach health education classes. In the smaller schools, that only have students in pre-school to 3rd or 4th grade, it has not been possible to rearrange teachers' schedules so that each teacher instructs the health education classes for his or her grade level.

HOW WERE STAFF RECRUITED AND TRAINED?

The Health Education Manager is an expatriate position recruited by IRC headquarters. Health Specialists were recruited from the refugee population. Qualifications for this position include:

- medical training to at least the level of registered nurse
- strong experience with health education
- supervisory experience
- teaching experience

New Health Specialists receive on-the-job training by shadowing and observing another Health Specialist or the Health Education Manager. Health Specialists also participate in frequent training-of-trainer workshops focused on specific topics or skill areas.

Candidates for the School Health Counsellor positions are identified by Health Specialists from among refugees living in specific camps and towns who were already trained as nurse's aids, practical nurses, registered nurses, or physician's assistants. Qualified individuals were asked to fill out a form about their educational and professional background. This was followed by interviews and final selection. Qualifications for the counsellor position included:

- previous medical training (preferably at least to the level of licensed practical nurse)
- experience providing health education
- experience working with groups of young people
- some concept of or experience with counselling

Newly hired counsellors attended a three-day training workshop designed to clarify their roles and responsibilities and that included sessions on first aid, self esteem, conflict resolution, post-traumatic stress syndrome, counselling, reproduction and contraception. Of the original eighteen counsellors, five have been replaced

during the course of the first year of the counselling project; most returning to their homes in Liberia. A second training, held when this HOW TO manual was being written, focused specifically on enhancing counselling skills. It gave counsellors a chance to learn more about the needs of young people and counselling theory as a basis for practical application of newly acquired skills.

The Health Education Department is also partially responsible for the training of health education teachers. In addition to the standard training course on teaching techniques and child development offered to all teachers by the Training Department, the Health Education Department occasionally holds special training workshops specifically for IRC health teachers. Most recently, in October 1997, they were trained on the use of the new 4th-6th grade health education curricula.

HOW ARE STAFF SUPPORTED AND SUPERVISED?

The Health Education Manager is based in the main IRC office located in N'zerekore. She makes visits to supervise the Health Specialists in the two other offices in the Forest Region (Macenta and Gueckedou) at least once every 4-6 weeks. Health Specialists based in each of the three offices are provided with motorbikes to visit schools and make monthly field visits to the School Health Counsellors in their regions.

The department holds regular meetings to provide support for staff and co-ordinate the various health education programmes. The Health Education Manager meets with all the Health Specialists about once every six weeks to plan for up-coming activities, co-ordinate the implementation of activities, and resolve problems. The Health Specialists hold regional meetings with their counsellors every two months. During these meetings, counsellors discuss their recent activities, job-related problems, and special issues they are addressing. The meetings also provide Health Specialists with an opportunity to explain any new programme initiatives or up-coming workshops, help the counsellor problem-solve, and distribute supplies. The Health Education Manager attends the counsellors' meetings wherever possible to stay in touch with what is happening in the field.

The Health Education Manager also meets at least once a month with the heads of the other IRC departments. These meetings are designed to promote information sharing between departments and facilitate inter-sectoral co-ordination. They also provide an opportunity for the manager to garner support for activities from other departments and to solicit their assistance in passing on information or carrying out distribution. Relevant information from inter-departmental meetings is relayed from the Health Education Manager to the Health Specialists.

WHAT MATERIALS DO THEY HAVE TO WORK WITH?

The Health Education Department is responsible for identifying, ordering, and creating adequate supplies of appropriate reproductive health education materials. IRC has developed or modified (from other sources) picture cards, games, and training materials. Some of the picture cards are distributed to schools for use by health education teachers, others are used by Health Specialists and School Health Counsellors during health talks and workshops. Some have also been distributed to Young Women's Social Clubs to stimulate discussion.

Songs and dramas on reproductive health topics play an important role in educating students and community members. The songs and dramas, mostly written by students, teachers, and Health Specialists, offer a simple, memorable way of communicating information. They have been included in a book produced by the department and distributed to all schools. Health clubs, peer educators, and YWSCs use songs and dramas they create or those taken from the department's book to present messages about reproductive health topics and the prevention of reproductive health related problems.

The department has finally compiled a good library of reference books, curricula, activity books, pamphlets, and videos on reproductive health topics. Reference books are distributed to health education teachers, YWSCs, peer educators, counsellors, and Health Specialists. The YWSCs were also given posters and brochures. Peer educators were given wooden penises to demonstrate proper condom use. Videos on contraceptive use, unplanned pregnancy, AIDS, STIs, and women's issues are shown to YWSC members, peer educators, and office staff near sub-offices to facilitate discussion.

HOW DID THE COMMUNITY'S ATTITUDE FACILITATE THE PROGRAMME?

The programme has been fortunate in that parents have generally been supportive of programme activities. There is openness among Liberians and Sierra Leoneans to discuss sensitive issues related to sexuality resulting in very little opposition to IRC's reproductive health education programme. Where teachers, principals, or parents have been opposed to information or activities, Health Specialists have been successful in addressing concerns, clarifying the programme purpose and gaining their support through direct contact.

Refugee communities have been involved in some aspects of the reproductive health education programme through local PTAs (Parent-Teachers Associations). PTAs are formed in every school and the members are informed about health talks and health clubs activities. PTA members and other parents have attended health talks and health club presentations of songs and dramas.

WHAT WERE THE COSTS INVOLVED?

IRC's reproductive health education programme has been supported by funding from the United States Bureau of Population, Refugees, and Migration (USBPRM), the Dutch Government (Stichting Vluchteling), and The Andrew W. Mellon Foundation, The David and Lucille Packard Foundation, and The Buffet Foundation.

Programme costs outlined here reflect annual expenses based on current programme activities provided to 163 schools covering most of the Guinea Forest and Forecariah regions (Forecariah is located about 700 kilometers from IRC's main office in N'zerekore). Main costs are salaries, per diem and local travel, programme supplies, training workshops, equipment, administrative costs, and other programme costs. Salaries, per diem and local transport are for the entire health education programme, not only the reproductive health education component.

PROGRAMME COSTS (US \$)

Salaries	60,000
Per diem and local travel	11,500
Programme supplies	11,000
Training workshops	12,000
Equipment	3,000
Administrative costs	13,000
Other programme costs	14,000
TOTAL	124,500

Current level programme costs equal about \$124,500 per year constitute about 4% of IRC/Guinea's annual budget, and is quite inexpensive considering the scale of the programme.

Salary expenditures represent salaries for one Health Education Manager, four Health Specialists, and 18 School Health Counsellors. The annual salary and benefits for the expatriate Health Education Manager total approximately \$30,000. Salaries for four Health Specialists total \$12,000 per year; with monthly salaries ranging from \$170 to \$225. School Health Counsellors are paid about \$85 per month totalling \$18,000 per year for all counsellors.

Per diem is calculated at a rate of about \$5/day for expatriates and \$3/day for local staff totalling \$2,500 per year for the Health Education Manager, Health Specialists, and School Health Counsellors. The \$9,000 cost of local travel covers the transportation to meetings for the Health Education Manager, Health specialists, School Health Counsellors, and peer educators and for field visits for the Health Education Manager and Health Specialists.

Programme supplies include books, pamphlets, videos, copybooks, pens, poster sheets, crayons, paint, tape, drums, costumes, cassettes, film, metal trunks, etc. Training includes workshops for teachers, counsellors, peer educators, and Young Women's Social Clubs member. Training costs are generally \$12 per participant per day including food, lodging and transportation.

The equipment line included in this budget covers the cost of department computer and printer. These items are essential to the programme. Administrative costs include expenses such as office supplies, insurance, financial services, etc. Administrative costs were calculated at about 12% of the total reproductive health education budget.

Finally, other programme costs include items such as health fairs; World AIDS Day and International Women's Day events; zonal and regional song and drama competitions; and photocopying of picture cards and educational materials. The biggest expense in this line is for the song and drama competitions which require transportation, food, and lodging for a large number of students.

HOW IS THE PROGRAMME MONITORED AND EVALUATED?

The reproductive health care programme is monitored through a series of observation forms and monthly report forms. The Health Education Manager observes health talks conducted by Health Specialists. Health Specialists observe health talks given by counsellors as well as health teachers during health education classes. The counsellors, peer educators, health clubs, and YWSCs submit monthly activity reports to the Health Specialists. Counsellors and peer educators also submit monthly condom sales logs. This information is combined with the activities of the Health Specialists and included in the monthly reports submitted to the Health Education Manager.

Programme evaluation is done via student reproductive health surveys. The Health Education Manager and Health specialists conducted the first survey in March-May 1997. Using a self-administered questionnaire, the department collected information on reproductive health knowledge, attitudes, and behaviours of 1,100 IRC students in 7th-12th grade. This will provide baseline data for future analysis. A second survey will be conducted before the end of the 1997/1998 academic year to assess changes in knowledge, attitudes, and/or behaviours.

WHAT WERE THE RESULTS AND ACHIEVEMENTS OF THE PROGRAMME?

The IRC Health Education Department is unable to report quantitative changes in students' knowledge, attitudes, and behaviour related to reproductive health issues at this time. Results of the 1997/98 survey will provide this information. The project's results and achievements are currently measured in terms of materials produced and distributed, people trained, level of participation in programmes, and activities implemented. In this respect, a great deal of work has taken place. Some of the successes are as follows.

MATERIALS DEVELOPED AND/OR DISTRIBUTED

- Developed new 4th, 5th and 6th grade health education curriculum.
- Produced 7 IRC picture cards on reproductive health topics and distributed to all elementary schools for use during 1997 health education classes.
- Supplied elementary schools with reference books for health teachers such as *Understanding Reproduction, Birth and Contraception, What's a Virus Anyway?* and *AIDS - Answers to Questions Kids Ask*.
- Distributed IRC-produced visual aids to YWSCs including 4 picture cards on unsafe abortion, 1 on rape, 1 on gender-based violence, and 6 pictorial discussion starters on relationships between men and women.
- Supplied YWSCs with reference books and pamphlets such as: *Our Bodies, Our Selves; Where Women Have No Doctor; It's Perfectly Normal; What's Happening to My Body; Making a Life for Yourself; and Having Your Period* and posters on the male and female reproductive systems, STIs, and AIDS.
- Produced and distributed a small booklet with games and activities related to STI/AIDS prevention to peer educators as well as copies of *It's Perfectly Normal*.

- Developed a take-home training packet on reproduction, contraception, STIs, AIDS, condom use, and communication skills for student peer educators.
- Created take-home training materials on reproductive health and counselling skills for School Health Counsellors.
- Developed special materials on reproductive health including picture cards, puzzles, flashcards, and games for health talks and workshop sessions.

TRAINING WORKSHOPS CONDUCTED

- Trained 279 health teachers in the use of the new health education curriculum as part of a three-day workshop held in October 1997. This workshop also included a session on STIs and their prevention.
- All IRC teachers participated in workshop sessions on human reproduction and contraception (February 1997) and on AIDS and its' prevention (October 1997).
- Trained first group of 96 peer educators in regional three-day workshops held in June and July 1997. Second group of 83 peer educators trained in November and December 1997. This group also included students from grades 5 and above.
- A 3-day workshop on counselling skills was held February 1998 for 17 counsellors.
- In 1996 trained six leaders of pilot YWSCs on participatory data collection techniques used to collect reproductive health data from YWSC members.
- Regional 3-day workshops on gender awareness and self-esteem were held in December 1997 for 91 YWSC members.
- Trained 136 health club members to write and produce health songs and dramas during regional three-day workshops held in July 1997.

OTHER ACTIVITIES

- Developed and presented six health talks since 1995 on various reproductive health topics to 5th-12th grade students.
- In 1997, Health Specialists held health talks on AIDS and condom use for 436 vocational students and 61 office staff.
- Trained 140 peer educators who were working in 51 schools by end of 1997.
- Presently, 25 Young Women's Social Clubs are functioning in junior and senior high schools.
- Seventy-eight active health clubs.
- Created new song and drama book from entries submitted by students, teachers, and Health Specialists as part of a system-wide competition. The book designed for use by health clubs includes many entries on reproductive health topics such as unwanted pregnancy, STIs, AIDS, condom use, and abortion.

- School Health Counsellors provided 349 individual counselling sessions per month.
- Peer educators who submitted monthly reports in 1997 held an average of 1,516 one-on-one education sessions and conducted 107 group activities per month.
- On average, peer educators and school Health Counsellors sold 2,418 condoms per month.
- In 1997, 30 schools/health clubs held special programmes for World AIDS Day.
- Needs assessment for reproductive health programme and for Young Women's Social Clubs completed.
- Completed strategic plan including mission statement, job description for sponsors, and programme plan for YWSCs for 1998 with input from club members and Health Specialists.
- Completed data entry and analysis of student reproductive health survey conducted in early 1997.
- Continue to support the implementation of a policy that allows pregnant students to remain in school throughout their pregnancies enabling female students to complete their education.

WHAT ARE IRC'S PLANS FOR FUTURE REPRODUCTIVE HEALTH ACTIVITIES?

The Health Education Department plans to continue reproductive health education in IRC schools through 1998. On-going initiatives and activities include health education classes, health talks, peer education, YWSCs, counselling, and health clubs. Future activities will also include:

- **Health Talks** - A health talk on contraception has recently been conducted with plans to conduct one on another reproductive health topic underway.
- **Peer Educators** - The department hopes to maintain peer educators in all schools with grades 6 and above and to provide them with additional support. Regional meetings to enable peer educators to discuss problems and success will be held. They will also form committees responsible for producing regional peer education newsletters each semester and developing regional education campaigns. The department will provide training on visual aid design to all interested peer educators to assist committees in carrying out large-scale educational campaigns.
- **Young Women's Social Clubs** -The Health Education Department plans to maintain YWSCs in all junior and senior high schools. In celebration of International Women's Day the department will support the clubs in conducting programmes and will sponsor a poster and essay contest. In addition, a training of trainers workshop will be held for selected club members on reproductive health and gender violence. Participants will then develop activities or educational sessions, transferring newly acquired information to

other female students and club members. The department will also continue its efforts to provide supplies, reference materials and visual aids to the YWSCs.

- **Counselling** - The counselling programme will continue as will activities designed to improve the counsellors' ability to do their job. To this end, counsellors are receiving training on counselling skills. If funding is available, the counselling programme in the Forest Region will be extended to cover additional schools.
- **Health Clubs** - In 1998, IRC will also continue to support its health clubs by providing financial support for mini-health fairs (a portion of which focus on reproductive health issues) and World AIDS Day programmes. The department also plans to hold zonal and regional song and drama competitions in which clubs from different schools will present their songs and dramas to a panel of judges. The winning songs will be compiled on a cassette for distribution to all health clubs.
- **Programme Expansion** - In 1998, the Health Education Department plans to extend many of its activities to the Forecariah Region in order to serve the Sierra Leoneans who are still entering Guinea in that area. Plans are also underway to hire a Health Specialist, set up the peer educator programme in schools with 6th grade and above, start Young Women's Social Clubs in junior and senior high schools, and provide more support for health clubs in the Forecariah Region. The department will also select and train one health teacher from each of the ten schools in this region to provide counselling and first aid services, in addition to their teaching duties.

WHAT CHALLENGES WERE ENCOUNTERED?

The IRC/Guinea's Health Education Department has faced a number of challenges since its formation. One basic problem has been a lack of internal support for the health education programme. In the past, local staff members of other IRC departments did not understand the importance of health education or the role of the Health Education Department within a formal school system. As a result, these staff members were reluctant to assist the Health Education Department in carrying messages to schools, checking on the status of the clubs, or helping distribute materials. Expatriate administrators of the IRC/Guinea have also not always been supportive of the health education programme resulting in the lack of a department head or, as in parts of 1995 and 1996, sharing a department head with the Training Department. Under both of these arrangements, the Health Education Department lacked direction and did not implement many new initiatives. This problem was alleviated late in 1996 when a Health Education Manager was hired specifically to co-ordinate the activities of this department.

The level of support for the health education programme from the IRC administration has significantly increased since mid-1996. Under the current administration, the importance of open communication has been facilitated by regular inter-departmental meetings resulting in changes in the attitudes of other departments toward the Health Education Department. However, continued efforts need to be made in this regard.

Another major challenge faced by the Health Education Department has been the lack of adequate funding to carry out activities. Without sufficient funding, planned activities were not implemented or their implementation was delayed. Materials for offices, schools, and other programme participants were not purchased, and adequate numbers of staff members could not be hired.

In past years, the financial difficulties of the Health Education Department was related to lack of support from IRC administrators, who did not make efforts to search for adequate funding for department activities. Problems also resulted from key line items being left out of programme budgets (i.e. programme supplies or food and lodging for workshops). The department is looking forward to the resolution of funding problems in 1998. The current administration has allowed departments to develop their own budgets and has used them as a basis of soliciting funding.

A third problem faced by the Health Education Department has been the lack of a good needs assessment at the beginning of the programme. The department was started based on a few individuals' impressions of the health status and health education needs of refugee students. As a result, no clear programme goals and objectives were outlined at the start of the programme, the specific needs of different groups of refugee students were not always taken into consideration. An effort to systematically collect information on the reproductive health education needs of refugee students was first implemented in 1997. The department plans to continue collecting these kinds of data to better tailor the programme to the needs of the students.

Over the past three years, logistical problems have hampered the implementation of health education activities. These problems have been due both to the realities of working in Guinea and to the lack of continuous logistical expertise within IRC/Guinea. The IRC office has gone for months at a time without a qualified logistics co-ordinator and transportation and communication are ever-present problems in Guinea. As a result, it can take six months to a year for materials ordered overseas to arrive at the main office in N'zerekore. Distribution of newly arrived materials to schools, counsellors, and clubs, has been dependent on the good will of other programme staff travelling to rural camps rather than being handled by the Logistics Department.

The logistical problems are slowly being resolved. Guinea is slowly developing its infrastructure, new roads are under construction and communications systems are being up-graded. Within IRC, a local staff member has been hired to handle logistics and new logistical systems are being put into place. However, much work on both the national and organisational level remains to be done.

WHAT WOULD IRC LIKE TO DO DIFFERENTLY NEXT TIME?

If IRC were to replicate this project, it should:

- **Conduct a needs assessment at start of programme.** This would help develop appropriate goals and objectives early in the programme and would allow activities to be tailored to the needs of the students.
- **Initiate the programme sooner after the refugees arrive.** IRC's Health Education Department was not initiated until refugees had already been in

Guinea for three to four years, and the reproductive health education programme was started even later. If the programme had begun sooner, more students would have benefited.

- **Get teens involved sooner** Having teens involved in programme planning and implementation would help to boost their self-esteem and would ensure that the programme fits their needs.
- **Hire more staff earlier in the programme.** Until early 1997, when the School Health Counsellors were hired, two or three Health Specialists struggled to conduct and monitor all school-based health education activities. This limited the number and supervision of activities.
- **Get resource materials out to the field sooner.** The majority of the reproductive health education materials currently in use were obtained in 1997. This means that Health Specialists and teachers worked for about three years without adequate reference or resource materials.
- **Ensure that staff has adequate materials and supplies to carry out their work.** Health Specialists, School Health Counsellors, and health teachers need a minimum amount of supplies and resource materials to do their work effectively. As stated above, the Health Education Department has often lacked necessary materials.
- **Make sure all IRC departments “buy in” to the importance of health education, especially reproductive health education, as a part of a formal education system.** This could be accomplished by educating members of other departments about the importance of health education, keeping heads of other departments updated on activities planned by the Health Education Department, and by requesting input from heads of other departments about the implementation of programme activities, where appropriate.
- **Make a clearer distinction between health clubs and YWSCs.** Because the Young Women’s Social Clubs were started on a pilot basis, members have not had a clear idea of the goals of the club or the types of activities they should conduct. As a result, some YWSCs have begun to do activities that are very similar to those of health clubs (e.g. gardening). YWSC members need to receive guidelines about the purpose and function of the clubs shortly after their formation. Otherwise there is the risk that the YWSCs will become girls’ health clubs (rather than clubs focused on women’s issues).
- **Keep records about past department activities.** Clear records describing the implementation of past activities are required to ensure programme continuity and to carry out programme evaluation.
- **Educate local UNHCR offices on the importance of reproductive health education.** UNHCR has not been willing to fund IRC’s reproductive health education programmes. Therefore, a plan to educate local UNHCR offices about its importance should be implemented.
- **Ensure that budgets contain all line items needed for effective programme implementation.** Omitting key line items has made it difficult to implement reproductive health education activities as planned.

- **Initiate monitoring and evaluation of programme from its' inception.** This would include developing tools to monitor activities of the health clubs, YWSCs, counsellors, and Health Specialists on a monthly basis. In addition, a baseline survey of students' reproductive health knowledge, attitudes, and behaviours should be conducted early on for use as comparison data for future impact and outcome evaluations.

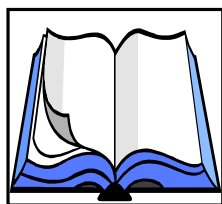
WHEN WILL THE PROGRAMME END?

The IRC formal education and health education programmes in Guinea are on going. Although Liberians are starting to go home, we plan to continue our programmes for them until the end of the current school year (i.e. July 1998). Given student interest and commitment to continue reproductive health education initiatives, we hope to secure adequate funding to follow the Liberians home and implement a similar programme in the counties adjoining Guinea (i.e., Lofa, Bong, and Nimba). This is not likely to be possible without sufficient support or supervision. IRC will remain in Guinea and existing programmes will continue for Sierra Leoneans until the conflict in that country is resolved.

HOW CAN THIS PROJECT BE SUSTAINED WHEN REFUGEES RETURN HOME?

As stated above, IRC hopes to transfer all or part of its reproductive health education programme to the school system in Lofa, Bong, and Nimba counties in Liberia. To replicate this project or create a similar one, funding will be required to pay for staff salaries and training. In addition, although materials developed or purchased in Guinea could be transferred to schools in Liberia, the larger number of Liberian schools will necessitate the purchase of additional materials. YWSC members have expressed their interest in continuing with their efforts in Liberia. However, it would be difficult for refugee students returning home to maintain the programmes initiated in Guinea without adequate support or supervision.

Sexual and Reproductive Health



Reading 5.1:

Learning and Teaching about AIDS in School

EXTRACT TAKEN FROM: LEARNING AND TEACHING ABOUT AIDS IN SCHOOL; UNAIDS TECHNICAL UPDATE OCTOBER 1997.

THE CHALLENGES

Despite the evident desirability of providing AIDS education to students, there are various obstacles standing in the way, including the following.

The Subject Is Considered too Controversial

In many societies, the adults responsible for children or their school education are often uneasy about teaching children about AIDS and sexual risk behaviour. They may feel that this encourages young people to experiment prematurely - even though several studies have shown that sex and HIV/AIDS education do not lead to increased sexual activity (see Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People, 1997). Policy-makers, teachers and parents with such views can object to the introduction of school HIV prevention programmes, on the grounds that the topic is too sensitive for children or controversial for society.

Overcrowded Curriculum

It is often difficult to find a slot for AIDS education in an already full and overcrowded school curriculum, especially when there are many issues competing for space. In theory, health education, which could embrace AIDS education, is supposed to be taught in schools, but in practice is often neglected.

Incomplete Coverage

Many schools do not have AIDS education. The reasons vary. The country may have no policies on AIDS education, or a particular policy specifically against AIDS education - or policies in favour of AIDS education that are vague or not properly enforced. In some cases policy-making on education is decentralised, so that education authorities in some districts include AIDS education in their curricula while others do not.

AIDS education - where it exists at all - is usually taught only in secondary schools. However, with high dropout rates in many schools, children - and particularly girls - frequently have left school before secondary school age, with the result that they do not get school AIDS education.

Information Is Taught, but not Skills

HIV education may be provided in schools, but it may deal only with medical and biological facts, and not with the real-life situation that young people find themselves in. Only if life skills are taught, and matters such as relationships, sexuality and the risks of drug use are discussed, will young people be able to handle situations where they might be at risk of HIV infection.

Poor Quality of Curriculum

This could be for several reasons, including:

- important areas of AIDS education, such as non-discrimination and support, are omitted;
- learning materials may be inadequate - for example, they stress biomedical information instead of social skills and means of prevention, or they are not age-specific, or else bear little resemblance to everyday life;
- materials for teachers may not exist;
- teachers may not be properly trained to organise classroom activities on sensitive issues;
- only one option in terms of sexual behaviour (for example, that of abstinence) is offered, regardless of the age of the students;
- the objectives of the course are not clearly identified, or refer only to knowledge, attitudes and values - not to behaviour;
- there is no provision for assessing how well students have learnt;
- AIDS education is not meaningfully integrated into the curriculum and its links with other health and social issues are not brought out;
- no education is provided on referral services, such as further information and skills training, counselling, and youth-friendly STI services.

THE RESPONSES

Young people are a huge asset to society, and it is worth investing in them to help bring the *overall* HIV epidemic under control. This can be done by promoting effective school programmes, complemented by preventive interventions in the community and through the media.

A Partnership to Reach a Satisfactory Consensus

Various “gatekeepers” normally determine whether and what kind of AIDS education is taught in schools, including policy-makers, religious leaders, parents, teachers and teachers’ associations. Although they may consider some aspects of AIDS education controversial or unacceptable, there is likely to be some consensus among them on certain issues - for instance, that students need protection from sexual abuse, that they should be able to refuse drugs, and that educational equality between boys and girls should be increased. It is wise to build on this existing consensus to create a partnership.

One then gradually extends the consensus to other matters - such as the premises that young people can learn how to make sound decisions, including

about avoiding risk behaviour, and that society should help rather than hinder them in such matters. One can promote agreement that some social norms are harmful because they encourage inequalities between girls and boys, or otherwise increase the vulnerability of young people - and that these norms should be challenged - while other norms that help protect them (such as school education for girls) should be defended.

It is encouraging to note in this context that wherever parents' views have been examined, studies show that parents always tend to support AIDS education in schools. Among these studies are on conducted by WHO in 1994 in Ethiopia and an evaluation in five Middle East countries in 1996 (see Report on Evaluation of Pilot Project on HIV/AIDS Education in UNRWA School and Other Institutions, UNRWA, Health Department, Amman, 1996).

In parallel, the partnership can be strengthened by involving the "gatekeepers", together with non-governmental organisations and young people, in conducting a situation analysis (see below), in disseminating the results of a pilot project or other piece of research on AIDS education, or in the launch of a school-based initiative.

Sound Policies on AIDS Education

Once a consensus is reached on basic assumptions among those responsible for the education of young people, then a set of national policies on AIDS education can be formulated. Even a one-or two-page policy document can suffice for effective programmes. The policies should cover the following areas:

- complete coverage of AIDS education in schools, in terms of geographic location and class level (age group);
- pre-service and in-service training for teachers;
- collaboration between parents, education authorities and community leaders in formulating curricula (see Pilot Projects on School-Based AIDS Education: A Summary, Geneva, WHO/UNESCO, 1994);
- definition of objectives and contents of the curriculum, as well as extracurricular activities, and integration of HIV/AIDS and STIs into selected subjects;
- links with local health services capable of providing friendly and welcoming STI and reproductive health services, including counselling, contraceptives and condoms, to young people.

An important principle when devising policy relating to AIDS and schools is that of human rights. Students and school staff living with HIV or AIDS have the right to education, to freedom from discrimination, to confidentiality, privacy, autonomy and security of the person, and access to information and education.

Make a Situation Assessment and Design a Good Curriculum

Several steps are recommended in designing a good curriculum for AIDS education, the first of which is to make a proper situation assessment. This involves studying students' patterns of behaviour relating to risk of HIV - finding out, for instance, at what median age they first have intercourse, what are their most common forms of sexual behaviour and of drug consumption (including alcohol), and when they tend to leave school. Such an assessment should start by

asking young people's views: what they think their emotional needs are, or what they want to happen when they have a boyfriend or girlfriend. Asking young people is essential for evaluation, as they are the users of the service. It is necessary too, given that young people do not necessarily share adults' attitudes on sexual and drug behaviour. The students must be assured of confidentiality so that they give honest responses.

The results of this situation assessment have a direct bearing on the rest of the curriculum design. The steps to be taken here include the following (each step is described in School Health Education to Prevent AIDS and STI. vol. 1, pp.11-30):

- defining the type of programme (including the age at which it is to be introduced)
- selecting objectives for the programme
- making a curriculum plan
- planning specifically for the production of learning materials, and for activities of the students
- developing teachers' guides (many good guides exist, or can be adapted; see, for example, School Health Education to Prevent AIDS and STI) and planning teachers' training
- planning orientation sessions for school administrators to gain their continuing support.

Ensure an Effective AIDS Education Programme

Effective programmes are those that have had a positive influence on behaviour as regards sex, drug use and non-discrimination - and not simply increased knowledge and changed the attitudes of students. It has been shown that effective programmes do all the following things:

- focus on life skills - particularly relating to decision-making, negotiation and communication - with the double aim of delaying first sexual intercourse and encouraging protected intercourse;
- concentrate on personalising risk through appropriate role playing and discussions;
- discuss clearly the possible result of unprotected sex - and in equally clear terms the ways to avoid such an outcome. Explain where to turn for help and support among peers, school staff and outside facilities;
- stress that skills useful for self-protection from HIV also help build self-confidence and avoid unwanted pregnancy, sexual abuse, and the abuse of drugs (including tobacco and alcohol);
- reinforce values, norms and peer group support for practising and sustaining safe behaviour and resisting unsafe behaviour, both at school and in the community;
- provide sufficient time for classroom work and interactive teaching methods such as role play and group discussions.

The most important HIV-related skills young people can learn are:

- how to make sound decisions about relationships and sexual intercourse, and stand up for those decisions;
- how to identify one's own personal reasons for resisting pressures for unwanted sex or drugs;
- how to recognise and avoid or leave a situation that might turn risky or violent;
- how and where to ask for support and to have access to youth-friendly health services;
- when ready for sexual relationships, how to negotiate protected sex or other forms of safer sex;
- how to show compassion and support for people with HIV and AIDS;
- how to care for people with AIDS in the family and community.

Three other elements have been shown to be important for effective AIDS education in schools. One is teaching primary and secondary students to analyse and respond to social norms. Social norms are formed by the media, by young people's peers, and by society at large. These norms in turn influence behaviour. Students should learn to decode and analyse these norms and understand which ones act in a potentially harmful direction and which ones protect their health and well-being.

Sexual abuse can occur inside schools. It is thus necessary to ensure a healthy school environment and combat factors such as discrimination against female students, bullying, and physical and sexual abuse - by both school personnel and students.

A second necessary element is good training, both for the teachers themselves and for peer educators - young people from the same age group, specifically selected to educate their friends about AIDS.

A third, vital factor is that of age. All experience to date has proved that HIV prevention and health promotion programmes for children should begin at the earliest possible age, and certainly before the onset of sexual activity. Effectively, this means that age-appropriate programmes should start at primary school level. This has two important benefits. First, education starts before sexual activity does, thus preparing the students to cope with future risk activities. Second, the education reaches children before many of them have left or dropped out, and this is particularly so - in many countries- for girls, who tend to leave at a younger age. Examples of countries that start AIDS education programmes at primary school level include Malawi, Thailand, Uganda and Zimbabwe.

In Zimbabwe, for instance, all schools since 1993 have had compulsory weekly lessons on life skills and AIDS for all students from grade 4 (9-10 year olds) upwards. Booklets for students and teachers are designed for each grade, and address four main themes: relationships, growing up, life skills and health. Topics range from discussions on gender roles and rape to coping with emotions and stressful expectations. In the classroom, self-esteem and assertiveness are encouraged, and role playing suggests ways to respond to peer pressures. Apart from using booklets in the classroom, students also do projects in the community.

All materials are reviewed and approved by a committee including the national AIDS programme, the Ministry of Education, and representatives from the major religious denominations. A large teacher training programme helps prepare serving teachers, as well as students in teacher training colleges (see O'Donogue J. Zimbabwe's AIDS Action Programme for Schools: Flashback and Hindsight. Harare: UNICEF, 1995).

Taking Media Messages into Account

Young people are frequently exposed to and influenced by the media. While schools are teaching one set of messages, the media may be providing other, conflicting messages. School-based programmes should take these into account. Young people also need to be equipped with the skills to "decode" media messages.

Evaluation

It is important to evaluate the impact of school AIDS education on students' behaviour - not only their acquisition of knowledge or adoption of desired attitudes. Because skills are the best predictor of behaviour, impact evaluation usually involves measuring to what degree skills have been learnt and practised, and safe behaviour sustained. Specific evaluation tools have been developed for this purpose.

It is equally important to monitor the response of the education system to check: that the quality of teaching is satisfactory; that learning and teaching materials are used correctly; that the local community supports the programme; and that increasing numbers of students feel that they have benefited from it.

Sexual and Reproductive Health



Further Readings, Videos and Websites

RECOMMENDED READINGS:

Reproductive Health in Refugee Situations: An Inter-agency Field Manual (1999): Geneva, UNHCR. This inter-agency field manual is the result of a collaborative effort of many UN agencies, governmental and non-governmental organisations and refugee themselves. In several important areas, the field manual provides programmatic direction with frequent reference to additional resource materials that should be obtained and used to ensure comprehensive and reliable reproductive health services for refugees. This is essential reading for all topics in this resource pack

HOW TO GUIDE (International Rescue Committee/UNHCR) - Reproductive Health in Refugee Situations: Reproductive Health Education for Adolescents. Geneva, UNHCR. This How to Guide describes the reproductive health programme implemented by IRC in Guinea and explores lessons learned.

FURTHER READINGS:

Wellbourn, A., (1995): Stepping Stones: A training package on HIV/AIDS, Communication and Relationship Skills. Strategies for Hope Training Series No. 1. London, ACTIONAID.

HOW TO GUIDE (UNHCR) - Ngara Crisis Intervention Teams - A Community Based Response on Sexual Violence Against Women. Geneva, UNHCR. Based on the real-life experience at Ngara refugee camps in Tanzania this guide is aimed at sharing with others the thinking behind, and lessons learned from, one successful approach.

Enger, D and Winskell, K (1999): Scenarios from the Sahel, Replication Guide. Senegal, UNDP. This books describes a very successful HIV prevention project conducted in Senegal, Mali and Burkina Faso. The project is unusual in the degree of attention paid not only to content but also to process, with the result that, at each stage of its development, the needs and views of young people defined the direction that the project should take. This book provides guidelines on how to replicate the project in other areas. It is especially relevant to Topics 2 and 5.

Dept. of Child and Adolescent Health Development (2000), Meeting an Urgent and Unmet Need: Making Reproductive Health Services Available and Accessible to Forcibly Displaced Young People. Geneva, World Health Organisation. This document covers these areas: the characteristics of forcibly displaced young people; the issue of reproductive health and why it is important to young people; where they are, and excellent examples of reproductive health programmes for

young people in both rural and urban settings. Useful reading for all topic in this Resource Pack.

Gordon, Gill (1999), Choices, London, Macmillan. This book is written specifically for young people between the ages of 10 to 24, and contains clear information, a variety of activities for peer educators, youth leaders or teachers to use, pictures, cartoons and quizzes. Useful reading in terms of Topic 4 and very useful to share with people who will be developing reproductive health programmes.

VIDEOS

There are a number of very useful videos that support the teaching of Sexual and Reproductive Health. A synopsis of a few follows:

Reproductive Health in Refugee Situations - What can you do?

A 12-minutes training/awareness building video targeted at non-health staff working in refugee situations.

The purpose is to explain what Reproductive Health (RH) is, the importance of RH for the health and well-being of women, men and young people and to give concrete suggestions how staff can integrate and support RH in their work.

The primary audience for this video are UNHCR and Partner staff from health areas such as: Field and Programme Officers, Community Services and Protection staff and other refugee workers who have direct contact with refugees. Others such as drivers and administrative staff could also benefit from this video.

A facilitator's guide accompanies the video that will aid staff in showing the video to colleagues and generate discussions on how to integrate RH into each and every staff members' routine work. The guide gives information on other activities which could take place after showing the video.

Available in English. To be used in the field and shown in routine UNHCR training programmes for non-health staff.

Women in Distress

Zawadi Bakar is an 11 year old Congolese girl living in Lugufu, a refugee camp in Tanzania. One time when she was out in the forest fetching firewood, she was raped by two men. Thanks to the Reproductive Health project funded by UNFPA, she could receive immediate psychological and medical treatment. The risk of being sexually abused, becoming pregnant or infected by sexually transmitted infections is always present in conflict situations. In 1994, UNFPA developed Reproductive Health activities to ensure the delivery of appropriate services to refugees and IDPs. This project in the refugee camps in Tanzania is being executed by the International Federation of Red Cross and Red Crescent Societies which also ensures the co-ordination with other NGO operations in this field.

From Awareness to Action

Describes the actions taken by Somali refugees in Hartisheikh Camp in Eastern Ethiopia to eradicate Female Genital Mutilation (FGM). UNHCR working with the National Committee on Traditional Practices of Ethiopia (NTCPE) implemented a pilot project in 1997 to assist the refugee community in eradicating this harmful traditional practice.

Two videos were commissioned by UNHCR-Ethiopia - one in Somali and one in English - to describe the positive actions taken by the refugee community to eradicate FGM.

The Somali Video is 25 minutes long and describes in greater detail how the project worked, what were the positive outcomes and how the refugee community is committed to eradicating FGM. In particular it describes how the community decided to perform an alternative ceremony, whereby the importance of an initiation rite into womanhood is recognised, but where no parts of the girl's body is being harmed. The ceremony is celebrated with music, singing and a feast meal. The traditional FGM practitioner has a ceremonial role. The Target Groups for this video are Somali speaking communities. It can be used to demonstrate how they can work together to change the practice of FGM.

The English video is a shorter version of the Somali one (15 minutes in length) and is targeted at programme planners and community-based workers wanting to start a FGM eradication project. It describes how the project worked with various groups in the community.

The Somali version of the video can be obtained from UNHCR

The English video can be obtained from Television Trust for the Environment (TVE-UK). TVE e-mail: tve-dist@tve.org.uk

A HOW TO GUIDE on the project has also been produced and should assist development and humanitarian workers to better understand how the project worked. A Video Guide accompanies this video as well.

A Compilation of Videos on Female Genital Mutilation

As part of a package of materials of FGM, several videos on FGM have been compiled on this video. The videos show how different countries are working to eradicate FGM and some of the important issues surrounding the practice. UNHCR's policy on Harmful Traditional Practices is also highlighted.

The compilation video is approximately 70 minutes in length.

WEBSITES

UNICEF

<http://www.unicef.org/programme/youth/index.html>

A special focus on adolescents' development and participation is presented.

WHO

http://www.who.int/home/map_ht.html#Family and Reproductive Health

The World Health Organisation site is a useful source of information for health topics and statistics.

UNDP

<http://www.undp.org/>

Health statistics are available in UNDP website from the Human Development

Report, along with a highlight on HIV/AIDS.

UNAIDS

<http://www.unaids.org/>

This website provides useful information on HIV/AIDS and programmes at country level.

ICPD

<http://www.unhchr.ch/other.htm> (go to ICPD)

This website provides all the documents of the Cairo international Conference on Population Development of 1994.

Division of the Advancement of Women (DAW)

<http://www.un.org/womenwatch/daw/>

The Division for the Advancement of Women (DAW) advocates the improvement of the status of the women and the achievement of their equality with men. The Division is a catalyst for advancing the global agenda on women's issues and for mainstreaming a gender perspective in all sectors. Useful information and documents on the Fourth World Conference on Women can be found in this website.