ARC resource pack

Study material

Critical issue module 4

Sexual and reproductive health

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This module is one of the following series of **ARC resource pack** modules.

Foundation modules

1 Understanding childhoods
2 Child rights-based approaches
3 Programme design
4 Participation and inclusion
5 Advocacy
6 Community mobilisation
7 Psychosocial support

Critical issue modules

1 Abuse and exploitation
2 Education
3 Children with disabilities
4 Sexual and reproductive health
5 Landmine awareness
6 Separated children
7 Children associated with armed forces or armed groups

All modules include:

- **study material** giving detailed information on the module's subject and a list of further reading
- **slides** giving key learning points and extracts from the study material, offering a useful resource when introducing training events and exercises
- **training material** for participatory workshops that comprises **exercises** giving practical guidance for facilitators and **handouts** for participants.

The following documents are also included in the ARC resource pack CD-ROM to ensure you can make the most of these modules.

- User guide
  An introduction to the ARC resource pack and the relationships between modules.
- Training manual
  Advice and ideas for training with ARC resource pack materials.
- Facilitator's toolkit
  General guidance on how to be an effective facilitator, with step-by-step introductions to a wide range of training methods.
- Definitions of terms
- Acronyms

See **Guidance for training on critical issues** at the end of this document for further help in developing ARC workshops.

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Introduction

The importance of the UN Convention on the rights of the child

The human rights of children are fully articulated in one treaty, the UN 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, the rights are indivisible and interrelated, and 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 of standards and principles and expresses clearly a holistic range of responsibilities of States parties to all children within their borders. By ratifying the convention, national governments have made a public commitment 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 right to sexual and reproductive health is held by all children, in all countries and in all circumstances. In many environments, sexual and reproductive health services have to reach out to those who have been traditionally unreached, which may include working children, children affected by armed conflicts, children affected by HIV and AIDS, children with disabilities, and rural children. CRC Article 24 on the right to health builds on and develops the right to life and to survival and development addressed in CRC Article 6. 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, CRC Article 24, paragraph 2 provides a list of appropriate measures that States parties must consider 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 (CRC Article 27) and the right to education (CRC Article 28). The need for full consideration of adolescents' health issues is underlined in CRC Article 5 with respect to the child's evolving capacities.

Overview of this module

Sexual and reproductive health is a major issue that affects profound aspects of the safe growth and development of children and adolescents. It is of major importance to provide sexual and reproductive health service for children and adolescents affected by emergencies, in order for them not to be doubly victimised.

Sexual and reproductive health covers a much wider range of issues than family planning, because it includes matters both before and after the years of reproduction. Issues such as finding a healthy sexual identity for oneself as well as a partner, maternal and newborn health, sexually transmitted diseases (STI) including HIV and AIDS and safe abortion and post abortion care are also included. Often there is an overlap with gender-based violence (including harmful traditional practices).

In this module, the notion **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.

The term **young people** refers broadly to anyone within the 10 to 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** nor **young woman** effectively describe the age range in question. **Sex** refers to the biological characteristics that define humans as female or male, whereas **gender** refers to socially constructed roles, attitudes, behaviours and values. The term **gender** also takes into account the relative power and influence society ascribes to men and women on a differential basis.

Five topics are covered within this module, but there are also many issues which cross-refer with topics in other **Critical issue** modules, such as:
Critical issue module 1 Abuse and exploitation; **Critical issue module 2** Education; **Critical issue module 6** Separated children; **Critical issue module 7** Children associated with armed forces or armed groups.

Facilitators are advised to use this module alongside other modules, including **Foundation** modules, when dealing with issues of sexual and reproductive health.

Structure and content of this module

This module aims to provide senior managers, sector coordinators and field staff with adequate information in order to ensure that sexual and reproductive health needs of children within their jurisdiction and care are fully met. After providing an overview of the issue of sexual and reproductive health and the impact emergencies can have on children and adolescents' enjoyment of this right, the module refers to the relevant legal instruments that underpin the right to sexual and reproductive health. This is followed by emphasising the importance of using tools for the child rights assessment and situation analysis. It is essential to identify gaps in the access and content in the sexual and reproductive health services for children and adolescents. Thereafter it gives practical information about how to respond adequately in setting up sexual and reproductive health activities in emergency situations. It explains the different levels of implementation of the right to sexual and reproductive health. Finally, it stresses the importance of setting up indicators for monitoring which changes have taken place in the enjoyment of the right to sexual and reproductive health for children and evaluating this process.

This module is structured using the topic sequence common to other Critical issue modules.

Topic 1 The issue for children Gives an overview of the issues of sexual and reproductive health in emergency situations, focussing on what kind of problems children and young people might face concerning sexual and reproductive health in such a context.

Topic 2 The law and child rights Introduces the legal framework for the right to sexual and reproductive health. It provides an overview of the key legal instruments related to the right to sexual and reproductive health, of the duty bearers and their responsibilities as well as the mechanisms in place for children, adolescents to

facilitate claiming their rights; and for parents and care-givers to support their children to claim such rights.

Topic 3 Assessment and situation analysis Looks specifically at the importance of using a child rights situation analysis. It is an essential starting point for understanding which groups of children in different areas and situations are denied their rights to sexual and reproductive health; who is responsible for delivering on this right; and why they are unable or unwilling to do so. Interventions aimed at enabling all children to enjoy their rights in this area must primarily work with those responsible for providing it.

Topic 4 Planning and implementation
Programming for sexual and reproductive health Provides an overview of the different types of intervention to provide appropriate sexual and reproductive health services in emergencies. Key elements of an effective sexual and reproductive health rights programme are outlined and examples of activities that should be undertaken immediately, and in the mid to long term are provided.
Advocating for sexual and reproductive health Looks at how strengthening the institutions improve the quality and access to sexual and reproductive health for children and adolescents. It gives an overview of the different challenges that might be faced in this area, the factors that contribute to changes in attitudes towards sexual and reproductive health issues and how advocacy can play a key role in improving access to sexual and reproductive health.

Topic 5 Monitoring, evaluation and learning Covers the process of monitoring and evaluation of interventions by measuring what changes have been made in the lives of children and adolescents with respect to their sexual and reproductive health rights.

Participatory exercises and handouts are provided. Facilitators are strongly recommended to develop regional or country-specific material such as case studies in order to make the training even more relevant.

Definitions of terms

The definition of reproductive health adopted at the International conference on population and development in 1994 captures the essential characteristics that make reproductive and sexual health unique compared to other fields of health. Reproductive health extends before and beyond the years of reproduction, and is closely associated with socio-cultural factors, gender roles and the respect and protection of human rights, especially, but not only, in regard to sexuality and personal relationships.

- **Adolescence** is a period in people's lives where a lot of things change rapidly, and profoundly. The changes take place at physical, intellectual, emotional and social levels. Due to the complexity in this process, the needs of adolescents are often ill defined and policymakers remain poorly equipped to provide the required support. Early adolescence is in the range of 10 to 14 years and late adolescence 15 to 19 years.
- **Reproductive health** is a state of complete physical, mental and social wellbeing 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. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (International conference on population and development (ICPD), Programme of action, paragraph 7.2, 1994)

- **Sex** refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as females and males. In general use in many languages, the term sex is often used to mean sexual activity, but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.
- **Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.
- **Sexual health** is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
- **Sexually transmitted infections (STIs)** There are more than 20 infections, including HIV and AIDS that are transmitted between people by sexual activity. Most STIs affect women and men, girls and boys. At times the health problems they cause can be more severe for the female population. If the STI is contracted during pregnancy, it can cause serious health problems for the baby.
- **Sexual rights** embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include but are not limited to the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; consensual sexual relations; consensual marriage; and decide whether or not, and when, to have children.
- **Traditional harmful practices** refers to harm caused to children based on traditional beliefs, where the actor often is a family member. This is in contrast to classic human rights violations where the State is the actor violating the right. The State has the positive obligation to prevent such practices. If it fails to take appropriate measures, it has violated the rights of the child.

- **Young person** generally refers to anyone within the 10 to 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. Youth, is a slightly smaller span, covering people aged 15 to 24.

Topic 1
The issue for children

Key learning points

- Sexual and reproductive health is a very personal issue and concerns everyone for a large part of their lives. During adolescence, this growing awareness of sexuality can have an acute affect on the way young people conduct themselves and their lives.
- It is increasingly recognised that support and intervention to ensure good sexual and reproductive health for young people can have a lifelong beneficial effect: decisions or events relating to sexual behaviour and activity that occur between the ages of 10 to 24 can be a major factor in the direction that a young person's life will take.
- Sexual and reproductive health is part of the human rights that States have to respect and protect for all people. Focussing on the relation between various duty bearers and the right holders contributes to create sustainable improvements for young people in this area.
- Emergencies have a profound negative impact on the reproductive health of girls, boys, women and men and young people affected by emergencies are likely to be more at risk of developing sexual or reproductive health problems.

Sexual and reproductive health concerns all human beings throughout the larger part of the lifetime. Potentially ill health in this area can have lifelong effects. In the context of emergencies, displacement and other crisis settings, children and adolescents tend to run higher risks with regards to their sexual and reproductive health. These include risks of exposure to unsafe sexual practices, which in turn could lead to increased risk of sexual violence and exploitation, unwanted pregnancy, unsafe abortion and sexually transmitted infections (STIs). Early marriage and early pregnancy are significant factors in health problems related to sexual and reproductive health for adolescents (including maternal morbidity and mortality). This health risk is exacerbated when there is a very low age of marriage in particular for girls in some countries.

Children 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.

Participation remains one of the basic principles that always underpin the work in this area; indeed, the success rate of any intervention regarding sexual and reproductive health is entirely dependent on the active participation of the children of concern. The principle of **non-discrimination** is of central importance to work in this area, ensuring that all categories of young people have access to information and training that concern their sexual and reproductive health regardless of their ethnicity, social, cultural or other status is of paramount importance.

Sexual and reproductive health

Reproductive health extends before and beyond the years of reproduction. For example, a female child who is malnourished from birth or subjected to harmful traditional practices enters adolescence and adulthood with anaemia, physical

anomalies and possible psychosexual trauma related to the traditional practice. This can increase the probability of obstetrical problems during pregnancy and childbirth. It may also contribute to sexual problems, fear and abuse in a relationship.[1] Effective reproductive healthcare addresses these problems from birth with appropriate and culturally sensitive education and healthcare programmes.

Sexuality is not a topic on its own. It is inextricably linked to self-esteem, body image, identity, ideas about love, dating, hooking up, breaking up, pleasure, marriage, and ideas of what is right and wrong. Sexuality is one part of a larger continuum of thinking about identity and how humans share their most intimate and vulnerable feelings with others.

Although there is reluctance among adults to recognise that many adolescents are sexually active, many adolescents under 18 in fact are. Recent studies have shown that 46% of girls and 37% of boys between the age of 15 and 19 in sub-Saharan Africa have had sex, and that at least 15% of girls reported having sex before their fifteenth birthday.[2] Despite their sexual activity, however, these children are not usually targeted by sexual and reproductive health programmes and services.

Knowledge about consistent condom use varies from 53% to 83% for both males and females aged 15 to 24 in sub-Saharan countries.

Young people aged 14 to 24 account for an estimated 45% of new HIV infections worldwide.[3]

Sexual identity is the ability to be attracted to or fall in love with the opposite or same sex. There is a continuum of ways in which individuals relate to one another. A majority of people have heterosexual relationships, meaning they are attracted to the opposite sex. Others are bi-sexual, meaning they are attracted to both the same sex and the opposite sex. Homosexuality involves attraction to a person of the same sex.[4] Sexual orientation is not always constant in life, a person may experience periods in life where they are more attracted to persons of the opposite sex and other periods when they are more attracted to persons of the same sex.

The critical period of adolescence

In all cultures and countries around the world, sex and sexuality are sensitive issues, connected to intimacy, secrets and things to enjoy and things to regret. Sexuality is something private: the acts, the fantasies, infatuations, the emotions that go with sexuality, shame and guilt, fright, but also the passion and the enjoyment. What a person wants and what they refrain from create the attitudes toward sex and sexuality. What society wants and portrays creates the values that control sexuality. And what is respectively private and officially accepted does not suit everybody.

Societies often develop strategies to keep their children from thinking about sex, such as being involved in out-of-school activities like sports and clubs in order to keep one's mind off sex, stringing men along for money but not giving sex, and having oral sex or practicing masturbation. Often they do not perceive themselves as being at risk.

It is important to strengthen adolescents in their self-esteem, their capacity to make decisions for themselves, and their ability to think critically around common conceptions. Adults are often the gatekeepers of information for children and youth. If

youth are to receive objective information and positive messages about sexuality, protection etc, adults' own capacities to communicate such messages also has to be addressed (see also **Programming for sexual and reproductive health** in **Topic 4**).

> In most societies, the norms are based on heterosexual relationships and, thus, hinder the open expression of homosexuality even though global studies have shown that at least 3% to 7% of all populations are homosexual.[5] Homosexual young women and men often recognise their attraction for persons of the same sex early in life, sometimes even before puberty. Because of the stigma against homosexuality, many are not open and can be in heterosexual relationships because of social expectations to enter family life and have children although they are not comfortable in doing so.

Adolescent development has been described in the following words: '*Development is generally defined as change that is systematic, age-related, universal, predictable, enduring, and adaptive, in the sense that development usually involves some sort of lasting improvement in competencies and capabilities that occurs across the population around a given age'.*[6] During adolescence when children mature to adults, they go through a profound physical, intellectual, emotional and social process. When adolescents are compared to children, their physical features are changing, not only do they gain height and weight, but childish features transform into adult faces and postures. The intellectual change from childhood to adulthood is the capacity to think in abstract, more advanced ways and to be more efficient and effective in their reasoning. Through the emotional development of adolescents they become more able to see themselves in psychological terms. This enables them to reflect more on their own personality and they can increasingly explain their motivations and behaviours. The social development covers the increased importance of peers, the interest in romantic relations and the onset of sexual life.

It is commonly agreed that the period between 12 and 17 years is crucial for human development, for the following four interrelated reasons:[7]

1. In current society, adolescence is characterised by rapid change of the physical, intellectual, emotional and social capabilities. The speed and complexity of development in this part of life makes it a poorly outlined and moving target for policymakers.
2. Adolescence is a period where the individual has great ability to be shaped and formed, and the influence of friends, family and school and other environments over the direction of development is large. From the point of view of policymakers this period of influence is a great opportunity.
3. Adolescence is the period where patterns and behaviours become formed and firmly established, only to become increasingly difficult to alter when adulthood is reached. As events during adolescence cascade into adult life, many of these experiences have tremendous cumulative impact.
4. Finally, adolescence is a very variable period, within an individual as well as between different youths. Development is rarely a straight line; progressive periods are intercepted with times of regression. The variations make it hard to generalise about

the average level of maturity of adolescents and it is practically impossible to draw conclusions of the level of psychological capabilities of individuals who are the same age.

In conclusion, because of these realities, it is therefore evident that carefully designed interventions during this period of a young person's life can have lasting positive effect on his or her sexual and reproductive life.

Handout 1 provides an overview of the different stages of sexual development of children.

Protecting from sexual and reproductive illness

Sometimes stereotyped perceptions of gender roles and good intentions can lead to unwanted results, especially when it comes to issues such as sexual and reproductive health. If parents, care givers or other adults ignore the possibility of youth engaging in sexual activity, there may also be an opportunity lost in regards to providing accurate information and guidance that can lead to increased protection of children and youth.

Reproductive ill health accounts for approximately 36% of the total disease burden among women of reproductive age in developing countries. Three groups of diseases make up the 36%:

1. pregnancy-related deaths and disability
2. sexually transmitted infections
3. HIV and AIDS[8]

Maternal mortality is a huge problem in most developing countries. In the 20 countries with the worst mortality rates, between 650 and 2,000 women die from pregnancy related causes per 100,000 live births every year.[9] These rates are often related to teenage pregnancies, as girls under 20 are twice as likely to die in childbirth as women over 20.

In October 2000 a WHO consultation in Africa agreed that '*adolescents have a right to access health services that can protect them from HIV and AIDS and from other threats to their health and wellbeing, and that these services should be made adolescent friendly*'. The consultation recognised that health and development needs cannot be met by health services alone, but outlined an essential list of clinical services as follows.

- General health services for tuberculosis, malaria, endemic diseases, injuries, accidents and dental care.
- Reproductive health including contraceptives, STI treatment, pregnancy care and post abortion management.
- Counselling and testing for HIV, which should be voluntary and confidential.
- Management of sexual violence.
- Mental health services, including services to address the use of tobacco, alcohol and drugs.

- Information and counselling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use.

The appropriate range and characteristics of youth friendly health services must be decided by each country, based on local needs assessments. To take one example, South Africa has developed a package of essential healthcare services at a primary level, focused on reproductive health (pregnancy, STIs including HIV) and on violence, which is often sexual in nature. It advocates counselling, contraceptives, tests and HIV testing at primary care level, and that abortions should remain legal. This South African package focuses on the priority issues for young people and develops an approach that is culturally acceptable to most people. Another country might develop a different set of priorities, or a different method of working.

There is also an especially pressing need for comprehensive reproductive healthcare to be made available to refugees, displaced persons and populations affected by conflict and disasters. However, conflict and displacement are usually accompanied by a diminished capacity to respond to these needs, and this situation may be further aggravated by inappropriate responses.

Gender considerations

In many cultures, women are considered by some people to be the property of fathers, brothers, husbands or the extended family. Some fathers exchange their young daughters with older husbands or traders, for cows or money. Some husbands believe they 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 threatened or abused and beaten for refusing sex. Especially in already vulnerable situations such as an emergency, women and children are at increased risk of being abused, exploited or forced to engage in sexual activity in order to get or keep a job, obtain food, security, education or other necessary goods and services. For further information on gender-based violence, see **Critical issue module 1** Abuse and exploitation.

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. It should be noted that although the majority of victims of sexual violence and exploitation are girls and women, up to 1/3 of cases are boys. They may be targeted by adults who fear impregnating a girl or who count on the added shame and stigma to keep the event secret. Thus, boys' experiences are chronically under-reported. In situations where girls have less access to power[10] 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. As the situation stabilises in displacement and post conflict settings, there may be pressure to replenish the population. This may result in girls being forced into pregnancy.

To ensure equal sexual and reproductive health for all and for countering sexual exploitation and abuse and to protect women, men, girls and boys from HIV infection, cultural concepts of masculinity that are based on virility and promiscuity have to be challenged and changed. The active participation of young men and boys in this work

can pave the way for them to become key players in finding durable solutions rather than being associated with the problem.

Transactional sex can reportedly be encouraged by some parents, both covertly and passively, in order to obtain items that are needed by the family. In a study from Zambia the following was revealed.

> Several groups of boys and girls narrated instances when a mother or grandmother would ask the girl to seek sex partners so that there is some money at home and they can have enough food to eat. However, it was mentioned that the girl would not be told directly to go and have sex but a mother could pass comments like *'sure ti gona nanjala na bakazi balipo pano'* (surely how can we sleep on empty stomachs when there are girls in the house?)[11]

For children to have the power to either refuse sex or to insist on contraceptive use, the economic, social, cultural, and political conditions which form their power must be altered. For this to happen, girls must:

- have social security so that they are not forced to work in underpaid and exploitative environments
- have control of if, when and how many children they have
- participate fully in all decisions that affect them and their families
- have full access to gender-sensitive basic and continuing education, including sexual education
- have access to peer support groups or other kinds of networks and resources that promote self-esteem.

The impact of emergencies on sexual and reproductive health

Armed conflict and disasters can have a profound negative impact on the reproductive health of women, men, girls and boys. In emergencies, attention is often given to immediate life-saving measures and insufficient priority is given to reproductive healthcare, although poverty, loss of livelihood, disruption of services, breakdown of social support systems, and acts of violence combine to destroy health. Young people affected by armed conflict and disasters, whether they are refugees, displaced or continue living in their 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 affected by war or disaster. They may, in addition, have 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 and their social structures previously referred to may be torn down. 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 and violence. The absence of traditional forms of guidance in the transition to adulthood may result in earlier and

increased risk-taking behaviour. In terms of resettlement or repatriation, adolescents might find themselves in another cultural or social situation which contradicts the norms that they have become used to. Separation from homeland often also means that children lose traditional ways of income, or the traditional means to fend for themselves.

The boredom, hopelessness, uncertainty, insecurity and frustration of refugee life can also result in risk-taking behaviour. Besides unsafe sexual activity, other risk-taking behaviour includes tobacco, drug and alcohol abuse, poor nutrition, and violence inflicted both by and on adolescents. The desire to plan for the future may diminish, affecting adolescents' motivation and ability to take the necessary steps to avoid STIs, HIV and AIDS and unwanted pregnancy.

Loss of income sources reduces the ability to make free choices. In this respect, unaccompanied minors, either boys or girls, are especially vulnerable. They may turn to prostitution in order to survive. They are also far more vulnerable to other forms of high-risk behaviour, including substance abuse, and to poor health in general.

The ideas of aggressive masculinity inculcated in boys associated with armed forces or armed groups can have a profound and long-term negative impact on their own reproductive health and on that of the communities with which they come into contact. For a boy to make his first sexual experience under group pressure and in violent forms is bound to leave traumatic memories.

In peacetime, girls, whether married or single, run the highest risk of sexual exploitation. In conflict and displacement, this situation is likely to be aggravated. Girls (both married and unmarried) who become pregnant may find themselves without the support to cope with pregnancy, childbirth and raising a child. Access to family planning services may be poor, resulting in an increase in the number of unwanted pregnancies and possibly unsafe abortions. The risks of unsafe abortion may be exacerbated when both social support networks and health services are disrupted.

Among the STIs that pose a threat to children who have been displaced due to natural disasters or conflict, the impact of HIV and AIDS is of particular concern. HIV and AIDS affects children directly and indirectly in many different ways, ranging from the psychological impact of living with one or both parents who are terminally ill leading to the loss of one or both parents, to the less obvious impact of reduced access to quality education and health services. The impact of HIV and AIDS on the health of children relates not only to the growing number of children being infected with HIV, but also to the effect HIV and AIDS has on access to healthcare for children who are HIV-negative.

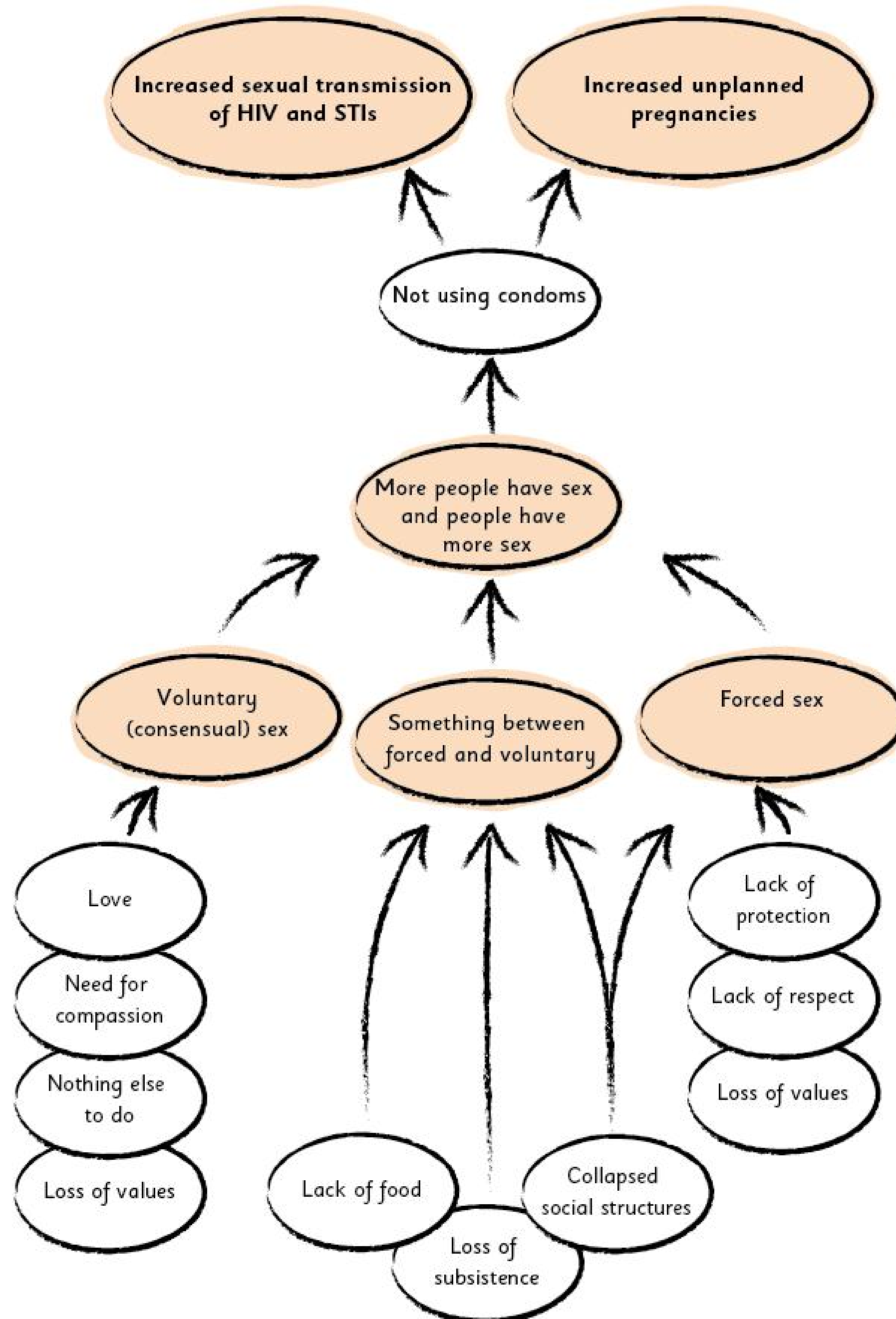
Effects of the HIV and AIDS epidemic on children and young people include:

- disintegration of traditional support structures and social safety nets
- loss of quality education due to loss of school teachers to HIV and AIDS
- reduced survival and development rates of children through its impact on health, family livelihoods, social welfare and protection
- discrimination and exclusion from the community as a result of stigmatisation.

HIV has a detrimental effect on the education of children due to exclusion, loss of earnings or the need to redirect household spending towards medical treatment, which severely limits funds for schooling.

Handout 1 lists several considerations that may affect young people in emergencies.

The figure below shows some of the dynamics of increased sexual transmission of HIV and other STIs in conflict, refugee and displaced settings: all conditions still hold for adolescents as for adults except to a greater degree.



Training material for this topic

Exercise 1 The risks for young people when they are refugees and displaced

Exercise 2 What is adolescence?

Exercise 3 What did you do when you were an adolescent?

Handout 1 Definitions

Topic 2
The law and child rights

Key learning points

- The right to sexual and reproductive health is an integral part of the broader right to health, which is extensively protected by a number of legal instruments. These can be used effectively for advocacy and promotion of the reproductive, and sexual, rights of young people.
- A rights-based approach shifts the focus and role of young people in programmes from recipients to actors, empowering them to participate in decisions that affect their lives and emphasises the importance of choice and non-discrimination.
- An understanding of sexual and reproductive rights issues as they relate to young people can serve to influence policymakers and programme planners to develop programmes which better address young people's needs.
- Sexual and reproductive health is part of the human rights that States have to respect and protect for all people. By focussing on the relation between various duty bearers and the right holders, accountability is increased and the chances to achieve sustainable improvements are better.
- Due to the rapid and far-reaching changes which take place in the life of young people who approach adulthood, they have special needs in relation to the right to sexual and reproductive health. In order for young people to be able to fully enjoy this right, non-discrimination and their right to participate in decisions and programming are of key importance.

This module provides an overview of the international legal framework that protects the sexual and reproductive health. Participation remains one of the basic principles that underpin all work in this area. The success rate of any intervention regarding sexual and reproductive health is highly dependent on the active participation of the concerned children. The principle of non-discrimination is a key concern, ensuring that all young people can enjoy their sexual and reproductive health rights regardless of ethnicity, social, cultural or other status. The right of youth to be properly informed, supported and cared for extends to all regardless of their ethnicity. Of particular concern are the needs of young people often generally marginalised in societies, such as children with disabilities and those living directly or indirectly affected by HIV and AIDS. Other groups that often are overlooked or excluded are children with lesbian, gay, bisexual or transgender sexual identities.

A rights-based approach seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that negatively affect sexual and reproductive health of children and adolescents. It places young people at the centre of their own development processes and seeks to empower them to be able to claim their rights and make decisions that affect their lives.

Topic 2 builds on **Topic 1** by giving the reader an orientation of the relevant international legal framework that should guide all work in this area. The introduction to the legal framework is followed by a discussion of which rights and values the law seeks to protect. This module concludes with a concretisation of the legal and moral

responsibilities various actors have in order to ensure that young people enjoy all their sexual and reproductive health rights. The remaining topics will complement this discussion by highlighting the need for a comprehensive situation analysis in **Topic 3** and programming with specific focus on advocacy in **Topic 4**. Finally, this module ends with a discussion on the importance of effective monitoring in **Topic 5**.

A rights-based approach to sexual and reproductive health

A rights-based approach to sexual and reproductive health is based on the following principles:

- universality of human rights, of equity and non-discrimination
- interdependence of civil, political, economic, social and cultural rights
- dignity of every human being
- the right of every human being to claim his or her rights (participation and empowerment)
- the responsibility of the State and other duty bearers to respect, protect and fulfil human rights.[12]

The relevant international human rights used in this module are located in the CRC, which was later interpreted by the Committee on the Rights of the Child (the committee) in the General comment on HIV and AIDS and the rights of the child (CRC 2003). The basic principle of a rights-based approach is that it identifies the State as a duty bearer. The international legal instruments should be seen as minimum standard requirements, and is important to recall that reproductive health rights may also be ensured by national laws.

CRC Article 2 **Right to non-discrimination** obliges countries to ensure the fulfilment of all rights for every child without discrimination on any grounds. Therefore, refugee children and children who are not nationals of the country of displacement have the same rights to access to sexual and reproductive health services and information. The committee highlights this right in HIV and AIDS prevention in relation to stigma, taboos and negative judgments based on sexually active girls or sexual orientation. Programmes that are designed to change such harmful attitudes should be promoted.

CRC Article 3 **Best interest of the child** states that '*the best interest of the child shall be a primary consideration'* in all actions undertaken by the State. The committee provides this as evidence for all countries to place children at the centre of their HIV and AIDS responses. The best interest of the child is usually considered to be fulfilling the right to survival, the right to participation, and the right to non-discrimination.

CRC Article 6 **Right to survival** pertains to children's right to survive into adulthood in all ways. The committee has interpreted this article as indicating the need for countries to address children's sexuality, even if this is contrary to society's generally perceived notions of what is acceptable for children. The rationale is that some traditional practices, such as early and forced marriage, are harmful to children and may increase their risk of acquiring HIV. In order to prevent such risks, children should be provided with proper education and information about their sexuality.

CRC Article 12 **Right to participation** says that children have the right to have their views respected. In relation to HIV and AIDS, the committee said that children should be actively involved in the design, implementation and monitoring of HIV and AIDS

policies and programmes. In particular, '*a variety of approaches are likely to be necessary to ensure the participation of children from all sectors of society, including mechanisms which encourage children, consistent with their evolving capacities, to express their views, have them heard, and given due weight in accordance with their age and maturity'* (CRC, 2003 p4).

CRC Article 6 **Right to health** Sexual and reproductive health is an essential element of the right to health, as they cannot be separated from children's overall wellbeing and their right to the '*enjoyment of the highest attainable standard of physical and mental health'*. The right to health is directly linked to the inherent right to life, survival and development. The right to health is recognised by CRC Article 24 for all children without any discrimination. Under CRC 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 (CRC Article 12).

Details of the CRC and other international instruments can be found in **Foundation module 2** Child rights-based approaches.

Sexual and reproductive health as a human right

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 wellbeing 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 protects freedoms as well as entitlements, such as: reproductive choice, marriage, family planning, safe motherhood, protection from HIV and AIDS, nutrition, education, protection from harmful traditional practices, and protection from unsafe abortions.

- **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.
- **Family planning** Measures must be taken in order to develop family planning education and services.
- **Marriage** Men and women have the equal right to marry, with a free and full consent and to found a family. The betrothal and the marriage of a child, as defined by national legislation, is specifically prohibited. Early maternity is often an immediate result of early childhood marriage and can have adverse effects on the physical development of the mother and her child.

- **Safe motherhood** Appropriate prenatal and post-natal healthcare for mothers must be ensured by the States Parties.
- **Reduction of infant and child mortality** Appropriate measures to reduce infant and child mortality must be taken. States parties shall also place a special emphasis on the provision of primary and preventive healthcare ie. among others, infections and STIs.
- **Protection from HIV and AIDS** 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. 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.
- **Nutrition** Special attention should be given to child nutrition, to women during pregnancy and lactation, to adolescent girls due to anaemia related to menstruation (although IDA rates are often high among boys as well during the growth spurt) and to the girl child because of existing discrimination in her access to nutrition.
- **Education** States parties should develop preventive healthcare, 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 and AIDS. Health education is also highlighted for safe motherhood and childhood: *'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. Practices which should be reviewed 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 children living with disabilities
  - traditional harmful beliefs
  - early marriages and dowries.
- **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.

Human rights relevant for children affected by HIV and AIDS

In order to tackle HIV and AIDS effectively, the heavy impact the disease has on the lives of children must be properly understood. It affects their civil, political, economic, social and cultural rights. Some of the main human rights relevant for HIV and AIDS programmes include the following.

- The right to life, survival and development and the right to health. For example, without access to medical care and treatment, people with AIDS will die sooner and more children will become orphaned. This in turn has a whole range of impacts on children's survival and development.
- The right to education and to access to information. If people do not have access to information, they cannot protect themselves against HIV and AIDS and may not be able to obtain treatment and care.
- The right to freedom of speech.
- The right to freedom from torture, cruel, inhuman or degrading treatment.
- The right to not be discriminated against.

Sexual and reproductive healthcare may also be safeguarded by national laws, which extend government responsibility for such care beyond international obligations. The policies of the host country should guide the implementation of sexual and reproductive health services in emergencies, and there may be circumstances where national laws are conflicting with international standards. In such circumstances, it is important to maintain an open discussion considering the potential for development and change in the national framework.

Responsibilities of the State and other duty bearers

All countries that have signed and ratified the CRC have agreed to uphold the principles contained in the document. Furthermore, '*they have the main responsibility for bringing about the realisation of children's rights and are accountable both to the international community and to all people living within their borders'.*[13] This does not mean that countries have to enable these rights themselves. They can call on other agencies for help. However, the ultimate responsibility in ensuring that children's rights are upheld rests with the individual countries, and thus all accountability should also be found there.

With regard to children's sexual and reproductive health rights and the role of the State, the Committee on the Rights of the Child issued the General Recommendation 4 on adolescent health and development in the context of the CRC. The committee specified that governments are obliged to take certain actions to protect adolescents' right to sexual and reproductive health and that the governments must:

'Provide children with access to sexual and reproductive information, including family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and AIDS and the prevention and treatment of sexually transmitted diseases (STDs)'.[14]

The legal responsibility that primarily is directed towards the State and its agents is complemented by moral responsibilities that involve a much wider range of duty bearers. It is in the best interest of the child that those holding legal responsibilities and those with primarily moral responsibilities cooperate and coordinate their efforts to

create an environment where the sexual and reproductive rights are fully enjoyed by all children.

Minimum responsibilities of governments and policymakers

Government ministries and departments (for example: health, education, social welfare, labour, interior, justice) are responsible to undertake preventive, promoting and remedial action. With regards to sexual and reproductive health this includes activities such as providing necessary child-friendly information and education that helps young people to make informed decisions in life style related matters. Furthermore, the State is responsible to provide an effective healthcare system. Necessary services shall be provided, respecting the confidentiality and privacy of children and young people. An affordable, accessible system of redress must be made available to individuals or groups so they can demand their rights. State parties also have the obligation to monitor the provision of health services and ensure equal access and quality of care.

Policymakers are responsible for developing public health policies that are based on human rights and to place gender considerations at the centre of such policies. Such policies should not only focus on sexual and reproductive health rights but also on the broader range of human rights that influence young people’s health, education and vulnerabilities, and take into account the youth-friendly information young people may require. A particular concern is the development of policies that will allow adolescent mothers to continue their education.

Accountabilities of other authorities and actors

Armed forces are obliged to respect human rights as well as humanitarian principles such as providing access to relief agencies. Codes of conduct should be introduced regulating the interaction with civilian populations, particularly children, including mechanisms that combat impunity if there are infractions of the code.

Peace keeping forces have a responsibility to carry out their mandated mission, and abide by the UN Code of conduct for peace keepers, which prohibits any type of sexual activity with children (persons under the age of 18 years).

Humanitarian organisations are responsible for ensuring that food, money and medication reach the intended recipients with a minimum of leakage, waste or corruption. Humanitarian agencies should include HIV prevention programmes in their programmes. Agencies working in conflict areas and in refugee camps should protect vulnerable women and children from abuse and exploitation, provide adequate food, water and shelter to reduce the need for survival sex and reinforcing codes of conduct on sexual exploitation and abuse.

NGOs should support children in holding the authorities accountable. They can also support State agents and communities with sexual and reproductive health education, including HIV and AIDS. They also discharge their work by lobbying others in government, private sector, media and religious organisations to provide such education. NGOs should also demonstrate successful strategies for overcoming the cultural, social and political obstacles among parents, teachers, government officials, religious leaders and the media that stand in the way of free access to accurate information.

Teachers should ensure a learning environment, free from violence, abuse and exploitation. They also have a central role in ensuring that children can access the knowledge and skills they need to protect themselves from HIV infection.

The media, religious leaders and politicians should allow and promote free access to accurate sexual and reproductive health information.

Health professionals are responsible for providing quality sexual and reproductive care on an equal basis to girls and boys, without discrimination of marginalised groups.

Parents are responsible to protect the health of their children, to protect children from abuse, neglect and exploitation, and to provide them with the objective and relevant information and education they need to protect themselves.

Men and women are responsible to accept and promote women's equality, not to use violence against women, to share decision making and family resources, and to raise their children in a gender-sensitive way rather than to reinforce gender roles.

International donors are responsible to provide aid where the government is not capable of meeting its obligations, and governments which need support particularly in the health sector have the legal obligation to request such assistance.

Making it possible to claim sexual and reproductive health rights

For children to be in a position to effectively enjoy their sexual and reproductive health rights, a number of measures have to be put in place. Some are legal or administrate in nature, and others are practical. For instance, to protect the physical, sexual and mental integrity of adolescents with disabilities, there is need for legislation that prohibits abuse, and discrimination. Furthermore, to give full effect to this right, those in charge of criminal investigations and law enforcement, need the appropriate skills to meet the special needs of children with disabilities. Additionally, administrative routines and procedures have to be put in place so that **all** children, including those with disabilities or living with HIV and AIDS have effective access to preventive information, treatment, care and support when their sexual and reproductive health is concerned. Systematic data collection, with disaggregated information by sex, age, origin, and socioeconomic status is necessary in order to monitor the health and development of young people (see **Topic 5**). Finally, other measures may include awareness raising campaigns, in formal as well as informal education systems and other forms of skills development including self-care skills, specifically designed for young children.

Training material for this topic

Exercise 1	Related reproductive health rights and their effectiveness
Exercise 2	Sexual rights of young people
Handout 1	A summary of reproductive health rights
Handout 2	Scenarios
Handout 3	Young people's sexual and reproductive health rights

Topic 3
Assessment and situation analysis

Key learning points

- A rights-based approach to assessing and analysing the situation of young people's rights to sexual and reproductive health aims at creating a strong basis for developing sustainable and positive change, with the active participation of children.
- A child rights situation analysis (CRSA) requires a good understanding of how children's experiences are likely to **impact on their survival and development**, and how various aspects of life in an emergency situation will facilitate or impede development. An understanding of the **socio-cultural background** of the children directly affected by the emergency, and of those indirectly affected (such as the host society) is required.
- Human rights as well as humanitarian standards and principles should be applied both in terms of **what** information is sought, and **how** assessments and analysis are undertaken. Codes of conduct and guidelines on handling sensitive information apply.
- The analysis should look at the needs and challenges children face in the area of sexual and reproductive health in the short, medium and long term. The analysis should ensure the inclusion of children normally marginalised, such as those not identifying themselves with the heterosexual norm, and those living directly and indirectly affected by HIV and AIDS.
- The process should analyse the immediate, underlying, and structural and root causes to why children do not fully enjoy their sexual and reproductive health rights. The emphasis of the analysis is on the capacities of various duty bearers to carry out their responsibilities.
- To achieve change in structural causes may take time. Eradicating harmful traditional practices such as female genital mutilation (FGM) may require long-term and systematic interventions. In such work the active involvement of boys and men is a key factor for a successful programme.

This module aims at improving the reader's conceptual understanding of an appropriate situation analysis in relation to sexual and reproductive health issues, and to strengthening their practical skills in the same area. At this junction it is important to recall that a situation analysis simultaneously discharges two functions: firstly, it becomes a key source of facts and information on which the following programme design will be based. Additionally, it is in and of itself an intervention, possibly the first concrete interaction with the young children that are of concern together with the community at large. Often the first impression will shape how the population perceives the efficiency of the organisation and the programmes.

Participation remains one of the basic principles that underpin all work in this area. Therefore it is necessary to consider the appropriate involvement of children in the design, preparation and carrying out of the situation analysis. The principle of the best interest of the child remains imperative, not only regarding the voluntarily participation of children, but throughout the whole design of the situation analysis. Human rights principles and codes of conduct apply to all assessment and analysis processes.

A CRSA emphasises the existing resources within the community at large, and particularly those resources children have. To carry out CRSA means recognising children as rights holders and social actors, and creating environments conducive to children and adolescents, specifically with regards to sexual and reproductive health services.

CRSA comprises two broader aspects.

- Firstly, the **assessment** should establish the current situation regarding two aspects:
  - sexual and reproductive health services in place
  - what problems and challenges children and adolescents might face in the area of sexual and reproductive health.
- Secondly the analysis should give insights into the underlying causes to the problems and challenges children face in this area.

Foundations module 3 Programme design provides more information on conducting a situation analysis. In sum it is required:

- that the process is participatory and inclusive
- that the principle of **do no harm** is applied
- that consent is gained from those providing information, and that they receive information in advance on the process and the possible outcomes of the same.

Topic 3 builds on to the two previous topics by familiarising the reader with the specific issues that are necessary to consider when a CRSA is carried out, in this area. Relevant areas to asses are proposed and some tools useful for the analysis are introduced. This is followed by a discussion of some of possible root causes that may negatively affect sexual and reproductive health of young children. The remaining topics will complement this discussion on CRSA by introducing programming in Programming for sexual and reproductive health in **Topic 4** giving a specific focus on advocacy in Advocating for sexual and reproductive health in **Topic 4** and finally this module is completed with some practical and conceptual considerations to effective monitoring in **Topic 5**.

Participation of children and young people

The active participation of children, as well as the community as a whole, is essential to ensure the acceptability, appropriateness and sustainability of sexual and reproductive health interventions. Children have the right to be heard in processes and programmes affecting their own lives. Their involvement should therefore be a central feature from as early a stage as the designing of the situation analysis. Involving young people in this work is furthermore a concrete strategy for empowering children who have experienced displacement due to armed conflict or disasters. Active participation serves to give them a greater degree of control over their own lives and the services which are provided to them.

Young people have numerous strengths that can contribute significantly to the correct assessment of the situation. They can be far better placed to communicate with their peer groups than many adults, especially those who are perceived to be in authority. Children and adolescents are the experts of their own situation being the ones who understand the actual problems and fears that they and their peers face. Last but not

the least, children are better equipped to identify successful strategies for addressing these issues, and are therefore a crucial resource for providing sustainable solutions.

The usefulness of involving children and adolescents has to be balanced with the requirement to respect confidentiality of those who provide information. All actions and decisions affecting children have to be based on what is in children's best interests in the short and long term. Working with young people involves understanding their vulnerabilities and constraints as well as their strengths. Achieving an appropriate balance requires a flexible approach to the participation of children in work relating to sexual and reproductive health.

The general requirement to seek consent of everyone who contributes information to the CRSA requires specific attention in respect of sexual and reproductive health. For instance, assessing care and treatment in relation to sexual and reproductive health is likely to involve issues of confidentiality. Therefore, already in the design of the CRSA, it must be given due consideration on how to approach confident information, be it in the form of medical reports or direct interviews. It must be made clear in a way that corresponds to the development and maturity of the children involved how their information will be used and what the consequences are foreseen.

For further discussions on the participation of children and youth in all stages of the intervention, see **Foundation module 1** Understanding childhoods and **Foundation module 4** Participation and inclusion.

Conducting a child rights situation analysis (CRSA)

The CRSA is but the first step in an ongoing process of revising the situation that concerns the sexual and reproductive health of children during emergencies. A rights-based approach has two drivers:

1. to improve the enjoyment of rights as an **end result** (children enjoy sexual and reproductive health rights and are enabled to fulfil their potential)
2. to respect and fulfil rights that are concerned with the **process** of achieving this result.

CRSA should be conducted in as highly **participatory** a manner as is possible, specifically involving children with various backgrounds, as well as the community at large.

A CRSA assists in understanding challenges children face with regards to sexual and reproductive health, it also brings out who is not able to fully enjoy their rights in this field, and it begins to map out which actors have responsibilities that are not fully discharged. This may include assessing the existence and quality of a wide range of services and activities such as preventive work, treatment, care and support related to sexual and reproductive health. Each of the elements can further be analysed as to their availability, accessibility, acceptability and quality from the point of view of children. The whole situation analysis should be guided by the principles derived from humanitarian and human rights law (see **Topic 2**). In particular, codes of conduct that have been developed by many of the humanitarian actors can be relevant tools in relation to sexual and reproductive health.

Ethical behaviour

The ethical behaviour is highly important in relation to any assessment and even more so during an emergency when many people may be traumatised and vulnerable. For this purpose, it is important to establish ground rules for how to behave ethically whilst assessing and analysing the sexual and reproductive health rights. In the preparation and design if any situation analysis due regard has to be given to confidentiality and consent. Essentially, the protection of any data gathered in the field should be given a high level of attention. For instance WHO has guidelines and tools that can support in the collection of sensitive data.[15]

The ethical standard of **informed consent** may mean that there are circumstances when the person giving information not fully grasps the consequences for her- or himself. Such could be the case, if gender-based violence may be suspected to cause the problem and the assessment may make young informants vulnerable to reprisals or put them at risk of being stigmatised by the community. Such consequences of involving children and youth in the CRSA have to be soberly considered, and the best interest of the child should work as the primary guide in deciding the appropriate level of participation.

Although there may not primarily be problems of confidentiality or putting young people at risk, it may still prove challenging to involve both girls and boys in the situation analysis.

- Young people may live in cultures in which their right to participation is negated and in which they are discouraged or prohibited from discussing reproductive health issues or sexual practices.
- The society may strongly disapprove of young people 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.

Additionally, as a part of the ethical behaviour, it is fundamental to establish a referral system, of whom to contact and refer to if the team during its assessment encounters or learns about a child that may be in immediate need of treatment or counselling. Many organisations have their own guidelines, which should be studied before the CRSA begins.

Sources of information

The CRSA will require the collection of both **quantitative** and **qualitative** data. Such information gathering will involve different tools and techniques, with a view to bring complementary information to the analysis.

Information should be sought from **primary sources** (girls, boys, fathers, mothers, carers, teachers, health workers, community leaders, with firsthand experience) and **secondary sources** (such as reports, survey censuses, databases, maps, and publications, already collected and analysed by other actors). A useful source of secondary information is the documentation of the Committee on the Rights of the Child, particularly concerning the host country.[16] To examine these documents with particular regard to the right to health, (including sexual and reproductive health) may give important information as to the situational context and other socio-political

background factors. Secondary information may be rather general in character, and will not provide sufficiently many details to complete a CRSA.

Useful information of sexual and reproductive health can also be found in **other sources** such as national government publications, websites (for instance World Health Organisation (WHO), International Women's Health Coalition (IWHC) or verbal briefings about the people and the specific situation.

Coordination and cooperation

The capacity of existing resources to work in a **coordinated** way in order to achieve maximum efficiency, coverage and impact should also be part of a situation analysis. The cooperation with other agencies is important to avoid duplication of work, and to ensure that limited resources are put to as effective a use as possible. Expertise should be shared between the agencies so that the quality is enhanced and gaps can be covered. A **shared framework for analysis** will make it easier for agencies to contribute information in accordance with their focus area of intervention.

Collaboration with stakeholders from local levels to government levels is necessary to ensure sustainability of the following interventions. Collaboration is necessary to maintain transparency of all humanitarian activities. Furthermore stakeholders often turn out to be key persons when it comes to accessing certain information. As part of coordinating the whole assessment and analysis work, the available time frame has to be outlined making short-, medium- and long-term considerations.

More information can be found in **Foundation module 3** Programme design.

Key areas to assess

The aim of the assessment is to get a picture of the sexual and reproductive health services accessible to children and adolescents, as well as to establish which problems children and young people face with regards to sexual and reproductive health. This requires that two aspects are covered in the assessment:

1. the concrete and direct services available
2. the contextual aspects, such as the values and norms in the community.

With regards to the overall contextual aspect, the assessment may focus on numerous areas, some of which are highlighted in this topic. In order to ensure that no children are discriminated against by being excluded from access to sexual and reproductive health, a gender analysis and a mapping of excluded children[17] should be included in any CRSA as a minimum. Special attention should be given to include children traditionally marginalised when it comes to sexual and reproductive health, such as children living directly or indirectly affected by HIV and AIDS. Given the fact that some children do not identify with the heterosexual norm, the CRSA should be inclusive by not taking this norm for granted.

The assessment should be undertaken in a **systematic** manner. Although it is not always feasible to gather complete and accurate information, a systematic approach will help to minimise the dangers associated with bias.

With regards to the concrete and direct aspects of sexual and reproductive health services available to children and adolescents the assessment as a minimum should focus on the following.

Capacities for child-friendly service delivery such as health providers' facilities for voluntary counselling and testing (VCT) including HIV and AIDS testing. Service delivery should be examined as to the criteria of accessibility, availability and quality.

The **accessibility** of the services to children and adolescents requires that drop-in clients are welcomed, or if this cannot be accommodated, that appointments can be arranged rapidly. Accessibility also requires that the services are affordable to young people.

Acceptability of the services ensuring that there are separate spaces, and that privacy and confidentiality is honoured, in particular with regards to young people. The option to delay pelvic examination and blood tests should be available.

The assessment of **quality** examines if the range of services available is broad enough. In those cases when services are not provided a referral system should be in place. Quality also requires that the there should be educational material available, and alternative ways of accessing information and counselling should be provided.

In order to get the most comprehensive picture possible of the situation, information on service providers needs to be complemented. It is necessary to gather baseline data covering the demographic structure of the youth of concern, with a specific attention to not overlook marginalised groups. Analysis of **baseline data** allows for the understanding of the characteristics of the population, identify behaviours and antecedents and determine programme coverage and exposure.

The **knowledge, attitudes and skills** towards sexual and reproductive health of the people concerned should be assessed.

Protective assets and strengths of the children concerned have to be documented, as well as capacities with their community at large. CRSA requires an appraisal of **capacities and resources** of the children of concern, as well as of their problems and needs. Children are the principal resource when it comes to achieving long lasting change that improves their sexual and reproductive health.

Key stakeholders need to be identified, ranging from the actors in the community, the agents at district level, and national authorities. Relevant interventions by other humanitarian organisations also need to be included here.

A situation analysis also has to assess **other existing and potential resources'** capacities and limitations for example: local NGOs, government agencies, UN organisations and religious organisations. It is important to recognise gaps and limitations and to acknowledge needs that cannot be met within the short term.

It is also important to note **current and potential constraints** that may impact on the intervention. These can be of different kinds:

- security (possible threats to the stability of the situation)
- gender or ethnic (cultural or gender related patterns in the community should be identified)
- legitimacy (how the community views humanitarian organisations generally as well as what amount of goodwill they ascribe to a specific agency will also influence the outcome).

The situation analysis must take account of the long-term needs of children and adolescents. This inevitably involves an element of **forecasting**, predicting political

changes and anticipating particular durable solutions. In turn this requires an analysis of the wider political situation within the region.

Analysing sexual and reproductive health rights of young people

The assessment should be followed by a process of analysis which aims at identifying the underlying reasons of why not all children fully enjoy sexual and reproductive health rights. The analysis should identify ways to improve the situation. By using the tools of analysis, the relation between rights holders and duty bearers is explored.

The analysis tools are used to explore the relation between rights holders and duty bearers, and the aim is to produce information that can contribute to the improvement of the situation. Good analysis is an important input into the process of decision making.

By using the tool for causal analysis, (the tool is introduced in more detail as Tool 1 in **Foundation module 3** Programme design, **Section 3**) different types of causes can be identified. For example, the lack of relevant and child-friendly education on sexual and reproductive health in the school curricula can be an **immediate cause** to misconceptions in this area. Or for instance, the lack of adequate sexual and reproductive health services for young people can be the immediate cause for ill health in this area.

By asking '*but why?*' the analysis can move deeper and begin to look **at underlying causes**. The lack of adequate formal education on sexual and reproductive health may be caused by a policy that this is not a matter for the formal education system. Perhaps the analysis will show that the lack of appropriate resources (knowledge about sexual and reproductive health rights, appropriate training materials, the skills needed to teach a topic which in many cultures is seen as sensitive) further reinforces the policy of not providing formal education in this field. When it comes to addressing causes involving policies, laws and resources, the analysis may reveal related complex issues and require interventions that take significant time in obtaining results (at least five years).

The shaping of policies and laws are often based on attitudes and values in the society. It may well be that in order to change policies and laws, the attitudes held by people in various positions first have to change. It may well turn out that the same underlying or structural causes give rise to several problems. To change such **root or structural causes** require long-term interventions. To achieve change in this area different levels of society have to be influenced, including the family, community and decision makers. In the example of the right to sexual and reproductive health education for all, it may be required that the ministry of education changes the policy which shapes the curricula in this area; that the community leaders if not promotes then at least supports such a change in the curricula, and that parents agree to allow their children to take part in this education.

When the work with addressing defined problems begins, it can be a useful activity to **map responsibilities**. The tool for mapping responsibilities is introduced in more detail as Tool 2 in **Foundation module 3** Programme design, **Section 3**. This tool helps analysing who is responsible for taking action, and it provides a deeper understanding of how duty bearers relate to each other. Such analysis can reveal if actors normally responsible are absent, overwhelmed by the emergency situation or unable to deliver what is required of them. The absence or incapacity of a duty bearer

may indicate the desirability of a **gap filling** intervention. The capacity gap must be identified in context, because gap filling should as far as possible be done together with other duty bearers so that when it is no longer needed a sustainable capacity remains in the institution. In this way, capacity is **built back better**.

In order to design programmes that improve the capacities of duty bearers to deliver sexual and reproductive health services for children and adolescents, a Capacity gap analysis can be a useful tool (the tool is introduced in more detail as Tool 3 in **Foundation module 3**, Programme design, **Section 3**). Such an analysis examines the access to and control over human resources, economic resources and institutional capacities.

Culture and gender as underlying causes

Underlying causes which present challenges to the full enjoyment of sexual and reproductive health rights, 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.

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 she or he thinks, learns and does as an individual, and what her or 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. Such practices extend to matters of sexual and reproductive health.

In terms of sexual and reproductive health, 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.

Female genital mutilation and cutting (FGM)[18]

FGM has been practiced for many thousands of years and probably originated in the patriarchal social system in which women were subordinate to men. Because a wife was the most important acquisition of a man’s life, she became an investment that had to be controlled. The suppression of his wife solidified the man’s position of power, which among other things entailed his right to her genitalia and offspring.

The importance of genital mutilation is evident in certain countries by the requirement in the marriage contract for the 'virginity test'. This means that the future bridegroom's family has the right to inspect the mutilation scar before paying the bride price. According to some social anthropologists, the smaller the opening to the vagina, the higher the rank accorded to the woman, which may affect the marriage negotiations. Women who have not undergone FGM are often castigated and expelled from the social community. This is why it is important to also reach the men in the campaign against genital mutilation; change will not be possible until men accept marriage with women who have not undergone FGM.

There are historical records of beliefs that women could become nymphomaniacs, homosexual, or sexually hyperactive, resulting in 'harmful' masturbation, if the clitoris was not excised. Women in Europe were subjected to FGM for such reasons as late as the early 1900s. Nowadays some women believe that they are unclean if they have not undergone FGM and others believe that uncircumcised women are prostitutes. Many believe that the clitoris is a remnant of masculinity and must therefore be removed; only after she has undergone FGM does a girl become a woman and eligible to join the company of her elders.

In many societies where FGM is practiced, the people believe that the female orgasm kills sperm and that women will become more fertile after the procedure. The truth is precisely the opposite. Genital mutilation can cause damage that reduces women's chances of getting pregnant.

The consequences of FGM depend on the type performed and the extent of mutilation. The immediate consequences of the mutilation are severe pain, bleeding, and shock. Some girls even suffer nervous breakdown. The urethra can be damaged and many girls have difficulty urinating afterwards. Even if all victims do not experience all symptoms, the long-term consequences for girls' health are often pain in the genitals, especially while the wounds are healing, but also later in life. Itching, scarring, cysts, infections, infertility, and urinary disorders are common. Pain in the vulva caused by cutting of the nerve paths and difficult menstruation are other problems that may arise after genital mutilation.

Some people claim that it is better if the mutilation is done when girls are very small, since they will not remember the experience when they get older. New research findings show that the body and the nervous system remember and that FGM can affect how victims of genital mutilation experience pain as adults.

It can be painful for men to have intercourse with a circumcised woman. In some cultures, it is the man's duty to 'open' or dilate the woman after they marry. Although men sometimes dilate an infibulated woman in advance, penetration can still be painful for the man. It may also be emotionally difficult to be compelled to cause the woman to suffer.

The role played by religion with respect to FGM is often discussed. But the practice predates Christianity and Islam and is not connected to any religion. FGM is not mentioned or commanded in any religious scriptures. Neither the Bible nor the Quran mention female circumcision. Nevertheless, FGM is practiced among Christians, Muslims, and animists. Within Islam, there is a widespread belief among certain groups that FGM is a commandment. The prophet Muhammad did not forbid circumcision when he came into contact with the practice, but he allowed it if the

procedure was not too extensive. However, Muhammad is not believed to have allowed his daughters to undergo FGM and he never advocated circumcision.

There is no question that FGM is not a Christian commandment, and no Christian girls can be subjected to it on religious grounds. Various Christian churches are working actively against the tradition, but despite those efforts, Christian girls undergo FGM if they live in areas where the practice is a tradition. There is nothing in Jewish scriptures or law (the Talmud and the Torah) that commands the circumcision of women.

Other relevant modules which may be consulted are: **Critical issue module 1** Abuse and exploitation; **Critical issue module 2** Education; **Critical issue module 7** Children associated with armed groups or armed forces.

Training material for this topic

Exercise 1	Barriers adolescents face when using healthcare services
Exercise 2	What does participation mean?
Exercise 3	Traditional practices and gender
Exercise 4	How do we become men and women?
Handout 1	Case studies
Handout 2	Youth participation
Handout 3	Gender roles and gender relations
Handout 4	Activity matrix

Topic 4
Planning and implementation

Programming for sexual and reproductive health

Key learning points

- Some activities have to be undertaken immediately in order to build a solid foundation for the work to come. Such initiatives include, but are not limited to, appointing a focal person for sexual and reproductive health matters; carry out a situation analysis, preferably by means of a joint assessment; and setting up a shared database where standardised information from various sources can be entered.
- Teenagers want a welcoming health facility, where they can drop in and be attended to quickly. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend.
- A strong impact of the programme is best achieved by systematic coordination with agencies reinforced by the collaboration with authorities and other stakeholders. Coordination will also increase the effective use of scarce humanitarian resources in that it avoids duplication.
- The successful programme outcome will most likely correlate directly with the level of participation that has been achieved. Young people should be involved in all stages of programme planning, implementation and evaluation.
- The holistic approach of the programme requires that activities at different levels are planned and budgeted for. Levels that should be covered are: prevention, service delivery, capacity building and advocacy.
- Areas that should be included in any programme are not limited to clinical services, but should be complemented by advocacy and protection work, with the aim to limit future ill health for children.

Effective and sustainable sexual and reproductive health programming must address the particular needs and interests of girls and young women, and also those of young men and boys. A gender-sensitive approach, therefore, must ensure the equitable participation of both sexes in such a way that all are able to contribute to, and benefit from, improved sexual and reproductive health. The participation of children in all aspects of the programme is part of using the rights-based approach. Focus should be kept on what they are doing, what they know and how they can contribute in a positive way to improving their situation with regards to sexual and reproductive health. The involvement of young people may not only make the programme into a better intervention, engaging children as active agents in their own development also builds their resilience.

Protecting sexual and reproductive health covers aspects of physical protection, psychosocial protection and cognitive protection. In respect of sexual and reproductive health, **physical protection** means to ensure that the environments where children spend their time, such as the school, their homes and the community at large does not pose a threat to their sexual and reproductive health. To achieve **psychosocial protection** of children in relation to sexual and reproductive health rights means to ensure that their integrity is protected, that survivors of sexual and gender-based

violence are reintegrated into the society without stigmatisation, and that children directly or indirectly affected by HIV and AIDS are not socially excluded. The **cognitive protection** in relation to sexual and reproductive health rights is ensured for example by providing children the access they need to life-saving health information, and strengthen their ability to analyse information and judge consequences of risk full lifestyles.

In order to establish a holistic programme, the initiatives need to take into account clinical **and** protective concerns, primarily addressed through advocacy elements in the programme. Attention to the activities in the early stages of the emergency must be balanced with the need to plan for the mid- and long-term interventions.

As this topic builds on all previous topics in a general way, it is specifically based on **Topic 3**, and raises issues of developing sustainable programmes for sexual and reproductive health. This topic continues with a discussion specifically focussing on Advocating for sexual and reproductive health and finally this module is completed with some practical and conceptual considerations to monitoring, evaluation and learning in **Topic 5**.

Participation and inclusion in programming

Involving children and young people in the work with their sexual and reproductive health rights is not a one-off event. It has to be built up as an ongoing process, which provides opportunities for the empowerment of children, as individuals and as a collective. It has to be ensured that all participation of children in programming should be voluntary, safe and meaningful.

Inclusion is about actively creating opportunities for all children to get involved in the programme, irrespective of factors such as gender, disability, ethnicity, class, caste or other status. Children are not always naturally inclusive, and they may well tend to reproduce existing patterns of discrimination in for instance gender issues. It is therefore of fundamental importance with regards to sexual and reproductive health programming that unequal power relations among children and youth are addressed and monitored.[19] In this regard, it is important to ensure that children who don't identify themselves with the heterosexual norm are not by default excluded or considered to be a non-issue in the relevant community.

The participation of children and young people may take different forms, but should be made relevant and meaningful to them by being based on the realities in their homes, schools, camps and communities. They should be given relevant opportunities to engage in the decision making and policy development on sexual and reproductive health of concern to them. Their participation may be of formal or informal nature, and can take place within or outside of formal structures such as child committees, clubs or networks.

At each stage of developing a programme, three potential degrees of engagement for children may be considered.[20]

1. **Consultation** takes place when adults recognise that children have views and experiences that can make a valuable contribution to matters that affect them. Mechanisms can be set up where children can share their perspectives. Examples of such mechanisms are focal group discussions (not permanent and ad hoc in nature) and child rights committees (permanent in structure, may also be based on election

processes, which have the added value of practically demonstrating and giving training in democratic principles).

2 **Participatory processes and shared decision making** is a meaningful way of including children in the work on sexual and reproductive health rights is to set up protection committees where children can work alongside with adults. To actively involve children in the design, development, implementation and monitoring of sexual and reproductive health programs, child committees may be given a formal status as advisory board. Successively, increased the delegation of responsibilities can be transferred to committees as their ability to make informed decision increases. Genuine partnerships among adults and children should be encouraged, with adults playing supportive roles.[21]

3 **Self-initiated processes** are those where children themselves are empowered to take action, and are not merely responding to an adult-defined agenda. The role of adults here is to serve as facilitators and support rather as leaders. In the area of sexual and reproductive health agenies should develop strategies on how to support self-initiatives taken collectively by young people. Circumstances may arise when individuals also decide to take initiatives, this may require support and at times counselling, if self-initiated process have unexpected consequences or negative side effects.

For a comprehensive discussion of participation and inclusion see **Foundation module 4** Participation and inclusion, **Section 1**.

Programming in different phases of emergencies

Early stage intervention

In the early stages of an intervention, a minimum initial service package (MISP) should be provided, as there are some aspects of reproductive health that must be addressed in this initial phase to reduce mortality and morbidity, particularly among women. The MISP works on two levels, providing minimum clinic services as well as minimum organisational measures.

In order to handle information in an appropriate as well as effective manner, a shared database should be set up and managed, where information from different sources can be collected and entered in a standardised manner. The MISP can be accessed at: http://misp.rhrc.org/pdf/module/MISP%20Module%20English%20Final%20REVISED%20Nov07.pdf

Effective programming will in the early stages of work have to focus on the assessment and the analysis of the actual situation with regards to sexual and reproductive health of children. Although such assessments are necessary to establish good programmes, a number of measures should be initiated parallel to the assessment.

An assessment of the prevailing situation for girls and boys is an essential first step. This should be informed by an understanding of the issues in **Topic 1** and should seek to identify which children are most at risk as well as what children and communities are doing to protect young children. See **Topic 3** and **Foundation module 3** Programme design for more information on how to assess the situation of individual children, their families, the community at large, and the wider social and political

context of the country of origin and host country, which can be helpful in determining the needs, the services that are available, and the gaps to be filled.

The work with developing **child-friendly procedures** needs to be an immediate concern to service providers. Such procedures include but are not limited to the protection of privacy and confidentiality of young people seeking services, same sex service provider available if needed and educational material should be easily accessible. **Handout 2** provides a checklist of youth friendly health services characteristics and **Handout 12** provides extensive information on quality care.

One person should be designated to act as the **focal point** for reproductive health. This person should have a strong commitment to reproductive health, experience of working in emergencies and a working understanding of rights-based approaches (which include participation and inclusion especially of girls and young women, and the accountability of duty bearers). The focal point should assume the overall organisation and supervision of sexual and reproductive health activities. The focal person assigned may also liaise with the cluster lead[22] for protection, UNHCR, as this is the area to which sexual and reproductive health belongs.

An early initiative to improve the outcome of the programme is to initiate a **stakeholders' meeting** cross-sectoral in nature involving the implementing agencies, service providers and children or young people, together with parents and community leaders. This could form an important platform for young people to begin voicing their concerns and have their views heard by the respective duty bearers. A stakeholders' meeting may also provide a good opportunity to exchange ideas of useful activities to include in future programming.

> At interagency coordination meetings, the reproductive health focal point should advocate with non-health colleagues for the use of a gender approach in needs assessment and for all sectors to take measures to prevent gender-based and sexual violence.

Where possible, **joint assessments** will enable all agencies to develop plans that are compatible and have a more comprehensive view of the priorities, resources and capacity gaps in the local population. Good coordination reduces waste, when resources and supply lines are shared by all the organisations involved in the humanitarian response. Coordination also facilitates the development of integrated rather than vertical reproductive health services.

For more information please see **Foundation module 1** Understanding childhoods; **Foundation module 4** Participation and inclusion; **Foundation module 6** Community mobilisation.

Mid- and long-term interventions

For any programme initiative, the mid- and long-term interventions need also to be looked at. Addressing the underlying and structural causes to lack of sexual and reproductive health rights for children inevitably require activities that aim at changing the values and views of the people concerned. Such work has to be built up over time. Advocacy directed at different groups and duty bearers will have to be carried out in a manner so that the activities re-enforce each other over time. In order to be able to

show changes in attitudes such indicators and benchmarks have to be developed for effective monitoring and documentation of the project. This information may also be shared with the community and can become an effective incentive to work towards behavioural change.

> After 15 years of child rights awareness programmes in a refugee camp, Save the Children had contributed to raising a generation of girls who where more conscious of their rights. A former chair of the Child Rights Committee at the age of 17 refused to obey when her family had selected a husband for her. As an immediate intervention Save the Children and UNHCR managed to provide her with shelter for the night, to protect her from physical harm. In the following days, representatives of the two organisations acted as mediators between the girl and her family. An agreement was finally reached, based on the girl's suggestion: she would accept her family's choice when she turned 18, by which time she would also have been able to finalise her formal education.
>
> Phugnido refugee camp, Ethiopia 2006

Examples of long-term aims of a sexual and reproductive health rights programme could be to foster new attitudes in areas such as gender issues, or promoting a more open view towards discussing sexual and reproductive health matters in the community generally and at school particularly, or to improve the development prospects of all children with specific regard to their sexual and reproductive health.

Key areas for sexual and reproductive health programming

A holistic programme on sexual and reproductive health rights will cover very diverse aspects ranging from prevention, service delivery to implementation and monitoring. It is important the each of the aspects provide meaningful opportunities for children to actively participate and contribute with their inherent resources, knowledge and skills. The main focus of a sexual and reproductive health programme is on protection and assistance, not as some youth workers felt, as suggested below:
'Problems we identified together included an over-emphasis on the bio-medical aspects of the (HIV and AIDS) epidemic, which left many young people thinking of HIV and AIDS as a battle between white blood cells and a spiky invader instead of something of relevance to their own everyday lives'.[23]

What sexual and reproductive health services do young people need?

Children and young people have expressed their views about what they want from health services in many surveys. They want a welcoming facility, where they can drop in and be attended to quickly. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend. They want a service in a convenient place at a convenient time that is free or at least affordable. They want staff to treat them with respect, not judge them. They want a range of services, and not to be asked to come back or referred elsewhere. Of course, those who plan and provide services cannot only think about the wishes of adolescents; services must be appropriate and effective, and they must be affordable and acceptable for the community too. However, services for this age group must demonstrate relevance to the needs and wishes of young people.

Health services can support the healthy development of young people when they:

- treat conditions that give rise to ill health or cause concern
- prevent and respond to health problems that can end young lives or result in chronic ill health or disability
- support young people who are looking for a route to good health, by monitoring progress and addressing concerns
- interact with young people at times of concern or crisis, when they are looking for a way out of their problems
- make links with other services, such as counselling services, which can support young people.

Youth value getting reproductive health information from healthcare providers but may feel shy asking them questions, since they may not know them personally.[24] On the other hand, lack of privacy and confidentiality is often mentioned by youth as a negative aspect of STI-related and voluntary counselling and testing (VCT) services (Amuyunzu-Myamongo et al, 2005; Berhane et al, 2005[25] and Flaherty et al, 2005[26]). In particular, youth are afraid of being seen by parents or people they know and becoming embarrassed. As one female student said:
'The big fear is that the health worker will reveal everything to the parents. We fear going to the health unit because of the parents. Maybe the parents will see the boy or girl going to the health unit.'
Flaherty et al, 2005 p35

Traditional healers can be seen as having an advantage in this respect, as they don't request as much personal information. In Zambia, these practitioners (ngangas) were also preferred because they did not require the care seeker to take off clothes, nor are they required to make appointments in advance.

Young people in crisis need counselling and community support beyond what health services alone can offer. This support comes from parents, families, teachers, trained counsellors, religious or youth leaders and other adults and from their own peers. In an emergency there will be high expectations of delivering appropriate services as rapidly as possible. In order to create a solid platform for sustainability it is important to avoid setting up parallel systems to those already existing. The pre-existing permanent structures then run the risk of being undermined and weakened by the temporary emergency intervention. As a result they may have even less capacities and resources to fulfil their responsibilities when the emergency response is scaled down. It is important that existing informal structures are not overlooked, such as traditional birth attendants (TBA) and community health workers (CHW).

Examples of resources and services that should be in place:

- affordable condoms are available for everyone who needs them, without discrimination
- prevention and confidential treatment for sexually transmitted infections
- medical practices should be safe: proper sanitation, use of sterilised needles
- protection of children and young people from physical and sexual abuse and from labour exploitation

- access[27] to adolescent-friendly sexual and reproductive health services and information
- voluntary and confidential health counselling and testing for HIV
- anti-retroviral (ARV) treatment where appropriate
- antenatal and post-natal care
- education and support on safer infant feeding methods should also be formulated with girls' mothers in mind
- privacy for counselling should be in place
- gender separate services should be available
- post abortion care (may be optional)
- other family planning methods than condoms available
- services for adolescents who are already pregnant or who have a child to delay second pregnancy.

Prevention

Preventive work on sexual and reproductive health includes practical aspects such as providing contraceptives in a culturally acceptable way, and communicative aspects which aim at disseminating information and knowledge that helps young people to make the right decisions when it come to their lifestyles. Some of the work in relation to sexual and reproductive health may even require long term interventions that aim at changing the values and cultural patterns in the community at large. The scope of people who can play a supportive role in assisting youth to make better choices is large and includes parents, teachers, community leaders, medical staff, NGO staff and peers. For the prevention aspect of a programme to be as effective as possible, it is necessary to decide which group is best suited to deliver which message. Note should be taken that different groups may have access to different youths. The various groups of people who can play key roles in supporting youth, need to be given the opportunity to build their capacities in the area of sexual and reproductive health rights.

Addressing harmful traditional practices

Programmes targeting traditional practices classified as harmful, need to be addressed through strong elements of community ownership and social mobilisation. Programmes which have been successful in this area have brought together a large variety of people, community and religious leaders, institutions, government officials, school teachers, health staff, all linked together to work for the same cause. A key success factor has been the systemic cross-sectoral approach.

A key element in the successful programmes was the important involvement of men. The quality of the community conversations should also be given sufficient attention, both in training and follow-up. Finally, the approach should be comprehensive, relating to a wider spectre of problems experienced in the communities.

More information about the importance of including boys and men is available in the section Advocating for sexual and reproductive health in this topic.

Combating HIV and AIDS with prevention, protection and harm reduction

A rights-based approach to HIV and AIDS programming has three broad components:

1. prevention, protection and harm reduction
2. treatment and care
3. impact mitigation.

To protect themselves from HIV infection, young people need power, skills, knowledge and resources. Girls should be provided with economic opportunities to avoid the necessity of transactional sex relationships. The ability to gain status through transactional sex needs to be critically reflected upon together with children.

Programmes should promote and support children's own strategies for staying healthy, such as providing opportunities for children who would like to abstain from sex to occupy themselves after school with sports, drama and clubs.

Sexually active girls should be provided with skills in explicit negotiation of condoms. Training in life skills usually includes negotiation, which could help, provided that it overtly deals with sexual behaviour.

HIV prevention programmes that only focus on education, often fail to achieve behaviour change. Rights-based programmes seek to ensure that all people have the power to refuse sex or insist on condom use, to avoid reusing dirty needles, and to be protected from unsafe medical practices. They also tackle the broader social and cultural barriers that prevent people from accessing relevant information. This includes the attitudes of parents, teachers, media, and religious organisations towards sex and sexuality.

The availability of condoms can successfully prevent the spreading of STIs and HIV and AIDS. The distribution of condoms needs to be accompanied with far reaching discussions on how the contraceptive is correctly used. The use of condoms to prevent pregnancies may not be looked at positively in some sectors of society; therefore the distribution has to be supported with a communication strategy to strengthen the preventive aspects of the programme. A carefully thought through communication strategy should also allow children opportunities to participate actively in the preventive part of the programme. Their commitment and involvement may well turn out to be the key factor for a successful outcome of the preventive part of any programme.

For information on HIV interventions with youth and HIV and AIDS interventions in emergencies see **Handout 8** and **Handout 9**.

Institution building

To increase the sustainability of any programme element dealing with service delivery, it is necessary to support the development of expectations in rights holders such that they place demands on duty bearers through their participation in claims, and in political processes. With regards to sexual and reproductive health rights this requires that the services are available and accessible to all children, in a child-friendly manner. People involved in delivering the service might require capacity building in child-friendly methodologies. It is also necessary to put in place mechanisms and procedures to protect the integrity and dignity of children. Healthcare staff should be sensitive to signs of anxiety, and know how to deal with young people in crisis, or

where to refer them. Services also need to include information and education to help adolescents to become active participants in their own health.

The fulfilment of some aspects of sexual and reproductive health rights depend on the capacities of institutions formally in charge of providing health and education to the children. An important element in any effective programme in this area is therefore the effective capacity building of these institutions. Children can be strategically well placed to help identifying capacity gaps in the institutions they interact with. Within the educational system, young people can be supported to create networks, awareness raising task forces that can become effective actors in the promotion of sexual and reproductive health rights at school, and in the community at large.

Handout 10 summarises providers' needs.

Advocacy

Clear advocacy messages have to be formulated in such a way that they reach the groups of children in the population of concern, in a way that is appropriate for them.

Advocacy messages should consist of general messages that relate to the promotion of good sexual and reproductive health, but additionally there are specific and important health messages concerning issues that children are likely to have to deal with. These include STIs including HIV and AIDS early and/or unplanned pregnancies, unsafe abortions, female genital cutting, substance abuse and nutrition. Research has shown that children do not value sexual education in schools as they often perceive it as being moralistic and negative about sex. It was found that children would like to know **how** they could protect themselves as many of them are already sexually active, rather than just focusing on the biological side of sex. Teachers also often feel uncomfortable how to address questions of sexuality and students questions. Messages should be formulated to correspond to the level of understanding of the children, young people or adults addressed. Advocacy and communication for behavioural change will be further discussed in Advocating for sexual and reproductive health which follows in this topic.

Programming for sexual and reproductive health

To work in a child rights-based manner with sexual and reproductive health rights should automatically put the emphasis of any programming on process. Young people have particular strengths that can contribute significantly to the success of such programmes. Parents, teachers, community and religious leaders should be consulted and briefed on the importance of sexual and reproductive health programmes for young people.

A key element in programming in emergencies is to come to terms with the prioritisations that need to be done, in order to quickly set up an efficient programme. A clear understanding and analysis of prevalent cultural and gender issues should inform any programme planning in this field.

Programme objectives

An objective (sometimes called an outcome or goal) describes a change in condition; an increase in a positive phenomenon or a decrease in a negative one. The goals that are formulated for the programme should be based on the international legal standards (see **Topic 2**) and an emphasis on the relationship between the duty bearer

and rights holder should be ensured. In adherence with the principle of participation, the goals should reflect standards of **procedure** alongside with the **substantive** goals of the programme. Additionally, it is important that the programme goals can be evaluated. Specific programme goals are established after reviewing existing data, epidemiological information and in-depth situation assessments. An example of a goal could be: decrease the HIV prevalence rate in XX community. While writing objectives, make sure that the action word denotes a change in condition rather than an activity. If the objectives include words like: provide, establish, support and hold they are probably activities rather than objectives. For example, behaviour change goals may be formulated as follows:

- increase condom use at first intercourse by youth ages 15 to 19 in the local district by 10% within one year
- increase incidence of healthcare-seeking behaviour for sexually transmitted infections, tuberculosis and voluntary counselling and testing (for example, 15% increase in calls or visits to facilities)
- increase use of universal precautions to improve blood safety
- improve compliance with drug treatment regimens by 25%
- adherence by medical practitioners to treatment guidelines
- reduce incidence of discriminatory activity directed at people living with HIV and AIDS and other identified high-risk groups (decrease numbers of reported discriminatory incidents by 30%).

Timeframe

For an effective programme to be put in place, it is necessary to determine a realistic time frame for the whole programme. It may well be that the programme would benefit from a flexible approach which allows the time frame to be revised, particularly for the mid-term and long-term interventions that are planned.

Accountability

The emphasis on the relationship between the duty bearer and rights holder is one of the cornerstones of a rights-based approach, requires the programming to highlight issues of accountability. For a sexual and reproductive health rights programme to effectively increase the accountability it has to address the need for systems and mechanisms that make it possible to hold a person or an institution to account, to let it be known that there are enforceable consequences to the violation of sexual and reproductive health rights of children. At one end of the spectrum of accountability there are issues of rule of law. The rule of law requires that there shall be no impunity for criminal acts such as rape and other sexual and gender-based violence and perpetrators should be brought to trial (see **Critical issue module 1** Abuse and exploitation). At the other end of the spectrum of accountability, signing a code of conduct on contact and behaviour with children as part of an employment contract contributes to achieving a similar purpose, which is establishing a system that discourages violations in that when there are transgressions, it is systematically and consistently dealt with.

Capacity gaps

There are choices to be made of what type of intervention to undertake, depending on the type of capacity gaps that has been identified. The shortcoming with the different duty bearers may include resources constraints, lack of motivation, poor leadership, working environment, and matters of dysfunctional systems. Not unexpectedly, it is common that several of these factors in combination cause the problems.

Coordination

A key to successful programming is the coordination not only among the humanitarian actors, but also between various programme components. The CRSA undertaken in an initial stage (see **Topic 3**), forms the basis for any programming initiative. For a successful outcome, coordination of various types is required between:

1. **sectors** (health, community services, protection, education)
2. **implementing agencies** (government, NGOs, UN agencies)
3. levels of **service providers** (doctor, midwife, traditional birth attendants (TBA) and health assistant).

Finally, in the programme areas that relate to service delivery, there must be links among critical programme elements, such as **supply** and demand.

Particularly in early stages of emergencies, the best outcome for sexual and reproductive health initiatives may be achieved by choosing **health-supporting** activities rather than through interventions aimed explicitly at reproductive health. As part of an integrated approach, close collaboration is necessary between partners providing healthcare to those affected by conflict and displacement. This will save resources, improve logistics, avoid gaps in coverage and prevent duplication of effort. The tendency to vertical delivery[28] of reproductive health services even in stable settings makes the need for close coordination doubly important to avoid wasting resources.

Collaboration

Working together with existing structures is important in order not to undermine already existing systems. Additionally it shows respect for already existing efforts to cope with the situation, and it provides a platform to increase the sustainability by providing relevant capacity building where it is needed. With sexual and reproductive health in particular, it is important to keep in mind that formal healthcare institutions and hospitals may be complemented by informal and traditional institutions such as TBAs. Involving both formal and informal structures in the work, will more likely improve the outcome of the programme.

For more information regarding implementation see **Foundation module 3** Programme design, **Section 4.**

Advocating for sexual and reproductive health

Key learning points

- Advocacy is an important strategy to achieve lasting development regarding sexual and reproductive health rights for children. Albeit strategically important, advocacy work is part of long-term interventions and should be seen as a complement to service delivery.
- Ministries and other policymakers of the government have important roles to play when it comes to creating the environment which supports positive changes in behaviours relating to sexual and reproductive health.
- An effective advocacy strategy is characterised by approaching a selected predefined group with the appropriate message. Developing messages and deciding how and when to disseminate them is tailored process that should be revised over time.
- Advocating for sexual and reproductive health in schools requires that teachers have been appropriately trained and that they have found ways to overcome their own embarrassment. Teachers who have not come to terms with their own embarrassment tend to focus on negative aspects of sexual and reproductive health and talk about it in an abstract way which is of little help in developing life skills in this area.
- Before people can move to change their behaviour, they need to understand facts which relate to sexual and reproductive health. They also need to learn preventive skills and have the access to appropriate services and products.
- The best prevention from HIV and AIDS is achieved by correct use of condoms. Although abstention and being faithful often are suggested, these alternatives are not considered to be realistic for young people.

Although there is a tangible need for delivering adequate sexual and reproductive health services to address current needs, such services do little to prevent future illnesses. Preventing future sexual and reproductive health related illnesses and complications often require profound changes in the society. In order to truly improve the situation, to effectively protect children from contracting STIs including HIV and AIDS, or to protect girls from complications related to early or unplanned pregnancies, long-term and sustainable change is essential. Such change commonly involves that people change their views of matters relating to culture and gender. Therefore curative interventions have to be complemented and backed up by preventive activities, where advocacy is one of the main strategic means to apply.

Before individuals and communities become motivated to reduce their level of risk or change their behaviours, they must first understand basic facts about sexual and reproductive health and HIV and AIDS, adopt key attitudes and learn protective skills. They must also perceive their environment as supporting behaviour change and the maintenance of safe behaviours, as well as supportive of seeking appropriate treatment for prevention, care and support.

The importance of involving young people themselves together with community leaders and family in this process should not be underestimated. An active effort to ensure that girls, women and mothers are involved in this process must be made. Furthermore, the consideration of non-discrimination is as important here as throughout the work on sexual and reproductive health matters. To include often

marginalised groups such as, children who do not share the heterosexual norm, minorities, children with disabilities or those living directly or indirectly affected by HIV and AIDS remains a central concern also with regards to advocacy activities.

Advocating for sexual and reproductive health reinforces Programming for sexual and reproductive health in that it in more detail examines advocacy as a programme element. **Topic 5** concludes this module by looking into the importance of monitoring and evaluation of sexual and reproductive health programmes.

Engaging men and boys in sexual and reproductive health work

Around the world, women carry disproportionate responsibility for reproductive health and family size.[29] While women receive the bulk of reproductive health education, including family planning information, gender dynamics can render women powerless to make decisions. Men often hold decision-making power over matters as basic as sexual relations and when and whether to have a child or even seek healthcare. But most reproductive health programmes focus exclusively on women. There is a need to reach out to men with services and education that enable them to share in the responsibility for reproductive health.

- Men's awareness should be enhanced of sexual and reproductive health, and support for their partners' reproductive health choices.
- Men's access to comprehensive reproductive health services should be increased.
- Men should be mobilised to take an active stand for gender equity and against gender-based violence.

In programming and policymaking, gender commonly refers exclusively to disadvantages to women or girls, while men and boys are perceived as oppressors and hence left out or ignored. Combating violence against girls and addressing discrimination of both girls and boys, however, requires the inclusion of boys and young men in programming and policymaking. In order to address gender-based discrimination and violence, boys and young men need to be perceived as not only possible perpetrators of violence and discrimination, but also as possible victims and as important actors and partners in solution making.[30]

Despite the fact that gender mainstreaming in programme and policy development has increased during the last decade, gender inequalities and discrimination persist, with substantial effects on the rates of gender-based violence and HIV and AIDS among young people, not least in Africa. For a discussion on culture and gender as underlying causes to problems, please see **Topic 3**.

Women are becoming infected with HIV at a faster rate than men.[31] This is so because socially and culturally, women are deprived their right to determine if, when, where and how sex takes place. UNAIDS' reports reveal that cultural beliefs and social expectations heighten men's vulnerability to HIV infection. Within the context of masculinity, men are expected to be physically strong, emotionally robust, daring and virile. This compromises the desire to live positively and manage stigma, denial and discrimination. Some of the resultant clichés from this perspective include '*real men don't cry'; 'real men don't stay at home like women'; 'real men are adventurous and risk takers'*. Unfortunately, some of these social conditioning and misplaced expectations translate into ways of thinking and behaving that endanger the health and wellbeing of men and their families including abuse of alcohol, narcotics and other

dangerous substances. These conditions and expectations can also lead to unsafe sexual behaviour that increases vulnerability to HIV infection. Sadly, many men consider their masculinity compromised or slighted by the very behaviour that can limit the spread of HIV and AIDS, namely: having one steady sex partner, taking no excess alcohol or other related substances, using condoms, abstinence, showing love, respect and caring for women and their families.

Studies have shown that more than 50% of infected married women contracted HIV from their husbands. Discrimination and social stigma and the fear of losing masculinity continue to prevent many men from accepting and disclosing their positive HIV status.

In analyses of HIV and AIDS in Africa, most reports focus on how women are made vulnerable by the sexual behaviour of men, often using an overly simplistic dichotomy that men always hold power in sexual relationships, and that women are powerless.[32] Without a doubt, too many women and girls have been made vulnerable by the behaviour of men and boys in conflict settings and in sexual relationships. However, in the development literature in general, and in many policy statements related to gender, African men, young and old, are presented in simplistic and overtly negative terms, and the concept of gender as it relates to men is ignored or misunderstood.

Examples of work with young men that apply a gender perspective:

- Men as partners programme in South Africa
- Stepping stones in Uganda and South Africa
- Awareness raising with male adolescents in Nigeria.

Emerging lessons from these programmes suggests the importance of:

- explicit inclusion of discussions of manhood or masculinities in educational activities
- the creation of enabling environments in which individual and group-level changes are supported by changes in social norms and in institutions
- broader alliance building
- incorporation of the multiple needs of young men.

Similar programmes are running in Latin America and Asia. Programme H in Brazil has worked with young men on gender roles, sexual and reproductive health, violence and other related matters. Measurable changes have been documented showing increased condom use and decreased rates of sexually transmitted diseases.[33] In India (Mumbai, Goa, Uttar Pradesh) the Yari Dosti programme has developed similar activities for young men in order to address sexuality and reproductive health. In this context reduction of violence against women has been a specific focus.[34]

Key areas for advocacy on sexual and reproductive health

Advocacy should be an integral component of a comprehensive sexual and reproductive health programme. Such a programme includes both services (medical, social, psychological and spiritual) and commodities (eg. clean delivery kits, female sanitation kits, free condoms, needles and syringes).

In order to create sustainability and lasting improvements concerning sexual and reproductive health issues within a population, extensive advocacy work and behaviour

change are of central importance. Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand basic facts about sexual and reproductive health and HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behaviour change and the maintenance of safe behaviours, as well as supportive of seeking appropriate treatment for prevention, care and support.

Advocating in schools

Schools remain a broad platform from which both children and their parents can be reached for advocacy on sexual and reproductive health matters. It has become clear that sexuality education should start with issues of identity appropriate to age. Sexuality must be discussed in the context of love, self-esteem, relationships and identity. Important topics that should be covered in all sexuality education are:

- gender
- homosexual, bisexual, heterosexual and transsexual relations
- ethnic and religious aspects
- socio economic status
- physical and psychological abilities and disabilities and age.

Sexuality education should be realistic and inclusive rather than exclusive (Nordstedt, 2006). Sexuality education has traditionally focused on factual and scientific explanations of the sex act. It is important that sexuality is discussed within the context of emotions, psychology, social pressure, gender perspectives and cultural norms.

Sexuality education is **not** about learning how to have sex or encouraging children to have early sex. It is not only about the dangers and risks of sexuality nor is it about making children scared of their own and others' sexuality. Sexuality education should be about confirming feelings and explaining sensations of the body in order to create strategies to understand a sexuality that is safe and secure. It is to effectively educate children in the values and moral standards which are important as well as acknowledging that children are sexual beings who, probably, sooner or later, will engage in sex with another person. Moreover, children are bombarded each day with scenes and images of sex in the media, thus the importance of giving them information based on facts and provide answers to and base discussions on questions children have.

Sexuality education has, by tradition, been connected to the understanding of reproduction and to moral values preaching restraints and abstinence until marriage. This does not respond to the reality and concerns of children and is not seen by them as a realistic approach to lead healthy sexual lives (Pattman and Chege, 2003a[35]).

Research carried out by Save the Children in several African countries showed that young people perceived the information on sexuality they received as being too uniform and not suited to the variations in development between children of the same age. Teachers are often embarrassed, adopting a moralist and negative approach to sex.

'Last year during AIDS awareness week our class decided that we would not endure another academic lecture and so we interrupted the speaker and asked real questions about bone (sex). The speaker stammered and got confused then said we were too young to know the stuff we were asking. But we insisted on knowing stuff like how to really bone for pleasure not for reproduction [laughter]. The speaker said she couldn't talk to us anymore because we were being unruly, though we really were not. She left the room and our teacher came and gave us a msomo (lengthy scolding) and so we were back to square one; learning everything we already knew and being taught nothing we wanted to know. They say they are giving us sex education but they are not.' [36]

Female Form 5 student in Kenya

Interviews with teachers have revealed that they were often embarrassed to talk about sex, and often adopt a moralistic approach to sex to protect themselves. This may explain why they presented only the negative aspects of sex. One aspect that has become clear is that those teaching about sexuality must be open, willing and able to question their own sexual identity and critically analyse their own thoughts, feelings and values on the subject. Once this is done, they must be willing to put these aside when discussing with young people so that the dialogue is open and non-judgmental. To be effective, sexuality education must create trust and begin with the realities of children and young people.

Teachers should be trained to be able to provide appropriate and interesting sexual education to children, even those who are currently abstaining. This will probably require that teachers receive training regarding their own sexuality.

Finally, discussing sexual and reproductive health in schools requires specific attention to gender aspects. Studies have revealed significant effects of gendered influences in the way that sexuality and HIV and AIDS is taught in schools. For example, teachers reported that girls became more timid when discussing sexuality, whereas boys became bolder. In some classes, when issues about HIV and AIDS or sexuality were discussed in mixed groups, girls said they kept quiet because they were afraid of being ridiculed by the boys. This is found in the following observation of an AIDS awareness lesson in a school in Kenya.

'Girls were quiet and shy, reserved, looked down when certain words were being mentioned, ie. 'sex', 'sexually active', 'sexual intercourse'. Boys got most of the attention from the teachers throughout the lesson. No attempt was made to engage girls in discussion; they were often forgotten. One girl was active but not noticed by the teacher.' [37]

Although school-based sexual and reproductive health education is an important ingredient in a successful programme, it must be remembered that not all children will be reached through this channel. Therefore, any school-based education needs to be complemented with other community-based initiatives in order to build a holistic protective programme on sexual and reproductive health for children and young people. Even children who have not visited sexual and reproductive health services should be reached with messages informing them about the confidentiality of services such as voluntary counselling and testing (VCT). However, in many countries, parental consent is needed for HIV testing under age 18.

Effective sexual and reproductive health advocacy

Effective advocacy comprises three main stages, including who should be influenced, what the desired change of behaviour is and how the message should be brought across. In order to make the right decisions here, the information and facts from a child rights situation analysis are required. The CRSA should also indicate which areas are of most concern, this will guide the prioritisation necessary for effective advocacy (see **Topic 3**).

Identify target population

When changing behaviour, the individual, community, or institution goes through a series of steps, sometimes moving forward, sometimes moving backward and sometimes skipping steps. Even when people adopt new behaviours, they may at times revert to old behaviours, at least under certain circumstances.

The first step for an effective advocacy is to identify the target population as clearly as possible. Target populations can include:

- individuals at high risk or vulnerability, such as sex workers, their clients, youth, migrant workers, uniformed services personnel, or separated children
- people providing services, such as health workers, private practitioners, pharmacists, counsellors and social service workers
- policymakers, such as politicians
- leaders and authorities, formal and informal, including law enforcement, social and religious leaders or community leaders and role models
- local communities and families.

Target populations can be defined as primary or secondary. **Primary populations** are the main groups whose behaviour the programme is intended to influence. **Secondary populations** are those groups that influence the ability of the primary population to adopt or maintain appropriate behaviours. For example, a programme objective may be to increase condom use among sex workers and clients (primary populations). But to achieve this objective, it may be necessary to change the behaviour or gain the support of brothel owners and police (secondary populations).

Responsibilities of ministries and policymakers

Advocacy involves direct communication with decision makers and others who have influence over them. It is about educating and convincing them to support and improve the situation of sexual and reproductive health for children. Its primary targets are the people with the power to influence changes at the policy level. Advocacy can occur either formally, through visits to and briefings of decision makers and others or informally, through conversations in corridors, restaurants, parking lots, where decision makers go about their daily lives, or at events that are not directly related to advocacy.

Development of a supportive environment requires national and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviours and cultural practices that may increase the likelihood of HIV transmission and other forms of ill health. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law.

Community leaders, role models and policymakers have an important role here to foster an environment conducive to positive change of matters concerning sexual and reproductive health. Given the fact that some children do not identify with the heterosexual norm, information on sexuality should be inclusive by not taking this norm for granted.

For more information on developing behaviour change communication strategies and plans, see **Handout 11**.

Segment target populations

Segmenting the group can further refine the definition of target populations. For example, sex workers can be grouped more specifically according to work location (street, home, brothel), income level, ethnicity, or language. Psychosocial characteristics can further define segments of the population. This includes knowledge, attitudes and practices typically demonstrated by a given group or audience; or by their role in society, their formal and informal responsibilities and their level of authority. Demographic characteristics include age, place of residence (or work), place of birth, religion and ethnicity.

Develop communication messages and products

When the target group has been defined, the messages need to be developed in a language that is relevant to them. Development of specific communication support material should be based on decisions made about channels and activities.
They can include:

- print materials for peer educators, such as flip charts and picture codes
- print materials to support health workers on specific care issues
- television spots for general broadcast
- promotional materials about the project, for advocacy
- scripts for theatre and street theatre
- radio or television soap opera scripts.

It is important to try out messages and activities at every stage with representatives from all audiences for whom the communication is intended, both primary and secondary. Discussions should also be done with other stakeholders, since their views may differ from those of the target population. This is not always possible, but with an eye toward minimising controversy, programmers should attempt it, since disagreement with stakeholders can derail or compromise a programme.

Pre-testing of media, messages and themes should evaluate the following.

- **Comprehension** If the intended target group understands the message
- **Attraction** If the message catches sufficient attention
- **Acceptability** If the attention attracted is of the right kind ie. increasing the will to learn more instead of repulsive or triggering the target group to switch off
- **Persuasion** Evaluates if the message and facts is convincing enough
- Audience members' **degree of identification** If the message is perceived to be of concern to the target group

Advocating against the spread of HIV and AIDS

This section provides more information regarding effective messages to combat the spread of HIV and AIDS. This information may be a useful base of knowledge in the work of designing appropriate advocacy messages.

Awareness raising on how to protect oneself from HIV and AIDS and other STIs is often approached by encouraging young people to **abstain**, **be faithful**, or use **condoms**, commonly known as the **ABC** advocacy. A recent study by Save the Children has questioned if this advocacy has the desired impact and effectively prevents new infections.

A study in Kenya found that 46% of youths gave the correct definition of **abstinence** as 'not having sex' (Pulerwitz et al, 2006[38]). However, there were conflicting results from the focus groups. Some male youths said that the community saw abstinence as being abnormal, while others said a person who abstains is considered holy and a role model. In general, abstinence was talked about by sub-Saharan African youths as an important way of avoiding HIV and AIDS. This was not necessarily linked to abstinence before marriage, particularly in Uganda and Malawi. It was seen as a strategy to be pursued after being diagnosed with an STI. For this reason, VCT sites were seen as an aid to becoming abstinent.

23% of youths in Kenya correctly defined **being faithful**. Youth usually confused the term being faithful with being loyal, honest or trustworthy (Pulerwitz, 2006). In Tanzania some youths were unclear about the meaning of being faithful, even after leaving a session with a VCT provider where they said that they would be faithful with their steady partner, but use condoms with other sexual partners (Thomsen et al, 2006[39]). Being faithful or fidelity is seen as a strategy to employ after having been tested for HIV and young men often expressed doubt that their female partners were actually being faithful, even if they said they were (Mash and Kareithi[40]). The being faithful part is difficult to understand. Practitioners need to be clear and straightforward to demystify the facts. But the practitioners (the messengers of the info) need to be credible within the local context.

In Kenya, 13% of youth correctly defined **consistent condom use** (most youth gave opinions, mainly negative, about condom use instead of defining it). Female youth talked about how condoms have '*virus*' or '*small holes that can allow the virus to go through*' (Pulerwitz, 2006). In Senegal, over 25% of adolescent girls and almost 40% of boys believed that it was possible to re-use a condom (Synergie Banlieue, 2007[41]). Young men in South Africa saw condoms as being unreliable or ineffective, primarily due to rumours that they contain dangerous fluids that can cause diseases (Mash and Kareithi, 2005). Although youths felt that it was important to use them, most did not like them due to fears that they would break, they were ineffective or even dangerous, they give less pleasure and that they convey a lack of trust to one's partner.

Tanzanian rural youths were also sceptical about the effectiveness of condoms and they expressed frustration over the contradictory information received from the government and NGOs '*condoms are good'* and the church '*condoms are bad'* (Masatu et al, 2005[42]). In addition to doubting their effectiveness, Zambian adolescents felt that condoms were inappropriate for young people because they were too big (Fetters et al[43]).

Abstinence not realistic for sexually active youth

Abstinence and being faithful were largely viewed as laudable behaviours, but not necessarily realistic (Amuynuzu-Myamongo et al, 2005; Pulerwitz, 2006; Synergie Banlieue, 2007). Some young people felt that abstinence was promoted by adults to keep youths from enjoying themselves, such as this young Ugandan male:
'Usually relatives tell you only problems of condoms even when you are using a condom, that it is not safe. It is not safe. They say you should abstain, so relatives control you.' Amyunzu-Myamongo et al, 2005 p27

We need more research to understand the perceptions of youth and the emotional drivers of their behaviours, as well as the perceptions of the stakeholders in the community which keep social and ethical mores in place.

Training material for this topic

Exercise 1 Rights-based programming

Exercise 2 Youth-friendly services

Exercise 3 Designing a sexuality education programme

Exercise 4 Reviewing information, education and communication (IEC) materials

Exercise 5 Exploring the diversity of young people's needs

Exercise 6 Meeting the needs of diverse groups of young people

Exercise 7 Early or unplanned pregnancies

Handout 1 Discussion questions

Handout 2 Youth-friendly statements

Handout 3 Your rights

Handout 4 Role plays

Handout 5 Programme settings

Handout 6 Discussion questions

Handout 7 Definitions

Handout 8 HIV interventions with youth

Handout 9 IASC guidelines for HIV and AIDS interventions in emergency settings

Handout 10 Providers' needs

Handout 11 Behaviour change communication (BCC)

Handout 12 Quality care

Topic 5
Monitoring, evaluation and learning

Key learning points

- Continuous monitoring of advocacy progress and the external environment are essential to keep on top of a fast moving situation and the changes in political power.
- Involving youth in advocacy will make the issues more relevant for youth, and will authenticate the need while furthering progress. This can happen in small ways with youth exercising their rights at the local level as well as at making the case for representation at higher levels.
- The evaluation and monitoring should measure at the programme level as well as at the population level. Examining the programme level provides an understanding of how the programme is working; the population level provides information of the impact of the programme.
- Evaluating impact of advocacy is difficult, but efforts can be made to track expected milestones and outcomes on the way to achieving objectives. Important lessons can be learnt about how to improve advocacy in emergencies. The key is to be clear about what is being measured and how it will be measured.
- Documentation and dissemination of the facts assessed and gathered in the evaluation and monitoring phase is an important step in improving the programme, soliciting new resources and promoting the institutionalisation of the activities.
- Because there is so much still to be learnt about motivations for youth behaviours, it is often good to try to build in an operations research piece to better understand such concepts as the drivers of youth behaviour, the value of the enabling environment on youth behaviour, or test the added value of an approach in one community versus another.

Why monitor and evaluate sexual and reproductive health programmes?

Monitoring and evaluation (M&E) shows if and how the programmes are working. M&E can be used to **strengthen programmes** as programme managers and staff can assess the quality of activities and/or services and the extent to which the programme is reaching its intended audience. Adequate data makes it possible to:

- compare sites
- set priorities for strategic planning
- assess training and supervisory needs
- obtain feedback from the target audience or programme participants
- prioritise resource allocation
- improve information for fundraising
- provide information to educate and motivate staff
- provide information for advocacy
- advocate for the effectiveness of the programme approach.

M&E results can help **institutionalise programmes**, in that stakeholders and the community understand what the programme is doing, how well it is meeting its objectives and whether there are critical needs inhibiting progress. M&E results can be used for educational purposes directed towards a board of directors, current and prospective funding agencies, local government officials and key community members, such as local leaders, youth and parents. Sharing results can help programme establish or strengthen the network of individuals and organisations with similar goals of working with young people. It can also give public recognition and thanks to stakeholders and volunteers who have worked to make the programme a success, and may attract new volunteers.[44]

The dissemination of M&E results both those that show how programme is working and those that find that some strategies are not having the intended impact, contributes to a **global understanding** of what works and what doesn't in improving young people's reproductive health. This advances the field by building a body of **lessons learned** and best practices that can strengthen these programmes around the world. Monitoring and evaluation results can develop a sense of ownership through participation, **improve coordination** and mobilise support for youth and the array of programmes that foster their health and development.

The following steps are included in an effective monitoring and evaluation process:

- agreeing on the scope and objectives of M&E plan with stakeholders
- selecting indicators
- systematically and consistently collecting information on those indicators
- analysing the information gathered
- comparing the results with the programme's initial goals and objectives
- sharing results with stakeholders, including youth.

In order to carry out effective monitoring and evaluation, a work plan has to be developed also for this part of the process. Such a plan will include several kinds of information:

- tasks involved in carrying out monitoring and evaluation, such as involving stakeholders, assessing the information
- needs of project, communicating M&E results and modifying the scope and number of targets as well as intervention based on results
- timelines for each of these tasks, with a space to check off when each is completed
- lists of who is responsible and who will be involved in each stage of monitoring and evaluation
- financial resources needed to complete each task.

Monitoring

During the programme implementation, regular **monitoring** should take place to keep track of progress and shape future activities. This is particularly important in emergencies where the situation can change very quickly. A strategy can be evaluated by revisiting each step in the process, asking questions such as: '*Are the decision makers being reached?'* It is important to be able to revise the strategy and to adapt

or discard those elements of a strategy that are not effective if the results of monitoring and evaluation indicate that such a change is necessary. Monitoring should be as simple and effective as possible. It may just take the form of regular meetings between key advocacy actors. Keep in mind that since youth are engaged as part of process, strategies need to be seen as interesting and fun.

Often monitoring receives inadequate attention, both in terms of collecting information and still more often, in making sure it gets fed back in usable form to people who need it for decision making and field implementation. Specific personnel must be designated to:

- make sure that the monitoring plan is developed with input from the people who will use it
- make sure that everyone involved knows the expected outcomes and has the appropriate tools and skills
- make sure that there is budget and time enough to carry the plan out.

Continuous monitoring is really important to ensure learning from experience so that new developments can be responded to quickly. It is important to know when to consolidate partial successes, and when to recognise that a particular tactic isn't working. Monitoring through regular meetings and updates is a way of building and strengthening relationships with allies and team members, and ensures the sharing of essential information. Monitoring also provides documentation that can be used for an evaluation of an advocacy strategy.

As well as monitoring the advocacy process, regularly assess progress in relation to long-term goals and objectives. This helps ensure the best possible decisions are being made about how to move forward.

A variety of methods and procedures are used to collect information about a programme and its target population. Indicators are used to measure how a programme is functioning and what outcomes it is having in the target population. An indicator is a measure of programme objectives and activities. Changes in indicators demonstrate that a programme is functioning and the effect, positive or negative, it is having on the target population. Information is collected on some objectives both **programme level** and **population level** in order to measure whether a programme's activities are being implemented, the quality of programme implementation, to what extent the programme is being utilised, or the changes that are taking place in target population, if any. In general, information collected during a process evaluation will measure programme-level objectives. Information collected during an outcome or impact evaluation will measure population-level objectives. To measure changes in objectives, baseline information should be compared to data collected after the programme has been operating for some period of time. Measuring programme-level objectives is an important part of understanding how a programme is working. Programme-level objectives are measured during a process evaluation, and provide information on how a programme is functioning. A process evaluation may offer insights into why the programme is having an impact (or not) and is important when scaling up or replicating a programme strategy.

What is an indicator?

An **indicator** is a measurable statement of programme objectives and activities. Once a programme's objectives and activities have been defined, indicators or measures can be developed for each objective and activity. Some programmes may have single indicators, and others have multiple indicators. Generally, it is preferable to have several indicators to capture the multiple dimensions of programme. However, a manageable number of indicators should be carefully selected so that they accurately reflect the programme objectives and activities and the evaluation priorities.

Some indicators at the strategic objective level that have been used in adolescent reproductive health programmes include:

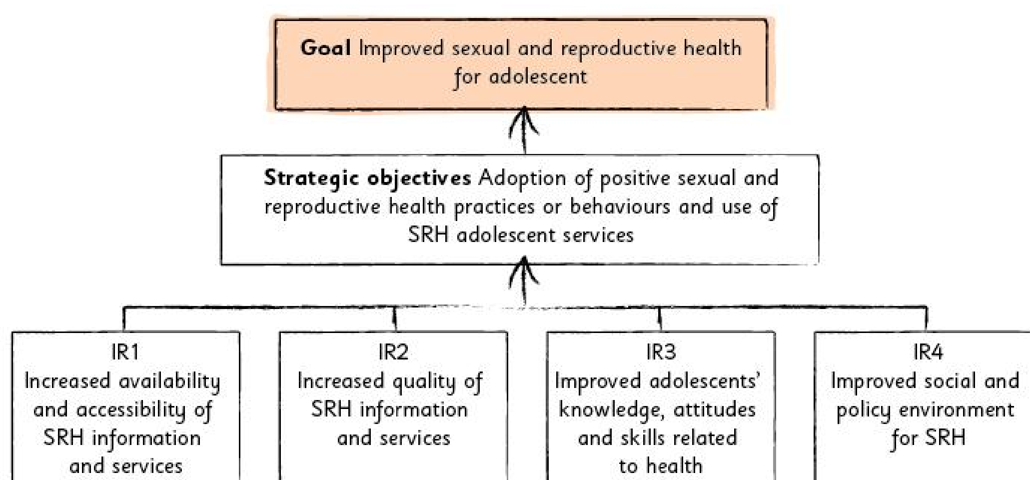
- number of total visits at service delivery points (SDPs) by adolescents during a set time period
- number of new adolescent clients visiting SDPs
- number of adolescents who have gone for VCT in a given time period
- percentage of adolescents who report adopting at least one positive practice (abstinence, monogamy, partner reduction, condom use, contraceptive use)
- percentage of adolescents who received sexual and reproductive health (SRH) services (type of service to be specified).

Indicators can be used to over time to measure programme outcomes. Comparing indicators from different sites will expose problems, and highlight good examples and excellent performance.

Indicators can be expressed in different forms. Numeric indicators are expressed as counts, percentages, ratios, proportions, rates or averages. Non-numeric indicators are expressed in words. They are also referred to as **qualitative** or **categorical** indicators. These indicators usually denote the presence or absence of an event or criteria. The following are examples of non-numeric indicators.[45]

- Peer education recruitment completed? (yes or no)
- Training curricula included topics on relationships and sexuality? (yes or no).

Indicators should be consistent for the duration of the monitoring and evaluation effort. If indicators are dropped, added or modified during the programme's implementation, it may not be possible to assess why changes are occurring in the target population.



Adapted from *Save the Children US, ARSH results framework*

Evaluate, elicit feedback and modify the programme

Evaluation refers to the assessment of a project's implementation and its success in achieving predetermined objectives of behaviour change. Outcome and impact evaluation measure the extent to which programme outcomes are achieved, and assess the impact of the programme in the target population by measuring changes in knowledge, attitudes, behaviours, skills, community norms, utilisation of health services and/or health status. **Outcome evaluation** determines whether outcomes that the programme is trying to influence are changing in the target population. **Impact evaluation** determines how much of the observed change in outcomes is due to the programmes efforts.

Behaviour change communication (BCC) interventions should be evaluated against their stated objectives and in reference to a baseline that may be qualitative or quantitative (or both). For large-scale interventions, baseline **quantitative research** may be repeated to demonstrate changes in knowledge, attitudes and reported behaviours relative to communication and project level behaviour change objectives. Change can also be assessed through qualitative research into target-group responses to interventions. **Qualitative evaluation** involves examining data that are designed to illustrate changes in audience behaviour.

As programmes evolve, target populations acquire new knowledge and behaviours, and communication needs may change. The needs of target populations must be periodically reassessed to understand where they stand along the behaviour change continuum. As epidemics develop, the types of information and communication needed by target populations evolve from basic HIV and AIDS information to discussions related to stigma, care and support and sustaining safe practices. Monitoring and evaluation studies should lead directly to modifications of the overall programme, as well as of the BCC strategies, messages and approaches. Day-to-day monitoring will provide information for making adjustments in short-term work planning. Periodic programme reviews can be designed to take a more in-depth look at programme progress and larger-scale adjustments or redesign. Involving stakeholders, target audiences and partners as much as possible will provide a better look at what is happening; help make appropriate decisions; and make sure that the people affected by any decisions will be fully aware of them.[46]

Evaluation takes a more independent look at the impact of advocacy work after a longer period. It focuses on impact in terms of achieving policy change objectives, and in other areas of change, such as increasing the capacity of civil society, or creating new ways for children and adolescents to participate in decision making. The evaluation findings can help improve future advocacy by suggesting different tactics to achieve a particular policy change, or just by analysing more generally how to improve advocacy for youth in emergencies.

Population-level objectives relate most directly to the sexual and reproductive health outcomes programme hopes to achieve. However, they are often difficult to measure because they deal with sensitive issues, such as whether or not young people are having sex. Although it may be difficult, population-level objectives should always be measured related to intermediate behavioural outcomes. Measuring short-term objectives related to the risk and protective factors that a programme identifies as influencing young people's behaviour is important for two reasons. First, in the absence of showing changes in behaviour, the achievement of short-term objectives is a good sign that a programme is **producing outcomes**. Second, measuring short-term objectives also helps **test assumptions** about the factors that influence the behaviour and decision making of young people. This information may provide insights into how a programme strategy is working, or not working, to influence the behaviour that produces long-term reproductive health outcomes.

Using the information

Although a lot of work may go into the compilation and examination of the facts covered in the monitoring and evaluation process, the final most important stage is to use the information as another effective tool in the sexual and reproductive health programme. If the report is not circulated and ventilated, it cannot be expected to contribute to improvements or necessary changes in the activities. A common form of disseminating the findings is to produce a written report, possibly supported by oral presentations. An evaluation report should emphasise only the most important and useful findings, highlighting information that will shape the decisions made by staff, donors, policymakers, communities and youth. Keep descriptive information, such as the background of the programme, to a minimum, as many readers will be familiar with the programme. Include an executive summary ie. an overview of the main findings. This summary should be written so that it can be distributed independently, for example, to policymakers who may be less likely to read a full report.

Training material for this topic

Exercise 1 Evaluating sexual and reproductive healthcare

Handout 1 Impact indicators, criteria and tools

Endnotes

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8 *World development report* World Bank and World Health Organisation, 1996

9 *Global health facts* The Henry Kaiser Family Foundation available at: www.globalhealthfacts.org

10 Power is the capacity to make decisions or the ability to influence control.

11 Fetters et al, 1998 p18

12 Respect requires the State to refrain from interfering directly or indirectly with the enjoyment of the right; protect is the obligation of the State to take measures that prevent third parties, ie. other citizens, from interfering with the rights guaranteed, and fulfil is the obligation to adopt budgetary, judicial, administrative and promotional measures towards the full realisation of the rights.

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16 For a complete listing of the various documents that are produced in relation to the Committee of the Rights of the Child, see **Foundation module 3** Programme design

17 See **Foundation module 3** Programme design for more information.

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22 The system with cluster leads has been developed among humanitarian organisations to improve coordination and interventions in emergencies. The system predefines coordinating organisations, in a number of areas. However, should the cluster leading organisation for any reasons not be in a position to take on the coordinating functions, it is of paramount importance that another suitable organisation carries out the functions.

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27 Access could both be in terms of transportations aspect (easy to walk to) or the stigma factor (comfort level of youth to go to the centre).

28 Vertical delivery of health services implies a selective targeting of specific interventions not fully integrated in health systems. The opposite is horizontal delivery, where services are delivered through public financed health systems as comprehensive primary care.

29 From Engender Health Men As Partners® (MAP) programme

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31 From *Men can make a difference: the Mmaak Manual for training men in HIV and AIDS prevention, care and support, 1st edition* Onyango M, Mkala Z, Okumu M and Hussey J, Movement of Men Against AIDS in Kenya (MMAAK) 2005

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Engaging men and boys in changing gender-based inequities in health: evidence from programme interventions 2007

34 *Young men redefine masculinity* Dosti Y, 2006. More manuals and resources on how to engage boys and men in sexual and reproductive health programmes can be accessed on the MenEngage website www.menengage.org/

35 'Finding our voices. Gendered and sexual identities and HIV and AIDS in education' Pattman R and Chege F *Africa: Young voices series no.1* UNICEF, Nairobi 2003

36 Mbugua, 2007 p1087

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38 *ABC messages for HIV prevention in Kenya: clarity and confusion, barriers and facilitators* Pulerwitz J, Lillie T, Kiragu K, Apicella L, McCauley A, Nelson T, Ochieng S, Mwarogo P and Kunyanga E, 2006.
Paper presented at The 2006 HIV and AIDS Implementers' meeting of the president's emergency plan for AIDS relief, Durban, South Africa, 12 to 15 June 2006

39 'Voluntary counselling and testing for youth and linkages to other reproductive health services: risks, perceptions, and needs for youth in Tanzania' Thomsen S, Lugina H, Katz K, Reynolds H, Johnson L, Reuben E and Kaaya N *YouthNet working paper no. 5* Research Triangle Park: Family Health International/YouthNet, 2006

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41 *Etude de base sur les connaissances attitudes et pratiques des adolescents de Pikine en santé reproductive. Rapport provisoire* Synergie Banlieue and Save the Children, Dakar 2007

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Guidance for training on critical issues

All Critical issue modules follow the same pattern of five topics.

- **Topic 1** The issue for children
- **Topic 2** The law and child rights
- **Topic 3** Assessment and situation analysis
- **Topic 4** Planning and implementation
- **Topic 5** Monitoring, evaluation and learning

Anyone facilitating a training or awareness-raising event on a specific critical issue should refer to the recommended **key learning objectives** below for each of these topics. With each of the sets of learning objectives is a suggested **sequence of information** to be followed when tackling the topic, in order to ensure that the learning objectives are achieved.

Topic 1 The issue for children

Key learning objectives that participants should be able to:

- describe why and how this critical issue impacts on the lives and rights of children in humanitarian settings
- be motivated to address these issues effectively.

Sequence of information

1. What this critical issue covers (might include definitions, different situations, manifestations, interpretations).
2. How it impacts on children (at different ages and stages; in different situations; considerations of gender and exclusion).
3. Why it is important to respond.

Topic 2 The law and child rights

Key learning objectives that participants should be able to:

- cite and justify relevant legal instruments and standards in relation to this critical issue
- identify key duty bearers in relation to the issues addressed in this module
- cite and respect key guiding principles in addressing these issues.

Sequence of information

1. Relevant legal instruments and standards.
2. Relationship between duty bearers and rights holders.
3. Guiding principles.

Topic 3 Assessment and situation analysis

Key learning objectives that participants should be able to:

- describe why rights-based assessment and analysis are essential components of any programming in humanitarian environments
- develop a plan and process for assessment and/or analysis that is informed by rights-based principles and approaches; and which addresses the specific issues raised in a particular module
- identify challenges that they may face.

Sequence of information

1. Why assessment and analysis is essential
2. Difference between assessment and analysis and where each is appropriate
3. Core principles
4. Key tools
5. Challenges and opportunities
6. Plan for assessment and/or analysis

Topic 4 Planning and implementation

Key learning objectives that participants should be able to:

- describe principles and approaches that should be part of any and all implementation strategies
- reflect on how these approaches should apply to the different implementation strategies that address the issues raised in a situation analysis
- make informed decisions about which of these strategies to prioritise and how to implement them effectively.

Sequence of information

1. Relevant guiding principles:
   Working to common goals
   Coordinated approach
   Participation and inclusion.
2. Prevention and implementation strategies:
   The three pillars
   Monitoring and reporting on progress in achieving children's rights.
3. Prioritisation and operational guidance

Topic 5 Monitoring, evaluation and learning

Key learning objectives that participants should be able to:

- describe overall (dimensions of) change to which all child rights-based programmes are working
- describe how interventions proposed in relation to this critical issue contribute to this process of change
- develop relevant indicators of progress at output and outcome levels
- use participatory and inclusive approaches in gathering and analysing indicators.

Sequence of information

1. Overview of dimensions of change to which all child rights-based programmes are working.
2. Clarity about relationship between impact, evaluation and monitoring processes and indicators required at each level.
3. Development of sample indicators for each level.
4. Guidance about appropriate and inclusive methodologies for M&E.

Links to Foundation modules

It is important to refer to relevant Foundation modules when gathering information to support activities in relation to individual topics. The links between Critical issue topics and Foundation modules are outlined below.

- **Topic 1** The issue for children
  Foundation module 1 Understanding childhoods
- **Topic 2** The law and child rights
  Foundation module 2 Child rights-based approaches
  Foundation module 5 Advocacy
- **Topic 3** Assessment and situation analysis
  Foundation module 3 Programme design
  Foundation module 4 Participation and inclusion
- **Topic 4** Planning and implementation
  Foundation module 4 Participation and inclusion
  Foundation module 5 Advocacy
  Foundation module 6 Community mobilisation
  Foundation module 7 Psychosocial support
- **Topic 5** Monitoring, evaluation and learning
  Foundation module 2 Child rights-based approaches
  Foundation module 3 Programme design

For further guidance on developing and running training and awareness-raising events please refer to the **Training manual** and **Facilitator's toolkit** on the ARC resource pack CD-ROM.

Planning guide

Ideally anyone facilitating a training or awareness-raising event should work with a small planning group of resource people who have a good understanding of the local area and the targeted training group. They need to ensure that:

- they agree the best possible capacity-building intervention with the commissioning manager for the event
- they make rights **real** in any workshop, for example by building in field visits, showing relevant videos and DVDs, encouraging personal reflections and developing a workshop **bill of rights** with the participants
- they emphasise participation, inclusion and accountability at all stages.

The table below can be used when considering how best to present or enable participants to achieve the **key learning objectives** of each topic covered.

Sequence of information	**Methodology** eg. exercises, discussions	**Comments** eg. specific target groups