HIV/AIDS EDUCATION FOR REFUGEE YOUTH
THE WINDOW OF HOPE

PREPARED BY THE EDUCATION UNIT
HEALTH AND COMMUNITY DEVELOPMENT SECTION
(DEPARTMENT OF OPERATIONS)

MARCH 2001

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

HIV/AIDS Education for refugee youth
The window of hope

"It's important to tell people about AIDS, 'cause...this thing is reality! It's happening all around the world and many people are not aware of this thing. It's killing people!"

"I will never get sick of hearing about it (AIDS) because the more you hear about it, the better you know about it and the better you can avoid it."

Quotations from youth after seeing the UNHCR supported South African/refugee theatre project "You're not alone", that was performed in 50 refugee hosting schools in Gauteng Province in August 2000. The project is documented on video, available from UNHCR Headquarters or UNHCR BO Pretoria.

Training of refugee youth Peer Educators on Reproductive Health/HIV/AIDS in Osire Camp, Namibia (UNHCR BO Pretoria)

" Many of you are parents...how would you react if you were told that out of five children, two would die prematurely, but that you still have a chance to stop their deaths [through education]? Which parents wouldn't mobilise all their financial, emotional and human resources and act immediately?

" To live free of HIV/AIDS, free of its pain and suffering, free of its devastating destruction, free of its fear -this is the right of every child born in every village, every township and every city on this great continent."

Mrs. Graça Machel, at the African Development Forum 2000: Leadership and Social Mobilisation on HIV/AIDS in Africa. (An excerpt from an advocacy speech on prevention of HIV/AIDS.)

- By the end of year 2000, some 36.1 million people world-wide will have been infected with HIV.
- **About half of all new HIV infections happen to young people between 10 and 24 years of age.** These youth are likely to develop AIDS and die within the next 10 years.
- In some countries, regions, districts in Africa, over 15 per cent of 15 to 18 year-old girls are already infected with HIV.
- **Each day, more than 8500 children and young people are infected with HIV – six every minute!**

Since virtually all cases of HIV lead to AIDS, and AIDS cannot be cured, this represents ***a death sentence for these young people****.* ***Hence, the threat of AIDS can not be ignored****, and must be addressed in all the programmes we design in refugee settings.*

This paper has been written to meet the need for guidance, expressed by our field colleagues in Africa, on how to introduce and implement HIV/AIDS education in our refugee programmes targeting youth. It is addressed to humanitarian workers in refugee settings, especially UNHCR Community Service Officers, education personnel and the staff of implementing partners working on education related issues. We hope that it will provide you with some ideas and practical inputs on how you can approach the issue of HIV/AIDS in formal and non-formal refugee education programmes.

NB: The statistics cited in this paper have been taken from the *AIDS Epidemic Update: December 2000* (UNAIDS/WHO 2000).

TABLE OF CONTENTS

1. INTRODUCTION

Kasulu Camps, Tanzania:

From April to December 2000, a total of 41 rapes were reported. Among the victims, 30 were minors, of whom 12 were between the age of 3 and 9 years old. In most cases, these rapes occurred when the children were left at home alone.

We all know the vulnerability and trauma that refugees - especially children and adolescents - are exposed to. The threat of AIDS is no exception: The complexity of refugee settings provides fertile ground for the AIDS epidemic. The impact of the epidemic on the education sector has already reached far too large proportions to dispute the need for an intervention.

A large number of adolescents in Africa are already living with HIV. In some parts of Africa, up to 30 per cent of secondary school girls aged 15 to 19 are presently infected with HIV.

Within a decade, HIV/AIDS will have significantly affected enrolments in educational programmes. For example in Kenya, the number of children of primary school age will be 13 per cent lower than if there had been no AIDS. In Swaziland, 23 per cent lower, in Uganda, 12 per cent lower, in Zambia, 20 per cent lower and in Zimbabwe 24 per cent lower.

One of the most visible and tragic outcomes of HIV/AIDS is the growth in the number of orphans. Recent estimates show that there are more than 18 million children below the age of 15 who have lost one or both parents to AIDS in the sub-region. We will gradually encounter more and more children affected by HIV/AIDS in our refugee operations.

Lamentably, many teachers have sexual encounters with their students.

Making teachers the recipients of HIV/AIDS messages during the course of teacher training will therefore hopefully benefit both the teachers and their students.

In almost all countries in the region, teachers, college lecturers, inspectors and educational managers are a very high-risk group for HIV infection. In Kenya, it is reported that teacher deaths rose from 450 in 1995 to about 1,500 in 1999. Côte d'Ivoire reported to be losing teachers at the rate of five per teaching day (900-1000 a year). In Sub- Saharan Africa, an estimated 860,000 children lost their teachers to AIDS in 1999. Schools have closed in Congo Brazzaville because AIDS has left them without teachers. In many countries teachers are reputed to abuse alcohol, making them more inclined to risky behaviour and possibly exposing their students to sexual abuse. Refugee youth and teachers are living with HIV and dying from AIDS related illnesses to the same degree as the non-refugee population.

This disaster will continue unless we all, irrespective of our function within an operation, take action to protect the young refugees from this deadly threat.

The question is no longer ***if*****,** but rather ***how*** we should respond to HIV/AIDS. This paper will therefore aim to give field personnel some practical guidance on how to get started in preparing an educational response to HIV/AIDS. This paper is not meant to be conclusive, but to be more of a first input. Our hope is that it will stimulate your own creativity and competence on how to build sound programmes in your specific settings. Even if you cannot follow all the recommendations and methodologies outlined in this paper, don't worry! *The most important thing is to get started.* **We have nothing to lose - But we can certainly make a difference in the life and future of refugee youth.**

2. WHY FOCUS ON EDUCATION?

Even though the HIV/AIDS epidemic has reached staggering proportions, we must remember that **most children and young people are HIV free!** The lowest HIV prevalence is found in children between the ages of 5 and 14. This age group is therefore referred to as "the window of hope". If we can equip these children and youth with the necessary information and means to avoid getting infected by the HIV virus, we can prevent them from dying of AIDS in the future.

2.1 UNHCR'S POLICIES ON REFUGEE CHILDREN AND HIV/AIDS[1]

Some 10 million out of the 22.3 million refugees and other persons of concern to UNHCR are children under the age of 18. In a context of an epidemic that is infecting *six young people every minute,* and which has already left behind millions of orphans, UNHCR is facing an enormous responsibility and challenge in terms of protection. In the eight African countries where at least 15 per cent of today's adults are infected, conservative estimates show that **AIDS will claim the lives of around one third of today's 15 year-olds.**

Refugee children remain a policy priority for the Office. The 1989 Convention on the Rights of the Child (CRC) constitutes an important normative framework for humanitarian action relating to the international protection of and assistance to refugee children. Article 3 of the CRC stipulates that the best interests of the child should be a primary consideration in all actions concerning children. In a world with HIV/AIDS**, it is undoubtedly in the best interest of refugee children and adolescents to be educated on how they can live in safe reproductive health, free of HIV/AIDS.**

Access to education is a fundamental right for all refugee children and serves as an important protection tool. Supporting refugee education and vocational training which integrate an HIV/AIDS component is therefore particularly vital in promoting the rehabilitation and protection of war-affected refugee children and youth.

We can no longer close our eyes to the deadly threat of HIV/AIDS. The 1951 Convention and 1967 Protocol relating to the Status of Refugees, as well as relevant fundamental human rights law provide the global, legal framework for the protection of refugees. In order to address protection concerns specific to HIV/AIDS, UNHCR has issued guidelines that highlight the need to adopt a rights-based approach.

UNHCR Policy frameworks both on Children and on HIV/AIDS make it clear that UNHCR and implementing partner staff, together with Governments, sister UN Agencies, and other organisations,, should assume responsibility for the protection of refugees from HIV infection and should promote the care of those who are already infected. If we fail to offer to the refugees the means to protect themselves against the HIV virus, a large number of people will be repatriated home to die. This is not the kind of "durable solution" UNHCR is working to achieve. **HIV/AIDS Education has therefore become a key element in fulfilling our protection mandate - there is no time to lose**.

All refugee relief operations must respect and protect human rights. The provision of HIV/AIDS education and services should be seen as part of meeting refugees' basic rights to life, health, education and information.

[1] IOM 78/98, FOM 84/98 and "UNHCR Policy on HIV/AIDS" (1998) available at UNHCR homepage: www.unhcr.org

- Refugee education programmes are important vehicles for educating young refugees about relationships and responsibilities in relationships.

- Fears that educating young people about sex and sexual relationships will encourage promiscuity and sexual experimentation are unfounded. Several major international scientific reviews have demonstrated that **well-structured sex-education programmes actually lower the levels of risk-taking and can delay the onset of sexual activity** among those who are not yet sexually active.

- Formal and non-formal education programmes within our refugee operations represent an established structure that can help us to reach children and adolescents both in and out of school. HIV/AIDS components can be included in most of the existing activities.

3. HOW SHOULD WE APPROACH HIV/AIDS EDUCATION?

Starting to address HIV/AIDS in refugee settings will primarily require commitment and a bit of creativity and "cooking skills" - we know there is no shortage of this in our operations! An HIV/AIDS education module should be incorporated in both formal and non-formal refugee education programs, bearing especially in mind that **out-of school youths are even more vulnerable than those in school.**

The objectives of any HIV/AIDS refugee Education programme should be two-fold:

1) **To prevent the further spread of HIV;**

2) **To fight stigma and discrimination and to create an environment of caring and empathy towards those who are already ill or infected.**

Over the past years, several resource materials have been developed and many HIV/AIDS education programmes have been carried out worldwide. We now know *what works and what does not.* Therefore, you should not feel discouraged if you personally lack medical or educational expertise. What the youth need to know about HIV/AIDS is very simple and practical. Furthermore, you will always find a partner organisation able to assist you. Resource materials and information are readily available (see attached list of sample resource materials). You have all the ingredients at hand to move from words to action! In partnership with the youth, teachers, refugee Parent-Teachers Associations, community leaders and implementing partners, you can build an attractive and efficient HIV/AIDS education programme, which will contribute to saving many lives.

3.1 WHAT WORKS?

- Programmes which are developed through consultation and consensus with the local community.
- Programmes which use participatory learning methods (e.g. games, role plays, small group discussions, songs, dance, puppetry...), that allow children and youth to contribute actively with their own experiences and creativity.
- Programmes that use culturally sensitive and accessible educational material (in terms of vocabulary, length and illustrations).

- Programmes which are designed and implemented *by* the youth *for* the youth, in which adults have only a facilitating role.
- Programmes that not only transfer information, but also develop skills that will help youths to make informed decisions about their relationships and their sexual behaviour.

Remember: Whether in school or out of school, the goal of education about HIV/AIDS and Sexually Transmitted Infections (STIs) is to **teach and promote behaviours that prevent the transmission of HIV/STIs and not merely increase knowledge about AIDS.**

A programme on HIV/AIDS should increase knowledge, **develop skills**, **promote positive and responsible attitudes**, and support the motivation of the youth.

The life skills relevant to HIV/AIDS preventive behaviours include: self-awareness, decision making, assertiveness to resist peer pressure to use drugs or to have sex, and practical skills for condom use. These skills are best taught through rehearsal or role-play of real life situations.

Attitudes derive from beliefs, feelings and values. HIV/AIDS education should promote: positive attitudes towards delaying sex; personal responsibility; condom use as a means of protection; supportive, tolerant and compassionate attitudes towards people infected with HIV/AIDS; and sensible attitudes about substance abuse, multiple partners and violent and abusive relationships.

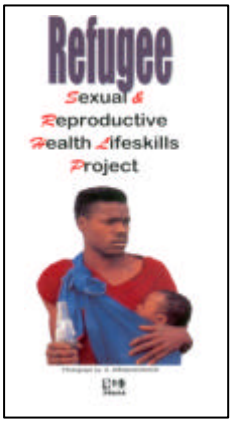
Youth respond most effectively to approaches that are non-judgemental, confidential, caring and creative and which encourage them to ask questions and make their own choices. They also respond most effectively to peer-driven initiatives (as opposed to adult/authority-led ones).

3.2 WHAT DOES NOT WORK?

- Programmes which do not allow the voices of the youth to be heard.
- Programmes that use resource materials that have not been adjusted to the local context and characteristics of the youth (age, language, culture, etc.)
- Programmes using medical vocabulary.
- Programmes that focus only on the different modes of HIV transmission without developing important life skills.
- Using a lecture-style methodology only.

3.3 INTEGRATION OF HIV/AIDS INTO EXISTING REFUGEE EDUCATION PROGRAMMES

The easiest way to start including HIV/AIDS into our refugee education programmes is to integrate small components into the existing activities. In practice, this can be done by:



- Focusing on HIV/AIDS in different school subjects, where the pupils themselves can contribute with their own experiences and thoughts;
- Bringing HIV/AIDS prevention and care messages into established out-of-school activities such as sports/youth clubs, etc., with a focus on healthy living and positive spare time activities;
- Using a variety of different mass communication media (radio, posters, leaflets, etc.) in order to present HIV/AIDS messages or to announce initiatives such as essay/poetry/ painting/puppetry/dancing performances or competitions about HIV/AIDS issues.

Since HIV/AIDS education should be very much directed towards participatory methods, the young refugees must be recognised in their potential to contribute to the programmes.

Ideally, HIV/AIDS education should take place in both formal refugee school programmes and out of school educational activities, mutually reinforcing each other. Where this is not possible, decisions on where to focus must be taken, bearing in mind that out of school refugee youth (particularly girls) are the most vulnerable.

3.4 CHALLENGES

To build an effective response to HIV/AIDS within refugee settings, **co-ordination** with existing structures is important. There is no need to re-invent the wheel or to establish overlapping or parallel programmes if ongoing activities can be expanded to benefit the refugee population. **Establishing and maintaining *good partnerships* with other agencies and stakeholders is the key to building sound programmes.** Possible partners include:

- UN organisations with local or regional representation (e.g. UNICEF, UNFPA, UNESCO, etc.)
- The National AIDS Control Programme, national/local authorities.
- The country 's UN Theme Group on HIV/AIDS.
- Local resource organisations (NGOs, Community Based Organisations).
- International Organisations such as IFRC, ICRC, IRC, MSCI, IOM, IPPF, etc.
- Local host communities.
- Service providers (health clinic, MCH clinic, STI clinic).

In 2000, the **UNHCR Branch Office in Uganda** initiated a project to strengthen the existing STIs/HIV/AIDS service delivery, with a major focus on adolescents (refugee and local) in and out of schools. Formulation of the project involves different stakeholders (AHA, AAH, ADEO, IRC and URCS), who will work in close collaboration with government structures to integrate the services into the corresponding district systems. This will thus make services sustainable beyond the project period.

One should especially be aware of the international youth associations that may be active in the host community. Many refugee youth belonged to such associations in their country of origin (e.g. World Association of Girl Guides and Girl Scouts (WAGGGS), Red Cross/Red Crescent, YMCA/YWCA, etc). These organisations are grass-roots based, and represent **an opportunity for reaching out to both the refugee- and host community** through existing networks. These organisations may also be already active in HIV/AIDS programming locally.

Another challenge is to establish links between your educational programme on STIs/HIV/AIDS and health/nutrition services as well as other services/activities, such as community services. An educational programme can serve as a point of entry to provide youths with important information as to where they can get support when confronted with problems related to reproductive health.

4. A STEP-BY-STEP APPROACH

Before you start planning any HIV/AIDS intervention, you will first need to conduct a *simple mapping* of the ongoing activities in your setting.

What you will need to do is:

- Find out whether HIV/AIDS education is covered (partially, fully or not at all) in the formal school curriculum and whether it is actually taught to the students
- Find out whether HIV/AIDS education is attached to the Non-Formal Education Programmes (NFE) and Out-of-School Activities (OSAs)

If HIV/AIDS education IS included in your ongoing formal and non-formal educational activities:

That's fine! But at some point, you will need to assess whether the HIV/AIDS Education components have an impact on the youth's knowledge and behaviour and if the programme will need improvements or can be used as a model for duplication. The monitoring and evaluation tools suggested in Annex 4 could be of use in this assessment of ongoing programmes.

Any lessons learnt on your HIV/AIDS education programme should be shared with your colleagues in other operations.

If HIV/AIDS Education is NOT dealt with in a consistent manner in the refugee education programmes, the following chapters will outline a step-by-step approach for building a response.

5. FORMAL SCHOOL SETTINGS STEP-BY-STEP

Responsibility for action within UNHCR: Education Officer/Community Services Officer, in most cases in collaboration with Governments, implementing partners and/or the refugee community(DELETE FULL STOP)

The formal school setting has the advantage of providing an established, institutional framework for learning. If the country of origin or asylum has already integrated

HIV/AIDS education in the curriculum, it should be followed, with enrichment as necessary (e.g. to introduce more role-play on risk-avoidance behaviours).

The comparative advantages of Formal School System to Non-Formal Education/Out of School Activities

- Schools can provide an efficient and effective way to reach large portions of the refugee youth population, including school personnel, families and community members.
- Schools can provide interventions that help reduce infection rates and the associated social stigma in a variety of ways (e.g. learning experiences, linkages to services, supportive environment).
- Schools reach students at an influential stage in their lives – when lifelong behaviours are formed.
- Schools provide a channel for the community to introduce HIV/AIDS prevention efforts and an opportunity to advocate for tolerance and understanding.

Step One: Advocacy and Community Commitment

Organise a meeting with the school authorities, youth representatives, Implementing partners and other concerned organisations, Parent-Teacher Associations and other influential community leaders, to reach a consensus/agreement on *the necessity* to provide the youth with the information and resources to live healthy and productive lives and protect themselves against HIV/AIDS. The trainers in the UNHCR/NGO 'ARC' (Action for the Rights of Children) network may be able to help as facilitators*.

Kakuma camp, Kenya

As Kakuma is an extremely diverse camp with at least 8 different nationalities represented, the International Rescue Committee (IRC) is about to start a series of workshops to develop community-appropriate approaches to HIV prevention and care within the different ethnic groups. The workshops will bring together community/religious leaders, women, youth, IRC/refugee staff and other key stakeholders.

HIV/AIDS prevention and care interventions should be developed *with* the community, not *for* the community. It is therefore of crucial importance to have broad-based support from the community at large.

Various gatekeepers normally determine to what extent sex education is taught in schools and its content. These gatekeepers may include local district authorities, community and religious leaders, parents, teachers, and teachers' associations from the refugee and host community. By involving these groups in the process, the planned interventions are more likely to be sustained. However, we must be careful not to limit consultation to the gatekeepers. The youth must also be represented and consulted.

A major challenge for HIV/AIDS programming is the inclusion of children and adolescents in the design and implementation of any intervention concerning them. Attention should be given to children and young people at risk and their experiences should be the key source of information upon which to act. Differences in the ways HIV/AIDS affects males and females should also be clearly identified.

The highly contentious nature of sexual health education for young people makes it important that sources of potential conflict are actively acknowledged from the start. Consultation with the community and religious authorities can give a sense of wider ownership from the outset, and **addressing the fears of parents is crucial**. Within the school itself the support of the head teacher is vital, and she or he needs to be constantly consulted and updated on the progress of the work.

The simple fact that the teachers have received teacher training does not necessarily imply that they are equipped to play the role of sexual health educators. This assumption has proved dangerous in attempts to implement school-based sexual health programmes in the past. The notion that teachers can simply add a certain teaching component to an existing curriculum and use the existing didactic teaching style has proved extremely naive.

Since many teachers (as well as parents and opinion leaders outside school) may see sex education as taboo, **in HIV/AIDS Education the programme design is as much a diplomatic process as it is a technical process.** Participation by these actors is thus especially crucial throughout the design, implementation and evaluation cycle of the project.

Step Two: A Community Task Force

This Task Force should ideally be composed of:

- Refugee Parent-Teacher Associations
- **Refugee community and religious leaders, traditional healers**
- **Refugee youth**
- **Refugee women**
- UNHCR's implementing partners, other organisations active in the community
- If possible, representatives from the district HIV/AIDS, Health and Education authorities.

Set up a community task force to participate in curriculum and resource material development.

Action plan used for establishing a refugee community task force in Tanzania: to ensure a broad representation of the youth in the community Task Force, NPA social and community health workers should undertake a youth census/registration of self-formed existing groups. Each youth group is requested to nominate a representative for

The Task Force members will act as focal points for their respective entities, making sure that they are kept informed and that their interests are taken into consideration. Community involvement from the outset is vital to ensure a sense of ownership from within the community. Resistance is minimised if the community feels responsible for the project's success. It is also important to use the Task Force throughout the implementation of the project, to feed results back to the community. This will demonstrate that efforts by various community members have been worthwhile, and will foster better support for the project.

A central task for UNHCR staff will be to identify one implementing partner, preferably with previous experience in HIV/AIDS and with a satisfactory credibility within the refugee community, that would be willing to take on the responsibility of managing and supporting the Task Force.. The ARC resource persons may help you in this process.

POTENTIAL QUESTIONS TO DISCUSS WITH THE TASK FORCE:

- When do boys and girls become sexually active?
- What do health workers and parents know about HIV and STI prevalence in the community?
- How does the youth perceive their risk of HIV/STI infection?
- What are their main health concerns?
- What are their attitudes toward sex?
- What are the most common sexual practices among adolescents?
- What do parents think about sex education?
- What does the community – of which the school is part - think about sex education?
- Is there any room for expanding Out-of-School Activities to support the school-based programme?
- Are teachers having sexual relations with students?

Step Three: Agreeing on the AIDS Curriculum

Let the Task Force find a consensus on an AIDS curriculum according to age and grade.

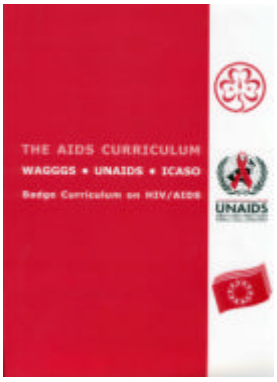
- The Task Force members should review a particular AIDS curriculum (see examples cited in annex) to see whether the information given fits the local context.
- If not, they should make the necessary adjustments.
- When the Task Force has reached a consensus, they should consult their respective entities to make sure that the agreed curriculum is acceptable and accessible to the community.

The AIDS Curriculum developed by WAGGGS (the World Association of Girl Guides and Girl Scouts)

This is *a suggested* curriculum that can get you started. The Task Force should however feel free to do choose another curriculum that they have identified if this is preferable. They should make the adjustments and adaptations they deem appropriate for the local setting[2].

The WAGGGS Curriculum fact sheets have been designed to provide girls and young women with important HIV/AIDS and sexual health information. They need a little adaptation if they are to be used for boys as well as girls. The activities are designed to help young people to:

- Acquire accurate information for themselves which they can share with their families and friends
- Become more confident on issues of sexual health (i.e. postponing sex and negotiating safer sex)
- Learn about resources in their communities, such as people they can talk to if they need information and help
- Explore issues of prejudice and how these are linked to HIV/AIDS
- Explore ways in which they can make a difference in the fight against HIV/AIDS.



The WAGGGS curriculum and fact sheets are organized according to age (10-12, 13-15, 15 and over).

[2] See also the IRC/UNHCR *How-To Guide on Reproductive Health Education for Adolescents* (1998). The guide's appendix 1 shows another sample curriculum on Reproductive Health/HIV-AIDS for 5th grade students.

Step Four: Selection of Resource Materials

The Task Team should be involved in the selection of resource materials that will be used by the teachers and youth in implementing the AIDS curriculum.

These resource materials should be as varied as possible and suitable for participatory learning methods. Examples of such materials are attached in Annex 1.
Other kinds of materials such as posters, leaflets etc could also be used as complementary resources.

Various resource materials are also most likely available locally. Local NGOs/CBOs working with HIV/AIDS should therefore be contacted to explore what kind of materials they have access to.

The resource material should be tested out and adapted to fit the local context. This testing can be done during the Training of Trainers (ToT, see next step).

Key questions to test the curriculum and the resource material

- Will the curriculum meet the information and life skills needs of the target group?
- Is it culturally sensitive to your setting?
- Is the language easy to understand?
- Are the pictures appropriate and clear in terms of presenting the message?
- Does the material avoid labelling and stereotyping people?
- Is the material suited for participatory learning methods?
- Does the curriculum and material build up practical skills (e.g. how to use a condom) and life skills/personal competence (e.g. negotiation skills for condom use)?
- Does the curriculum address the issues of peer pressure and of pressure from adults in authority for children to have sex with them?
- Is the material gender-sensitive, i.e. do girls and boys react differently to it?
- Does the material encourage discussion and openness? Does it avoid "preaching"?

Once the adjustments are carried out, the resource material must be duplicated in sufficient quantities.

See Annex 1 for suggested HIV/AIDS Education resource materials for planners, teachers and students.

Step Five: Training of Trainers (ToT)

Identify a pool of teachers who are willing to learn more about sexuality and Reproductive Health and become HIV/AIDS trainers. Arrange a training seminar for these teachers.

It is neither necessary nor feasible to train every teacher in every school about HIV/AIDS. A more practical strategy is to gather a team of teachers who are willing to become specialised HIV/AIDS trainers. These HIV/AIDS trainers should then rotate through all grade levels in their respective schools.

Even if you train a subset of specialised HIV/AIDS trainers, all teachers should be kept informed about the programme and its developments in order to secure support for the HIV/AIDS interventions and avoid contradictory and confusing information from other teachers. Monthly teachers' meetings to discuss the progress of intervention is one way of involving the whole school. The support of the head teacher is vital, and she or he should constantly be updated and consulted on the progress of the work.

Selection criteria for teachers that are to be trained as HIV/AIDS trainers

Not all people are equally suitable for communicating with young people, particularly with regard to sensitive issues such as sex and relationships. It is therefore important to identify ToT candidates who have strong communication skills. **It is highly desirable to select a gender-balanced group, where women and men are equally represented.** (In some cultures, however, it may be necessary to have ToT, and sensitive classroom discussions, separately for males and females.)

Examples of skills to look for in candidates:

- Ability to create an atmosphere of confidence among participants.
- Respect for the opinions of others, not imposing ideas.
- Experience working with groups of young people.
- Some experience providing health education.
- Patience and good *listening* skills (as opposed to *lecturing* skills).
- Confidence.

The ToT is also an opportunity to test the curriculum and resource materials with both future trainers and the youth, and to involve both users and beneficiaries in final adjustments to the curriculum and material.

What should the ToT contain at a *minimum?*

- Factual knowledge about sexuality and HIV/AIDS.
- Practical skills such as how to use a condom.
- Extensive training in participatory methods, where the teachers can try out discussion groups, games, songs, etc.
- Training on how to encourage open, non-judgemental communication.
- Important life skills for young people (decision making, negotiation skills, etc.)

See Annex 2 for an example of an agenda for a three-day ToT seminar.

Step Six: The Deployment of the HIV/AIDS Trainers

Set up a planning schedule for interventions in the various classes according to grade

In Guinea

The **International Rescue Committee (IRC)** found that to ensure the quality of reproductive health/HIV-AIDS education, not all teachers need to be trained. Only a few teachers, with good communication and interpersonal skills, were trained and later deployed to rotate through the various grades and schools.

Together with each school's administration, you must now plan the schedule for the HIV/AIDS trainers, so that all classes are covered. The trainers should be regularly supervised and encouraged through meetings held at least monthly, where experiences or possible problems can be shared and discussed.

In Tanzania

Refugee parents were concerned that sex education would contribute to early sexual activity among youth. UNHCR staff then reminded the group of the results of the KABP survey, which showed that, in some cases, sexual activity started as early as 7 years of age for some of the children in the camp.

Which grades should be covered?

There is no standard answer to this question. It is however obvious that if sex education is to have any substantial effect, it needs to take place *before the young people become sexually active*. In terms of covering most of the Window of Hope (5-14 years of age), we would suggest that some tailored interventions start at least in grade 4 and continue throughout all grades. However, it is essential to take into consideration the *actual age* of the children in the various grades. In the refugee settings, we know that this may differ greatly even from school to school, and teenagers may be represented even in the lowest grades. If this is the case, special sessions based on age group rather than grade can be considered.

When deciding which grades to target, your Task Force needs to make a *realistic* estimate of the age at which young people become sexually active, in ways that carry a risk of HIV/AIDS. Sex education must begin before children reach that age.

Step Seven: Monitoring and Evaluation

The implementation of the HIV/AIDS refugee education programme must be monitored and changes in knowledge, attitudes and behaviour of the youth evaluated. Remember: It is very important to involve the community task force in the monitoring and evaluation activities!

Monitoring: The information gathering that takes place throughout the project cycle

Evaluation: Periodic gathering of information, such as baseline, mid-term review and end of project evaluation. Collecting information, keeping records and making careful observations about the project's activities.

All of us involved in HIV education need to evaluate how useful our work is, and how to make it better. In order to secure a minimum of data that can help you improve your project, you need to ask questions and seek answers at three different stages of the project:

1. Before the project starts:

Mapping of the current situation.

- What are the factors favouring the spread of HIV?
- What are the most serious obstacles to reducing the spread and impact of HIV/AIDS?
- Who are the youths most at risk and where are they? Why are they at risk?
- Which factors protect against HIV infection?
- What existing data on reproductive health (RH), STIs and HIV/AIDS is available?
- Who is doing what in relation to children and sexual/reproductive health? What are the most important gaps and what opportunities are there to fill them?

In South Africa

UNHCR Branch Office Pretoria, together with the Centre for the Study of Violence and Reconciliation (CSVR), designed a baseline survey that was conducted among the 8 major refugee communities in Gauteng province. The survey tools were translated into 6 languages: English, French, Portuguese, Somali, Amharic and Kinyarwanda. They will be made available in early March 2001 in a How-To guide on the process of developing and conducting surveys on sexual and reproductive health/HIV-AIDS in an urban refugee setting.

2. During the project:

Are the activities being carried out as planned? What you need to keep track of is:

- Requirements for the project to occur: Labour, materials, time, infrastructure, etc. These inputs all have a cost – how much?

- Activities carried out during the project. They could include training, material development, product design and dissemination, education sessions, condom distribution, etc.
- Project results once the activities have been completed. They may include information/education materials for youth or trainers, an upgraded facitility or trained project personnel (trainers).

3. After the project has ended:

Did the project make a real difference in people's lives and what changes have occurred? Results from this evaluation are used to readjust activities, and to plan the next phase of a project or any new activities. By carrying out an impact evaluation of your education programme on RH/HIV/AIDS, you will be able to:

- Measure whether a student's knowledge, attitudes, skills and behavioural intent have significantly changed as a result of the programme.
- Demonstrate to education officials, the community and teachers that effective programmes can be carried out.
- Make a case for obtaining additional staff or funding.
- Increase the support from teachers, parents and communities for the programme.

To date, a certain number of tools have been developed within and outside UNHCR.

See Annex 4 for suggested monitoring and evaluation tools.

6. NON-FORMAL EDUCATION AND OUT-OF-SCHOOL ACTIVITIES STEP-BY-STEP

Responsibility for action within UNHCR: Education Officer/Community Services Officer, in most cases in collaboration with an implementing partner and the refugee population.

6.1 INTRODUCTION

A limited number of refugee youth are enrolled in formal schools, especially at post-primary level. In order to reach the large number of out-of-school youth with HIV/AIDS education, all opportunities must be used. Non-Formal Education (NFE) and Out of School Activities (OSAs) are often more likely to provide opportunities for people to discuss sexual and reproductive health concerns more freely. NFE and OSAs provide us with a number of entry points for HIV/AIDS education, if we are willing to spend a little time and creativity adjusting existing activities so they include HIV/AIDS components.

Investments made in NFE/OSAs will be lost if the children do not have access to information and services that protect them against HIV infection.

Sierra Leone

The American Rescue Committee, together with UNHCR BO Freetown, is about to start a project integrating Reproductive Health/HIV-AIDS IEC components into a micro-credit scheme. The goal is to demonstrate that it is possible to integrate an outreach and training programme including HIV/AIDS into a non-health project. By conducting peer education activities with youth, women, children and other key stakeholders in the community, the project will contribute to decreasing the vulnerability of the refugees and thereby give them a chance to harvest the fruits of their investments.

Examples of well-known NFE/OSAs include:

Skills training/vocational training/income generating activities (tailoring, bicycle repair, farming, type writing, etc.)
Vulnerable youth (young teenage mothers, unaccompanied minors, single women heading households etc) sometimes receive skills/vocational training or are provided with income generating activities of various types. Since there are limited income-generating possibilities available, such activities are often the only means for the youth (girls in particular) to improve their lives. Were an HIV/AIDS Education component attached to such activities, it would provide particularly vulnerable youths with an opportunity to learn about making informed choices and about protecting themselves from being infected by HIV.

Thematic issues (peace, environment, family health, literacy, etc.)

Non-Formal Education programmes are often organised around thematic issues. Ways of **including HIV/AIDS components into these activities are virtually unlimited**, if you are willing to invest a bit of creativity and commitment in the planning. The AIDS curricula

mentioned in Annex 1 can be used as a guide for inserting HIV/AIDS components in these courses and activities.

Youth Centres[3]

In some refugee settings, youth centres have been or are in the course of being set up. As they create a space specifically dedicated to youth, the Youth Centres offer a unique opportunity (through the various activities) to provide the refugee youth with Reproductive Health/HIV/AIDS education. Every kind of dance, drama and musical activity can be used as a medium to encourage the youth to express their own experiences and thoughts about HIV/AIDS issues, and to initiate a discussion around the topic. "Cultural workshops" with painting, poetry writing, puppetry, song, dance, etc., can also be arranged with HIV/AIDS as the thematic subject. Local HIV/AIDS NGOs or other resource organisations can also be encouraged to arrange thematic evenings on HIV/AIDS.

The Health of Adolescent Refugees Project – HARP

HARP was initiated in 1997 as a co-operation between the World Association of Girl Guides and Girl Scouts (WAGGGS) and Family Health International. The project aimed at improving the health of adolescent refugee girls with particular emphasis on reproductive health. Three countries were chosen to pilot the project: Egypt, Zambia and Uganda. A Guide pilot curriculum was developed (see attachment). A total of 900 Guides learned how to pass reproductive health messages to other adolescent refugee girls. As part of the Curriculum, each Guide was expected to talk to an additional 25 peers, both Guides and non-Guides, about what she had learned.

Health clubs

Such clubs are often connected with the schools as an after-school activity and are usually located on the school premises. These clubs aim at providing the participants with broad health education, ideally including HIV/AIDS, and can often be a very

[3] See: *Meeting the Sexual and Reproductive Health Needs of Young Refugees: A Strategic Approach* (UNHCR 2000, available from HCDS/DOS, UNHCR, Geneva)

valuable supplement to the formal health education classes, since the setting is more informal and suitable to the use of games, puppetry, songs, dance, etc. Since some of the refugee youth trained in school will join the club too, and there is a need to *co-ordinate the content* of the HIV/AIDS components presented in the health clubs with the formal school HIV/AIDS programme. The persons/agencies responsible for the Health Club should therefore co-operate closely with the HIV/AIDS teachers in the schools. In this way, one can ensure that contradictory messages are avoided, and that the contents and methodology of both programmes are as complementary as possible.

Sports clubs

HIV/AIDS messages could also be included in sports activities. By engaging in sport activities, the young refugees have made a healthy choice in terms of using their spare time to partake in positive and healthy activities – this is very compatible with information about HIV/AIDS prevention and care. Most sport activities for the youths are gender specific, and therefore provide a good setting to talk more openly about sex than do mixed-gender groups. Sports activities also provide a special opportunity to reach young boys – a vitally important target group for HIV/AIDS education – and encourage them to continue to make healthy lifestyle choices.

6.2 THE COMPARATIVE ADVANTAGES OF NON-FORMAL EDUCATION/OUT-OF-SCHOOL ACTIVITIES TO THE FORMAL SCHOOL SYSTEM

In most cases, the NFE/OSAs will have certain comparative advantages to the formal school setting when it comes to planning and implementing. Some of advantages include:

- NFE/OSAs are of a more flexible nature, and therefore easily adaptable, whereas the formal school system is subject to regulations.
- The NFE/OSAs setting is more suitable to alternative ways of learning, such as Peer Education, life skills, various participatory training methods (e.g. role-play, puppetry, etc.)
- The formal school setting is less conducive to discussions about personal matters, and this may make it difficult for young people to talk openly about sensitive issues such as sexuality.
- Unfortunately, many refugee children and youth are not enrolled in formal schools. This is especially the case with adolescents, a vitally important group to reach in terms of HIV/AIDS risk reduction. NFE/OSAs are therefore a unique opportunity to reach these vulnerable out-of-school youth, particularly when using the Peer Education approach, also known as Friend-to-Friend education.

It is thus recommended that NFE/OSAs be used as the vehicle to ensure that the most vulnerable of our refugee youth are reached with life-saving HIV/AIDS education.

What is Peer Education?

Peer Education typically involves using the members of a given group to effect change among other members of the same group (truck drivers, soldiers, commercial sex workers, PLWHAs, etc.) This approach is also widely used across the world to reach young people outside institutional settings and to help small groups of young people build their knowledge, attitudes and safer-sex skills. Evaluation show that these programmes can be very effective when properly combined with youth- friendly health services. There are many reasons why Peer Education is a suitable approach for youth in refugee situations:

Nyarugusu camp, Tanzania

In November 2000, UNHCR brought 26 youths (24 refugees, 2 host community youth) to a six-day training on changes during puberty, on life skills and other RH topics. People Living With HIV/AIDS (PLWHA) in Kigoma town were among the facilitators. The youths then returned to Nyarugusu to share their new skills with other youths in the camp. After their training, 11 of the participants expressed wishes to take Voluntary Counselling and Testing and learn their HIV status, highlighting the impact of PLWHAs on youth behaviour.

- In refugee settings where there is high unemployment and limited opportunities for secondary/tertiary education, Peer Education taps into a large pool of unoccupied youths in a cost-effective way.
- Youth Peer Educators are better able to reach marginalised groups denied access to formal structures (schools, health clinics, etc.)
- Peer Education by definition requires community participation and is an integral element of wider community development processes.
- Peer Education provides training and resources on RH/HIV/AIDS matters to marginalised youths, particularly girls who do not have access to formal education. Marginalised youth display the highest rates of new infections world-wide.
- Young people are natural experts in communicating with other young people, especially where adult-adolescent communication on sexual health issues is limited or even taboo. They are familiar with the language used by their peers and may therefore have better credibility than adults in delivering messages.
- The effectiveness of a single trained youth peer educator can be multiplied (cost-effectiveness).
- Young people often feel more at ease than adults do in challenging traditional norms and practices, such as female genital mutilation or “dry sex”.

See Annex 3 for a suggested agenda for Youth Peer Educator Training of Trainers.

6.3 THE METHODOLOGY STEP-BY-STEP

The step-by-step methodology for including an HIV/AIDS component in NFE and OSAs is very similar to the steps outlined for the formal school settings. The following table outlines the steps to be followed. Additional comments are included where necessary.

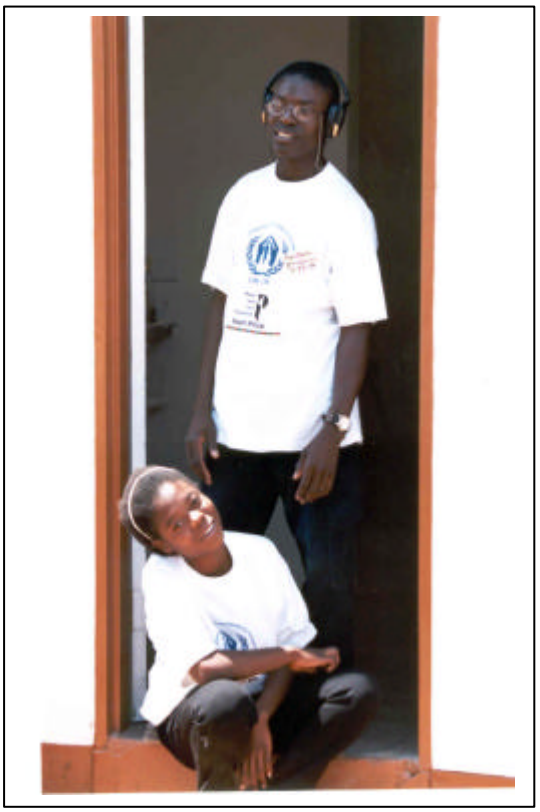
STEP	ACTIVITY	COMMENTS
One	**Inventory of activities*(DELETE FULL STOP)*** Make an inventory of NFE and OSAs to identify potential opportunities to integrate HIV/AIDS education. Each implementing partner, NGOs/CBOs working with the refugees should be contacted to map out who is doing what and where. This is also an opportunity to map out possible existing HIV/AIDS education activities in the local community.	This mapping has a two-fold objective: *1.* To avoid investing time and money on creating overlapping structures *2.* To identify possible local partners and resources All NFEs and OSAs should be included in the mapping: Peace education, environment education, income generating activities, skills training, youth clubs, etc. In addition, other stakeholders who have the ability to provide services to both host and refugee populations should be contacted (e.g. WAGGGS, IFRC, etc.)
Two	**Advocacy and Community Commitment** Organise a meeting with the youth, implementing partners, Parent-Teacher Associations and other influential community leaders in order to reach an agreement on the necessity to provide the youth with information and resources on HIV/AIDS.	It is very important that the youth are represented in this meeting, and that they feel ownership of these interventions right from the start.
Three	**Establishing a Task Force and examining the AIDS curriculum and resource materials** A consultative Task Force that includes important community stakeholders should be established. Youth representatives and the lead agencies in charge of each NFE/OSAs programme need to examine one or more HIV/AIDS education modules to see whether they are acceptable to them. If not,, they should make the necessary adjustments and share their recommendations with the Task Force. A UNHCR implementing partner or other NGO should take over the responsibility to maintain and follow up with the work.	**See Annex 2 for WAGGGS and other suggested HIV/AIDS resource materials** For more information about the creation and function of the Task Force, see Step Two under Formal School Settings.

STEP	ACTIVITY	COMMENTS
Four	**Youth Training of Trainers (ToT)** Within each NFE and OSA, youths - both male and FEMALE! - with communication and leadership skills should be identified and trained as HIV/AIDS trainers.	Some criteria to keep in mind when selecting youth trainers: ▪ Female/male: 50 per cent each ▪ Age group (e.g. 15-25 years old) ▪ Both educated and non-educated youths must be represented ▪ Try to secure diversity in terms of family conditions (orphans, separated youth, etc.) **See Annex 3 for a suggested agenda for Youth Peer Educator ToT**
Five	**Plan the interventions** An implementing partner or other stakeholders should be encouraged to take the lead in further implementation and follow up/monitoring of the programme. The planning of the interventions should be carried out in co-operation with the youth HIV/AIDS trainers.	
Six	**Supervision and Monitoring** The trainers should be offered regular supervision, and the HIV/AIDS education programme should be monitored and evaluated.	**See Annex 4 for suggested tools for monitoring and evaluation**

7. CONCLUSION

As you have discovered from reading this paper, the ingredients required to successfully integrate HIV/AIDS education into formal and non-formal refugee education programmes include:

- A recognition by UNHCR staff and implementing partners of the threat posed by HIV/AIDS to young refugees
- A real willingness and commitment to build on and extend partnerships with NGOs/CBOs that have some experience and expertise in HIV/AIDS.
- A bit of creativity to use/adapt the resource materials which are proposed to you; and
- **A real trust in young people.**



"I am shocked to learn that 1 in 2, that is, *half,* of our young people will die of AIDS. The most frightening thing is that *all of these infections were preventable.*

"We need bold initiatives to prevent new infections among young people. We need to aggressively work with families and communities to care for children and young people, to protect them from violence and abuse, and to ensure that they grow up in a safe and supportive environment.

"History will judge us harshly if we fail to do so right now".

Nelson Mandela
(Closing Ceremony of the XIII International AIDS Conference in Durban, South Africa, July 2000)

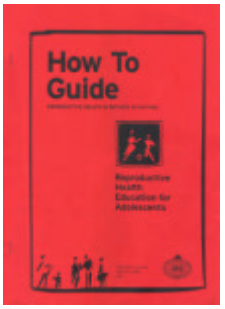
Annex 1

SUGGESTED RESOURCE MATERIALS[4]

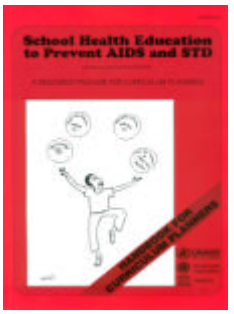
The material listed below is meant as suggested resources for your future work with HIV/AIDS Education. It should be regarded as a starting point for a "cut and paste exercise", since much more material is likely to be available locally if you check with the other organisations working in your area.

FOR UNHCR STAFF AND IMPLEMENTING PARTNERS

- *Reproductive Health Education for Adolescents: A How-to Guide on Reproductive Health in Refugee Situations* (International Rescue Committee/UNHCR, 1998)
  This is a documentation of a programme implemented by IRC in Guinea. It contains examples of curricula and training materials as well as sample monitoring forms, which can be adapted for use in other refugee situations.

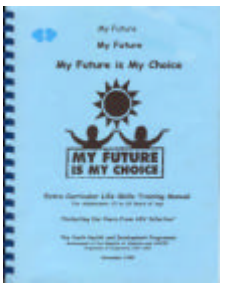


- *School Health Education to Prevent AIDS and STD: A Resource Package for Curriculum Planners: Handbook for Curriculum Planners* (UNAIDS/WHO/UNESCO, 1999)
  The book was prepared to help plan and monitor/evaluate HIV/AIDS education programmes. Contains a series of appendices, mostly evaluation instruments. The series also consists of a teachers' manual and a student's activity book (see below).



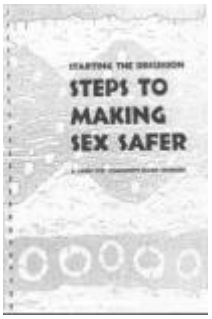
FOR TEACHERS AND TRAINERS

- *My Future is my Choice: Extra Curricular Life Skills Training Manual for Adolescents: Facilitators Guide*
  (The Youth Health and Development Programme, Govt. of Namibia/UNICEF, 1999)
  This is a 10-session programme which aims to give young people the information and life skills they need to make decisions about their future. The programme was developed with and for young people ages 15 to 18. The series also contains a participants' workbook.

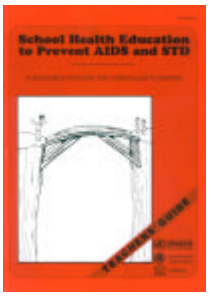


[4] Copies of the resources listed here will be sent to UNHCR regional offices, and will be available there for review.

- *Starting the Discussion: Steps to Making Sex Safer: A Guide to Community-Based Workers*
  (Appropriate Health Resources and Technologies Action Group (AHRTAG, 1996)
  This publication provides ideas on methods and concrete training activities. It also provides guidance on programme evaluation and assessment of teaching aids.



- *School Health Education to Prevent AIDS and STD: A Resource Package for Curriculum Planners: Teachers' Guide*
  (UNAIDS/WHO/UNESCO, 1999)
  This book contains concrete tips on how to deal with specific issues in HIV/AIDS Education, and how the various activities could be carried out. It also contains sample test items for student evaluation.

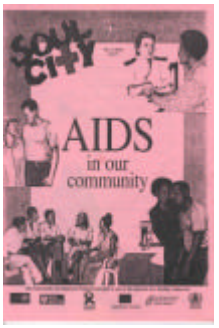


- *WAGGGS AIDS Curriculum*
  (World Association of Girl Guides and Girl Scouts, 2001)
  The WAGGGS curriculum was developed in co-ordination with UNAIDS and ICASO. Its fact-sheets were designed to provide girls and young women with important HIV/AIDS and sexual health information, and provide a grade-based structure for trainers.

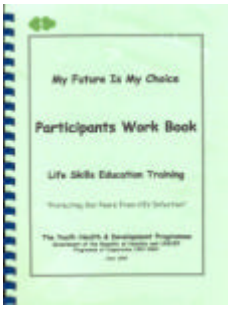
FOR STUDENTS

- Together We Can: Activity Kit
  (Jamaica Red Cross HIV/STD Peer Education Project, 1996)
  This booklet was originally produced for (and partly by) Jamaican youth, but the activities can easily be adapted for use in other contexts. Contains various exercises, games and other activities.

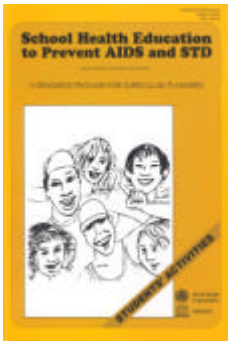
- AIDS in our Community
  (Soul City and Jacana Education, 2000)
  This booklet was developed for use in South Africa, but the material can easily be adapted to fit into other contexts as well. Contains factual information about AIDS, presented in an easy and illustrated way.



- My Future is My Choice: Participants' Work Book
  (The Youth Health & Development Programme, Govt. of Namibia/UNICEF, 1999)
  This booklet goes with the above mentioned facilitators' book, and is divided into 10 sessions according to themes.



- *School Health Education to Prevent AIDS and STD: A Resource Package for Curriculum Planners: Students' Activities*
  (UNAIDS/WHO/UNESCO, 1994)
  This is a comprehensive selection of different students' activities, compatible with the above mentioned guides for curriculum planners and teachers.



EXAMPLE OF AGENDA FOR A THREE-DAY TRAINING OF TEACHERS SEMINAR

Day One		Day Two		*Day Three*	
08.00-08.45	**Introduction** • Presentation of participants • Objectives of the ToT	**08.00-08.30**	**Introduction** • Review of day one • Warm-up activities	**08.00-08.30**	**Introduction** • Review of day two • Warm-up activities
08.45-12.30 (incl. breaks)	**Overview over the HIV/AIDS epidemic** • Transmission and prevention of HIV/STIs • Presentation • Questions and answers • Games	**08.30-09.30**	**Revision of AIDS curriculum and resource materials** • Group work and discussion • Adaptation of curriculum and material	**08.30-10.45**	**Presentation of Group Work** The two last groups present their work, followed by discussion
		09.45-10.45	**Teaching methods in HIV/AIDS Education** • What is a participatory method? • Why participatory methods?	**11.00-12.30**	**Evaluation of students** • What is evaluation • Why evaluate? • How to evaluate?
14.00-16.00	**Working as a community on Reproductive Health and HIV/AIDS** • Youth's attitudes to sexuality, reproductive health and HIV/AIDS • Parents' attitudes • Education about sex-related issues in school • How to discuss sensitive issues • How and why should parents be informed? • Dealing with parents' questions	**11.00-12.30**	**Preparatory Group Work:** Trying out participatory methods: E.g. four different groups: **1) Demonstration of condom use** Focus: Practical skills **2) Ice breaking game** (e.g. "the sweetheart game"). Focus: Setting up a conducive learning atmosphere **3) Questions/answers session** Focus: Communication, parents/children **4) Role play** Focus: How many children should you have, and why?	**14.00-15.00**	**Evaluation of the ToT** • Discussion/questionnaire
16.15-17.00	**Teachers' perceptions of HIV/AIDS** • Teachers' attitudes towards sexuality and people with HIV/AIDS • Teachers and students in school infected and affected by HIV/AIDS	**14.00-15.00**	**Group Work continues**		
		15.15-17.30	**Group Work presentation and discussion** • Two groups present their work followed by group discussion/analysis of form and contents		

SUGGESTED AGENDA FOR YOUTH PEER EDUCATORS TOT

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Introduction to SRH • Definitions • Rights & Responsibilities	**Steps in life** • Childhood • Adolescence • Adulthood	**How our bodies make babies** • Antenatal Care • Labour & Delivery	**Relationships** • Effective Communication • Setting Limits • Conflict management	**Contraception** Teach Back by youth: " How many children you should have and why"?	**Teach Back** by youth on condom promotion and use
	Self awareness • Self Esteem • Values & Beliefs • Decision Making • Personal Goals	**Biological/ Psychological development** • Child • Youth • Adult	**STDs** • Signs & symptoms • Effect • Transmission • Prevention • Treatment	**Abuse & Violence** • Forms of Abuse • Definitions • Effects • Rights & responsibilities • Sources of Help	**Substance Abuse** • Causes • Types • Effects • Where to find help	**Closing Activities** • Post test • Evaluation • Contracts
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
Orientation • Pre-test • Introductions • Training Overview • Expectations • Group Contract	**Family** • Role/structure of family • Parenting • Parents to children/siblings talks • Coping without Family	**Sexuality** • Definitions • Sexual Orientation • Sexual expression	**HIV & AIDS** • Basic knowledge on HIV/AIDS • Prevention • How do you know if you are infected or not?	**Contraception** • Methods • How they work • Effectiveness • Side effects • Where to find them	**Peer Education (PE)** • Roles & responsibilities • Methodologies • PE in our camp • Supports • Referrals • Record keeping	• Graduation • Exercises
	Sex & Gender • Status of women in relationships (boy/girl, husband/wife) • How to improve the status of women.	**Abstinence and Pre-marital sex** • Why, why not?	**Safe Sex & Risk Reduction** • Safe sex • Visiting a sex worker • How people become a sex worker	**Condoms** • Social norms on condoms • How to use condoms	**Family and Community care for persons living with HIV/AIDS** • Basic family care • Compassion and non-discrimination	

(Based on experience from Osire Camp in Namibia.)

Summary	Objectively verifiable indicators	Means of Verification	Assumptions
Goal Improved sexual and reproductive health among refugee youth			Behaviour change is encouraged by the provision of appropriate information
Purpose Reduce risk-behaviour	**By dd.mm.yy** • All refugee youth know what a condom is • All refugee youth understand the importance of, and can demonstrate, correct condom use • Increase the proportion of sexually active youth that report condom use at last sex act • X per cent of sexually active youth report consistent condom use • Increase the proportion of youth who choose to abstain • Increase in proportion of those sexually active reporting one current partner • Increased overall knowledge of reproductive health • Reduced feelings of invulnerability to STI/HIV infection • Increased self-esteem	• In-depth interviews • Questionnaires • Performance tracking systems • Spot checks • Focus groups discussions	Creating awareness and openness around the importance and proper usage of condoms will develop a positive attitude towards safe sex
Outputs • Curriculum on Reproductive Health/HIV-AIDS revised and implemented, and appropriate teaching methods identified • System for condom distribution established • Findings documented and disseminated	• Curriculum revised and approved • Teachers trained in curriculum use and appropriate methods, and reporting on these • Reporting on X number of children receiving training through participation in X number of education sessions • Youth aware of distribution system and have access to it. • X number of documents distributed/advocacy events held	• Performance tracking system • Monthly project reporting	With increased knowledge, the youth will be better equipped to make informed choices
Activities • Identify and access expertise and resources from UN agencies, NGOs, National/local HIV-AIDS control programmes etc. • Revise and adjust suggested curriculum and develop suitable teaching methods • Conduct any relevant (refresher) training with teachers and Peer Educators • Develop pre-test and implement research tools • Document and disseminate findings	**Inputs** • Relevant materials on types, symptoms and transmission modes of STIs/HIV • People, time, money, equipment (training materials, condoms...) • Material for Information, Education and Communication development • Transportation • Audio-visual equipment	Project accounts and documentation	