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An  
Assessment of the  
Impact of HIV/AIDS  
on the  
Education Sector in Nepal

Kathmandu February 2003



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**The Study Team**

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ADB	Asian Development Bank
BPMHF	BP Memorial Health Foundation
CDC	Curriculum Development Center
DEO	District Education Officer
DOE	Department of Education
FACS	Foreign Aid Coordination Section
FGD	Focus group discussion
FHI	Family Health International
FPAN	Family Planning Association Nepal
FSW	Female sex worker
HIV	Human Immuno-Deficiency Virus
HPE	Health Population Environment
IDUs	Injecting drug users
INGO	International non-governmental organisation
JRC	Junior Red Cross
KAB	Knowledge Attitude Behavior
LALS	Life Saving and Life Giving
MOES	Ministry of Education and Sports
MSM	Men having sex with men
NCASC	National Center for AIDS and STD Control
NGO	Non-governmental organization
NRCS	Nepal Red Cross Society
SC/UK	Save the Children UK
SC/US	Save the Children US
SLC	School leaving certificate
SRH	Sexual reproductive health
STD	Sexually transmitted disease
TOT	Training of trainers
UNDP	United National Development Program
UNICEF	United Nation Children's Fund
UoH	University of Heidelberg
VaRG	Valley Research Group

## TABLE OF CONTENTS

	Page
<b>The Study Team</b>	<b>i</b>
<b>Preface</b>	<b>ii</b>
<b>Acknowledgement</b>	<b>iii</b>
<b>Acronyms</b>	<b>iv</b>
<b>Table of Contents</b>	<b>v</b>
<b>List of Tables</b>	<b>vii</b>
<b>Map of Nepal</b>	<b>viii</b>
<b>Executive Summary</b>	<b>ix</b>
<b>1. INTRODUCTION</b>	<b>1</b>
1.1 Study objectives	1
1.2 HIV/AIDS situation	2
1.3 The school system	4
1.4 The study team	5
1.5 Structure of the report	6
<b>2. STUDY DESIGN AND IMPLEMENTATION</b>	<b>7</b>
2.1 School survey	7
<b>3. STUDENT BEHAVIOUR</b>	<b>9</b>
3.1 HIV prevalence	9
3.2 Sexual intercourse	9
3.3 Protected sex	14
3.4 Drugs and IDUs	16
3.5 Female sex workers	17
3.6 Men having sex with men	17
<b>4 HIV PREVENTATION AMONG SCHOOL STUDENTS</b>	<b>18</b>
4.1 Government policy	18
4.2 Health education curriculum	18
4.3 Curriculum delivery	20
4.4 Student knowledge	22
4.5 Other prevention activities	24
<b>5 TEACHER KNOWLDEGE AND BEHAVIOUR</b>	<b>26</b>
5.1 Teacher characteristics	26
5.2 HIV prevalence	28
5.3 Knowledge of HIV/AIDS	29
5.4 Sexual partners	30
5.5 Protected sex	31
5.6 Drugs & IDUs	31
5.7 Sexual harassment and misconduct	31

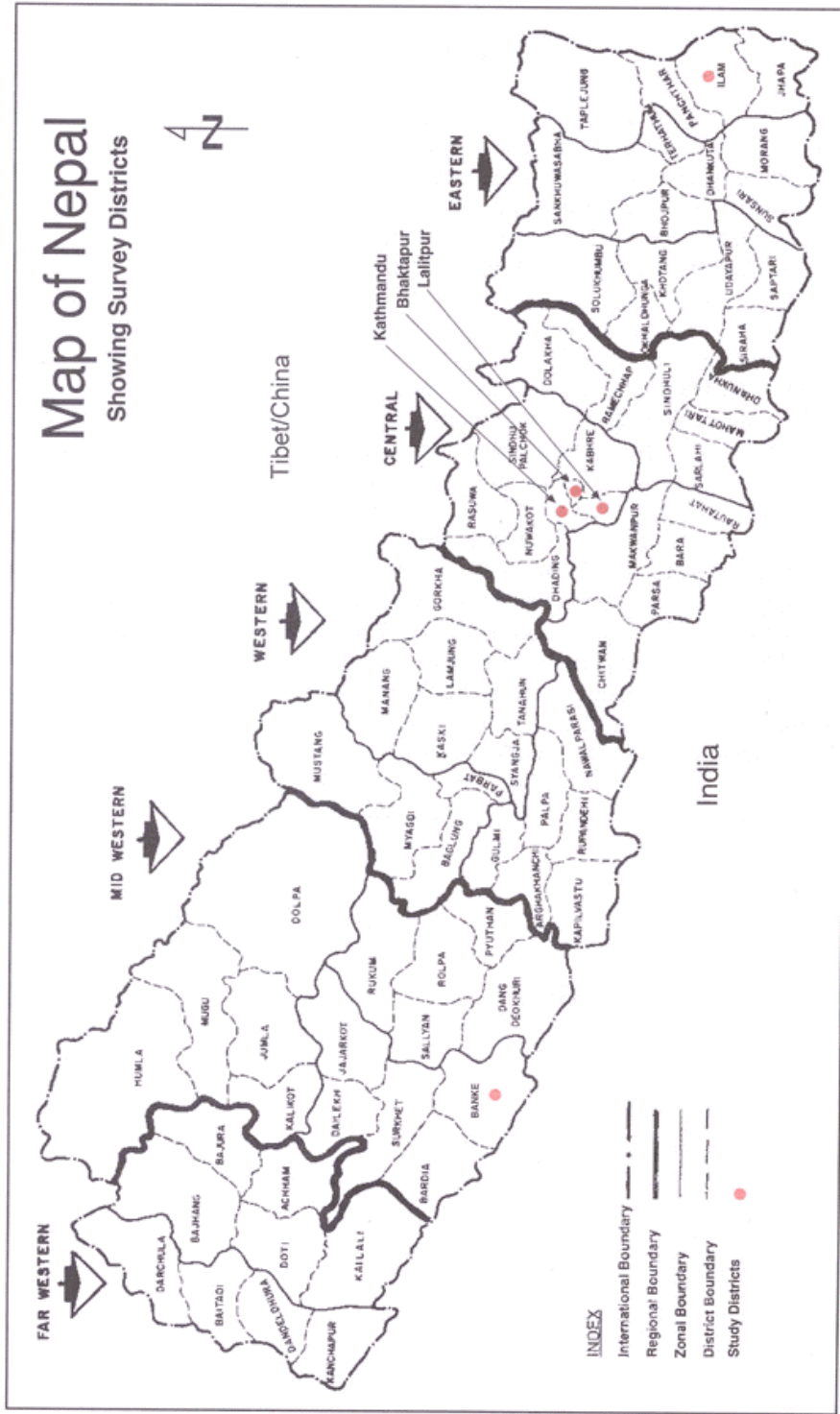
***An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal***

<b>6.</b>	<b>IMPACT AND SUPPORT</b>	<b>34</b>
6.1	Students	34
6.2	Teachers	40
6.3	Future impact	42
<b>7.</b>	<b>ENSURING A COMPREHENSIVE STRATEGIC RESPONSE</b>	<b>43</b>
7.1	HIV prevention among students	43
7.2	AIDS in the Workplace	44
7.3	Support for students	45
7.4	An HIV/AIDS management programme	46
7.5	Dissemination workshop	48
REFERENCES		49
ANNEXES		
1.	Peopled interviewed	52
2.	Survey instrument	58
3.	Health education curriculum: analysis of SRH topics covered in lower secondary and secondary school curriculum	78
4.	Resource materials and Handbooks on HIV/AIDS	83
5.	Summary of student focus group dislike cards	84
6.	Action Plan for the proposed AIDS Management Programme for the education sector 2003-2006	86
7.	Proposed Action Plans developed by workshop participants	88

## LIST OF TABLES

- 2.1 Description of school survey instruments
- 3.1 Primary and secondary school students agreeing with statements
- 3.2 Primary and secondary school teachers agreeing with statements
- 3.3 Median age of marriage and first sexual intercourse
- 3.4 Teenage sexual behaviour in seven districts, 2000
- 4.1 Student knowledge test on HIV/AIDS
- 4.2 Most important sources of information about HIV/AIDS among students
- 5.1 Age distribution of teachers
- 5.2 Marital status of teachers
- 5.3 HIV/AIDS knowledge test for teachers
- 5.4 Number of sexual partners among married men, 2001
- 6.1 Children on the Brink orphan estimates, 2001-2010
- 6.2 Orphan students at survey schools
- 6.3 EMIS and DHS primary school repetition rates 2000-2001
- 6.4 EMIS and DHS primary school dropout rates, 2000-2001
- 6.5 Student and marital status of adolescents, 2001
- 6.6 Orphan and two-parent students who have ever repeated a class
- 6.7 Orphan and two-parent students who have ever dropped out of school
- 6.8 Absenteeism rate among students
- 6.9 Reasons for student absenteeism from school
- 6.10 Mortality rates for teachers in 2000
- 6.11 Teacher ever-absent and absenteeism rates
- 7.1 Action plan and budget for the HIV/AIDS Management Programme for the Education Sector

## MAP OF NEPAL





## EXECUTIVE SUMMARY

This report presents the main findings of a comprehensive assessment of the impact of HIV/AIDS on the education sector in Nepal. The epidemic poses a potentially very serious threat to the attainment of national education objectives and, in particular, the Education For All goals. It is essential therefore that decisive action is taken by the Ministry of Education and Sports in order to face down this threat.

HIV/AIDS undermines education in two main ways. First, without effective medical interventions, teachers who become infected will eventually become sick and die. Increased morbidity and mortality can have a major impact on teacher productivity and the overall capacity of schools to deliver quality education. And secondly, the education of children whose lives are directly affected by HIV/AIDS can be seriously jeopardised. Those children who lose parents and other family members to AIDS frequently face enormous emotional and economic challenges, which can seriously affect their education.

The report focuses on the following three key questions:

- I. What is the actual and likely impact of HIV/AIDS on teachers and other MOES staff?
- II. What is the actual and likely impact on the education of primary and secondary school students who are directly affected by the epidemic?
- III. What has been and what should be done in the future to prevent HIV infection among teachers and students as well as support for all those who are directly affected by this scourge?

How seriously HIV/AIDS will affect teachers and students will largely depend on the extent to which they engage in high-risk behaviours, in particular unprotected sex with multiple partners and intravenous drug use with shared needles. The findings of this assessment indicate that HIV/AIDS has had little or no impact on the education sector to date. However, this could change very quickly. It is essential therefore that accurate baseline information is available that will enable MOES to monitor the situation in an effective manner and take whatever measures are necessary.

### HIV/AIDS IN NEPAL

The potential for spread of HIV is considered to be high because of the extensive use of sex workers, high rates of sexually transmitted diseases, low condom use, and rapid growth in the numbers of intravenous drug users, and an increasing number of internal and external migrants.

HIV sentinel survey data for a country of the size and diversity of Nepal is very limited. HIV prevalence among the 15-49 adult population is estimated to be 0.5 percent, with almost 60,000 cases projected for the end of 2002. The estimated ratio of male-female infection is 3:1, which means that female and male prevalence rates for this age group are around 0.3 percent and 0.8 percent respectively. HIV/AIDS in Nepal is classified as a 'concentrated' epidemic. Prevalence is particularly high among the female sex workers (FSWs) and intravenous drug users (IDUs).

## **STUDY METHODOLOGY**

The assessment relied mainly on primary data obtained from a survey of 24 primary and secondary schools in three locations: the Kathmandu Valley and Banke and Ilam Districts. The school survey comprises of nine instruments, which have been carefully designed to obtain fairly detailed quantitative and qualitative information on each of the three main impact areas (teachers, students and prevention). Special emphasis is placed on semi-structured focus group and participatory research methods.

In addition, key personnel were interviewed in the MOES/DOE, the Ministry of Health, Tribhuvan University, United Nations and donor agencies, and non-governmental organisations and all relevant surveys, statistical data and other documentation was reviewed.

## **STUDENT BEHAVIOR**

The risk behaviours of greatest concern are unprotected sex, especially with FSWs and the sharing of needles by intravenous drug users. The assessment reviews the available information with respect to the following areas of sexual and other behaviour: the proportion of students who have ever-had sex, the number of sexual partners, condom use to protect against HIV and STDs, sex with FSWs, and IDUs.

The weakness of HIV surveillance in Nepal makes it very difficult to establish the extent to which adolescents and youth in general are a high-risk group with respect to HIV/AIDS.

**Sexual activity:** Traditional cultural values and practices in Nepal strictly proscribe pre-marital sexual activity of any kind. Arranged marriages remain the norm. Young people and females in particular are therefore under strong social pressures and control from both their own families and society at large not to engage in any behaviour that adversely affects their marriage prospects.

The findings of the school survey show that the overall level of romantic and full intercourse sexual relationships appears to be quite high in lower secondary and secondary schools. 37.4 percent of Class 8-10 male students in Ilam and 12 percent of the male students in these classes in Banke indicated that they had had sexual intercourse. Although none of the 54 female student respondent indicated that they had ever had sex, interviews with teachers and students suggest that at least 15-20 percent of female secondary school students in Ilam and 5-10 percent in Banke and Kathmandu Districts have had sex.

A UNICEF survey of teenage (12-18) sexual behaviour in seven districts, which was undertaken in 2000 reports that 16 percent of male school students and 5 percent of female students had had sexual intercourse. Another survey of Class 9 and 10 students in Kailash District in mid 2002 finds that 12 percent of boys are sexually active, but only 1.5 percent of girls (all of whom are married).

**Multiple partners:** Little is known about the number of sexual partners among youth in Nepal. 11 percent of in and out of school male teenagers in the UNICEF survey had more than one partner, but this figure is only two percent among females. This implies that half of males and 80 percent of females who had ever had sex are monogamous and that a high proportion of first sexual partners eventually gets married. Qualitative evidence from the school survey also suggests that only a few students have multiple sex partners. However, the incidence of female students selling sex in return for money and other goods and services appears to be increasing.

**Protected sex:** Hard data on condom use among school students and youth in general is scanty. Condom use also appears to vary considerably from one district to another. Whereas all of the sexually active secondary school students in Ilam stated that they used condoms last time they had sex, the corresponding percentages for Bankey and Kathmandu are only 33.3 percent and 16.6 percent respectively. The UNICEF survey found that 70.2 percent of sexually active in-school male teenagers regularly use condoms compared with 61.5 percent among out of school males.

There is no accurate data on the incidence of STDs among youth in Nepal. A key problem is that the majority of youth with STDs do not attend government clinics because access to health services is very limited and many prefer to be treated at private clinics or through pharmacies. None of the 54 male student focus group respondents indicated that they had ever had an STD. These low rates of STD are encouraging and suggest that rates of consistent condom use are high.

**Drug use:** Drinking and various oral drugs are common among secondary school students in Ilam, but none of the survey respondents mentioned that any student was injecting drugs. However, IDU was reported at three out of the four secondary schools in Bankey. At one of the four secondary schools visited in the Kathmandu Valley, only one student was suspected.

**Female sex workers:** At three out of the four survey secondary schools in Ilam, it was reported that 5-10 percent of male students in senior classes have visited sex workers, especially in India. This percentage is much lower in Bankey (no more than 1-3 percent) and none of the respondents at the Kathmandu schools stated that students at the school visit FSWs. In Kailali District, 0.5 percent of recently surveyed male secondary students had ever had sex with a FSW (four percent of those who were sexually active).

## **HIV PREVENTION AMONG STUDENTS**

The new HIV/AIDS National Strategy recognises that youth are now 'highly aware of the of the HIV risk, but this awareness does not necessarily translate into safe sexual behaviour'.

The primary school curriculum does not include any topics on HIV/AIDS or any other area of sexual reproductive health. It is commonly argued that SRH education is inappropriate for primary school students mainly because they are too young. However, almost all primary school teachers at the survey schools believe that some SRH education should be offered at primary schools, the curriculum on HIV/AIDS and, more generally, sexual reproductive health

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

in secondary schools has much to commend it. SRH topics comprise a sizeable proportion of the curriculum in the three core subjects. The coverage of key subject areas is quite comprehensive. The main weakness of the curricula is that the content is not adequate, it is too content-driven, and does not focus on the development of essential life skills. In key areas, not enough information is given and issues are not well explained. Students are concerned that they do not have enough knowledge about SRH and AIDS. The curriculum hardly deals with attitudes, beliefs and values related to HIV/AIDS.

The quality of textbooks and other learning materials is another key issue. The textbooks are not appealing to a young audience, in particular because they do not discuss key concerns in a lively and engaging manner. There are virtually no other high quality supporting learning materials including wall charts, demonstration models, games, posters, and audio-visual material.

The competence and commitment of health education teachers is generally not adequate. Very few teachers have undertaken the appropriate pre-service training. The main reason for this is that, although these are compulsory subjects, the Ministry of Finance has not given the MOES a financial allocation to recruit trained health education teachers onto the permanent payroll. This problem is further compounded by the almost complete lack of in-service training.

Most health education teachers also lack the confidence and necessary commitment to be effective teachers. Common complaints from students are that teachers do not explain properly, are shy and not open, rush through or even skip the lessons, do not want to answer questions, and prefer English to Nepali words.

A supportive, student-centred learning environment is essential for effective SRH and life skills training. In particular, students have got to trust their health education teachers and feel confident enough to discuss sensitive personal issues with their fellow students. Such a supportive, 'student-friendly' environment does not exist in many schools.

**Student knowledge:** Knowledge levels about the causes and consequences of HIV/AIDS among primary students are very low. However, both female and male secondary students performed very well in the knowledge test.

All school students at the survey schools get most of their information about HIV/AIDS from the television and radio. Parents generally do not talk to their children about the epidemic. Almost one-third of secondary school students indicated that their teachers are one of their three most important sources of information. Unlike many other countries, health workers are not an important source of information.

**Other prevention activities:** There are a number of NGOs and other organisations that are also involved in HIV/AIDS prevention activities, both in and out of schools. However, the paucity of good quality evaluation data makes it difficult to reach firm conclusions about the overall impact and effectiveness on the knowledge and behaviour of young people.

## TEACHER KNOWLEDGE AND BEHAVIOUR

There are seven key characteristics of the teaching profession, which are crucially important in determining the HIV/AIDS risk profile of this large occupational group namely: gender, age, educational attainment, marital status, geographical mobility, spouse separation, and status, power and income.

AIDS-related mortality among women tends to be lower than men. At public schools in Nepal, only 21 percent of primary, 6 percent of lower secondary, and 10 percent of secondary school teachers are females. The younger the age profile of teaching staff, the greater the impact HIV/AIDS is likely to have on teachers. This is because HIV infection is concentrated in the age range 15-35. Nearly two-thirds of the teachers at the surveyed rural primary schools were under 35 compared to less than one-third in at these schools located in urban areas. Secondary school teachers have a relatively old age profile compared to other low-income developing countries.

Evidence from other countries suggests that better-educated and trained teachers are less likely to become infected. Only 18 percent of teachers in public primary schools were fully trained in 2000. The percentages of fully trained teachers in lower secondary and secondary government schools were 31 percent and 56 percent respectively.

The higher the proportion of married teachers, the lower the impact of the epidemic on the teaching profession is likely to be. This is because married teachers tend to have fewer sexual partners than unmarried teachers. Most teachers in Nepal are married and most unmarried teachers live with their parents or other family members.

The more often teachers are posted to new schools, the higher the risk that they could become infected. Teacher transfer rates are extremely low in Nepal.

Separated spouses are more likely to have extra-marital relationships and are, therefore, more at risk from HIV infection. Spouse separation is minimal among teachers in Nepal.

The social position and authority of teachers give them very considerable power over students. This power can be abused when teachers physically and sexually abuse students.

There is no information available that can be used to ascertain likely levels of HIV infection among teachers. Only 3-4 percent of the surveyed teachers agreed with the statement that 'some teachers at this school may be infected with HIV/AIDS'. Agreement rates are only marginally higher among student respondents.

**Knowledge levels:** Both primary and secondary teachers who completed the knowledge test are well informed about the causes and consequences of HIV/AIDS. They have obtained their information about HIV/AIDS almost exclusively from radio, television and newspapers.

## *An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

**Extra-marital sex:** The 2001 Demographic and Health Survey reports that only 2.3 percent of married men in Nepal had extra marital sex during the last 12 months. No corresponding information on single adults is available. The findings of the school survey indicate that extra-marital sexual relations are not common among teachers.

No cases of primary school teachers visiting FSWs were reported. It is clear though that a small minority of secondary teachers in as many as half of the survey schools have visited FSWs. None of the FSWs interviewed for the school survey indicated that teachers are an important client group.

**Protected sex:** No information exists on condom use and STDs among teachers. While teachers at the survey schools are generally well informed about condoms, most do not use them on a regular basis. For married couples, Depo-Provera appears to be the preferred form of contraception.

**Drugs and IDUs:** No cases of injecting drug use were reported among teachers either at the survey schools or other schools in the locality. However, drinking is widespread among both primary and secondary teachers, particular in Ilam. Excessive drinking can result in “uncontrolled situations”, which can lead to high-risk behaviour.

**Sexual harassment:** Sexual relationships between male teachers and female students are fairly widespread at secondary schools, particularly in Ilam. During the last five years, six teachers at the 12 survey secondary schools have impregnated school students.

### **IMPACT AND SUPPORT**

**Students:** There are three groups of school children whose lives are most directly affected by HIV/AIDS and whose education is therefore potentially at greatest risk: children who are HIV positive, children in households with sick family members, and children whose parents or guardians have died of AIDS. The extent to which the education of these children is adversely affected depends heavily on the level of physical and emotional support they receive from the extended family, the school, the community (including NGOs) and central and local governments.

The school survey found virtually no evidence of any student who has been directly affected by HIV/AIDS. Even though there has been little or no impact to date, HIV/AIDS could seriously affect the education of many more children should HIV prevalence rates increase significantly over the next five-ten years. It is essential therefore that the MOES carefully monitors the impact of the epidemic on the education sector.

**The orphan population:** No direct census or household survey data exists on the parental status of children in Nepal. It is estimated that 9.4 percent of Nepalese children aged between 0–14 years have lost one or both parents. However, two-parent orphans account for only 0.4 percent of the child population. None of the 750 students at the survey schools who completed the student questionnaire are two-parent orphans. The incidence of single-parent (maternal and

paternal) orphans is 3.0 percent and 4.4 percent respectively among female and male primary school students and 7.7 percent and 6.4 percent for female and male secondary school students.

**Enrolments, repetition and dropout:** Reliable data on never-enrolled children, enrolments, repetition and dropouts is essential in order to monitor any future impacts of the AIDS epidemic. MOES statistics on repetition and dropout rates are inconsistent with the limited amount of household survey data that is available

The school survey data indicates that one-parent orphans repeat and dropout more than students with two parents. While male orphans repeat more than female orphans at both primary and secondary schools, there are no major gender differentials with respect to dropouts at either type of school. However, absenteeism rates for orphans in secondary schools are much lower than for two-parent students. Overall absenteeism rates for both primary and secondary students are relatively low.

**Discrimination:** The main conclusion of a recently completed assessment of HIV/AIDS and orphans in Nepal is that orphans suffer from high levels of discrimination (UNICEF, 2002). Without appropriate education and support, AIDS orphans and children in AIDS-affected households will likely face high levels of stigmatisation and discrimination. Teachers at the survey schools do not appear to be seriously discriminatory in their attitudes towards PLWA.

**Teachers:** To date, no teacher at the survey schools appears to have been directly affected by HIV/AIDS, both with regard to individual HIV infection or other household members. Nor is there any other secondary evidence that indicates any teachers are or have been either sick with or have died from AIDS-related illnesses.

No information exists on HIV prevalence among teachers or any other occupational group in Nepal (apart from truckers/transfer workers and female sex workers).

A total of 196 government teachers (152 primary, 28 lower secondary, 16 secondary) died in 2000, 0.2 per cent of the total employed and 11 percent of all teacher attrition in that year. The mortality rate among secondary teachers was nearly 40 percent lower than for primary teachers. The geographical pattern of teacher mortality does not correspond in any way with the known geographical distribution of HIV infection in Nepal, which suggests that teachers have not been directly affected.

It is not possible to compare teacher mortality with the mortality rates for the population in general and other major occupational groups. Census mortality data for 2001 has not yet been fully analysed and is unreliable since deaths are under-reported by at least 40 percent.

Any significant increase in HIV infection among teachers will, in the absence of life-prolonging anti-retroviral drugs, eventually result in corresponding increases in teacher morbidity and absenteeism. The productivity of teachers (especially women teachers) who have to look after affected family members could also be adversely affected. It is important therefore to monitor carefully teacher absenteeism over the coming years

### *An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

There is no 'AIDS in the Workplace' programme for teachers in Nepal. Consequently, no HIV/AIDS activities have been organised for teachers or any other MOES staff as part of a comprehensive, ministry-wide programme.

**Future impact:** It is very difficult to project with any degree of accuracy HIV prevalence and AIDS-related mortality rates. The only accurate way of making robust projections of the epidemic on teaching staff is to test a random sample of teachers. Without this information, big assumptions have to be made about current and likely future prevalence in order to generate projections of likely impact. If the overall adult prevalence rate increases to 1.0-1.65 percent by 2005 (in accordance with 'low' and 'moderate' scenarios made by UNAIDS), and it is assumed that teachers have the same HIV prevalence rate as the population as a whole then around 1,100 to 1,800 of the currently employed teachers could become infected. Without medical intervention and, in particular, the provision of anti-retroviral drugs, the median time between infection and death is likely to be around 7-8 years in which case AIDS deaths among teachers will average between 200-250 per annum up until 2010.

The 2002 Children on the Brink report estimates that there will be 45,000 AIDS orphans in Nepal in 2010. Population projections based on the 2001 Population Census have not yet been made but, assuming no increase in the 0-15 age group, this would mean that AIDS orphans will account for approximately 0.5 percent of this population in 2010. There will be around 3000 two-parent AIDS orphans (0.03 percent of under-15 year olds).

### **RECOMMENDATIONS**

On the basis of this assessment, the report recommends that the MOES designs and implements a comprehensive action plan. If properly implemented, this action plan will ensure that the very serious threat posed by HIV/AIDS is effectively contained.

**Prevention of HIV among students:** There is a strong case for the introduction of family life and sexual reproductive health education in Classes 4 and 5 in primary schools. Key topics should include parent-child relations, child-child relations, sexual reproduction, body organs, puberty/ physical development, menstruation, causes and consequences of HIV/AIDS, and simple life skills.

The report recommends that, as part of the health or social studies curriculum, one period per week is devoted to sexual and reproductive health education in both Classes 4 and 5. One teacher in each of the 21,000 public primary schools should receive short, intensive in-service training at Teacher Resource Centres. The MOES will probably need assistance for the training of trainers.

At the secondary level, it is also essential that at least one trained health education teacher is employed at every secondary school in the country. Both lower secondary and secondary school students should also benefit from good quality life skills education and key adolescent sexual reproductive health topics should be treated in sufficient depth. It is recommended therefore that a comprehensive review of health and population education is undertaken as



soon as possible. Considerably more emphasis should be given to SRH education in the lower secondary grades and high quality, youth-friendly learning materials should be available in all schools. There may also be a need for separate SRH classes for female students, which are taught by properly trained female teachers. Finally, it is recommended that a comprehensive needs assessment of school-based peer education is undertaken.

Given the paucity of information on the sexual and other high-risk behaviour of students attending post-secondary education and training institutions, a comprehensive KAB study should be undertaken of these students.

**AIDS in the Workplace:** Even though HIV prevalence levels are still very low, it is essential that MOES has a comprehensive AIDS in the workplace programme. At this stage of the epidemic, the main priorities are to monitor carefully the HIV situation among staff and to ensure that everything is done to prevent HIV infection among teaching staff. This programme should be based on the best practices that have been developed elsewhere and recommended by the International Labour Organisation.

There are almost 150,000 schoolteachers in Nepal and probably another 20-25,000 teaching staff at other post-secondary training and education institutions. It is very important therefore that the MOES, as the major employer, has accurate and sufficiently detailed information on the incidence and pattern of HIV infection among staff. This is not only essential for planning purposes, but also in order to design effective HIV prevention programmes. It is recommended therefore that a representative sample of teachers is tested for HIV. There are now well-established procedures for this. Testing would be done on a purely voluntary and anonymous basis.

Most teachers have only a rather superficial understanding of the causes and consequences of HIV/AIDS. It is important that this knowledge is deepened and teachers are made fully aware of the dangers of high-risk activity. It is recommended therefore that a high-quality Teacher Handbook on HIV/AIDS and related SRH issues is prepared and distributed to every teacher in both public and private schools as well as other education and training institutions. The distribution of the Handbook should also be accompanied by in-service training.

**Support for students:** Although very few children have been directly affected by HIV/AIDS, it is important though that these children receive appropriate support. Two areas should be addressed. First, it is recommended that MOES issues a clear policy statement with regard to discrimination against both students and teachers who are directly affected by HIV/AIDS. Secondly, schools should, where necessary, provide additional support for children who have been orphaned as a result of AIDS. However, AIDS orphans should not be separately targeted, but rather they should receive the same assistance as any other disadvantaged or needy student.

**An AIDS management programme:** These recommendations should form the basis of a comprehensive action plan. Appropriate organisational and management structures are required in order to ensure that this plan is effectively implemented. It is recommended therefore that a high-powered HIV/AIDS Technical Committee is established in MOES, which has overall

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

responsibility for an HIV/AIDS management programme for the education sector. The Secretary MOES should chair this committee and its members should be drawn from senior management in all the key divisions in the Ministry. Representatives from the university, private schools, NGOs involved in peer education and other HIV prevention and support activities, and other key ministries and public agencies (in particular NCASC) should also be invited to sit on this committee.

The experience from other countries clearly shows that part-time HIV/AIDS Focal Point Coordinators usually lack the authority, time, and resources to be able to implement HIV/AIDS action plans and other interventions in the education sector. It is essential therefore that a full-time HIV/AIDS Coordinator is appointed. She should report directly to the Secretary and the HIV/AIDS Technical Committee.

The success of the National HIV/AIDS Strategy depends critically on a coordinated multi-sectoral approach to both HIV/AIDS prevention and mitigation. It is essential therefore that all HIV/AIDS activities in the MOES are carefully coordinated with the activities of other key organisations at both the national, district and village levels. In particular, MOES staff should actively participate in District AIDS Control Committees where these have been established.

## **1. INTRODUCTION**

This report presents the main findings of a comprehensive assessment of the impact of HIV/AIDS on the education sector in Nepal. The epidemic poses a potentially very serious threat to the attainment of national education objectives and, in particular, the Education For All goals. It is essential therefore that decisive action is taken by the Ministry of Education and Sports, along with everyone in the school community (managers, teachers, students and parents), and civil society in general to face down this threat. The level of HIV infection in Nepal is low, but is increasing quite rapidly. The experience from the high prevalence countries in sub-Saharan Africa shows just how quickly HIV can spread with devastating consequences. The message is clear: act now otherwise it will be too late.

HIV/AIDS undermines education in two main ways. First, without effective medical interventions, teachers who become infected will eventually become sick and die. Increased morbidity and mortality can have a major impact on teacher productivity and the overall capacity of schools to deliver quality education. And secondly, the education of children whose lives are directly affected by HIV/AIDS can be seriously jeopardised. Given the nature of this disease, very few children of school-going age will suffer from AIDS-related illnesses. However, those who lose parents and other family members to AIDS frequently face enormous emotional and economic challenges, which can seriously affect their education. Increased demands from home can make it more difficult to attend school and some orphans may dropout out of school altogether.

### **1.1 STUDY OBJECTIVES**

The specific objectives of this assessment as set out in the Terms of Reference for the study team are as follows:

- Review existing cross-sector policies, structures and strategies in relation to combating the impact of HIV/AIDS in Nepal
- Review the education system and assess potential impact of HIV/AIDS in education
- Review existing literature and related documents on HIV/AIDS including the National Strategy on HIV/AIDS
- Review the Human Resources Development plan and program for the education system
- Prepare a draft plan of action for the education sector in implementing the HIV/AIDS programme
- Share experience from other countries with the stakeholders
- Take approaches conducive to skill transfer

The report focuses on the following three key questions:

- I What is the actual and likely impact of HIV/AIDS on teachers and other MOES staff?
- II What is the actual and likely impact on the education of primary and secondary school students who are directly affected by the epidemic?

- III What has been and what should be done in the future to prevent HIV infection among teachers and students as well as support all those whom are directly affected by this scourge?

How seriously HIV/AIDS will affect teachers and students will largely depend on the extent to which they engage in high-risk behaviours, in particular unprotected sex with multiple partners and intravenous drug use with shared needles. The findings of this assessment indicate that HIV/AIDS has had little or no impact on the education sector to date. However, this could change very quickly. It is essential therefore that accurate baseline information is available that will enable MOES to monitor the situation in an effective manner and take whatever measures are necessary.

## **1.2 HIV/AIDS IN NEPAL**

The potential for spread of HIV is considered to be high because of the extensive use of sex workers, high rates of sexually transmitted diseases, low condom use, and rapid growth in the numbers of intravenous drug users and an increasing number of internal and external migrants. UNAIDS is concerned that 'a highly conservative culture and a tradition that labels every action with moral underpinnings is driving HIV/AIDS underground' (UNAIDS, 2001: 4).

### **1.2.1 Overall HIV prevalence**

HIV sentinel survey data for a country of the size and diversity of Nepal is very limited. Most countries rely mainly on anonymous testing of pregnant women attending antenatal clinics in order to estimate HIV prevalence for the adult population as a whole. This kind of testing has not been done for over four years in Nepal. The National Centre for AIDS and STD Control (NCASC) is currently making concerted efforts to improve HIV surveillance data.

HIV prevalence among the 15-49 adult population is estimated to be 0.5 percent, with almost 60,000 cases projected for the end of 2002. The estimated ratio of male-female infection is 3:1, which means that female and male prevalence rates for this age group are around 0.3 percent and 0.8 percent respectively.

HIV/AIDS in Nepal is classified as a 'concentrated' epidemic. Prevalence is particularly high among the female sex workers (FSWs) and intravenous drug users (IDUs). HIV prevalence rate estimates for the 15-24 age group range from 0.18 percent (low) to 0.38 percent (high) (see UNAIDS, 2002). One-third of all new HIV infection occurs in the 14-25 year age group.

Reported HIV cases rose from 1400 in 1999 to 2174 in 2001. There were 606 reported AIDS cases in June 2002. The profile of individuals with HIV in late 2000 was FSWs 21 percent, FSW clients 61 percent, IDU 11 percent, and mother-to-child transmission one percent. 93 percent were aged between 15-39 and women accounted for 30 percent of the total.

### **1.2.2 Female Sex Workers**

There are no reliable estimates of the overall size of the FSW client group in Nepal. However, according to UNAIDS 'significant numbers of Nepali males are clients of sex workers' (UNAIDS, 2002:16).

HIV prevalence among FSWs in the Kathmandu Valley was 15.7 percent for street-based workers and 2.5 percent for non-street based workers in 2001 (FHI, SACTS 2001). HIV prevalence among FSWs at five locations in the Terai was 3.9 percent in 1999 (latest year available). In the Kathmandu Valley, the 2001 surveys found that 18 percent of FSW clients always used condoms and 53.7 percent used them 'most' of the time.

Up to 100,000 Nepali women work as sex workers in Mumbai. A 1999 survey by FHI reported a prevalence rate of 17.1 percent among Nepali FSWs who had returned from India compared to four percent among FSWs who had not worked in India (see FHI, 1999).

### **1.2.3 Intravenous drug users**

Estimates of the size of IDU population in Nepal vary enormously. However, according to UNAIDS, 'alarming numbers of teenagers are turning to intravenous drugs' (op.cit: 12). IDUs are concentrated in the Kathmandu Valley and border towns in the Terai. In the Biratnagar area alone, there are reported to be 10-15,000 drug users. The number of IDUs in the Kathmandu Valley has been put as high as 25,000.

Two surveys of IDUs have been undertaken during the last two years. Almost half of an IDU group tested in 2000 was HIV positive. 72 percent had pre-marital sex with multiple partners, two-thirds of which was unprotected. The large majority of these drug users are relatively well educated - 37 percent have attained Class 9-10 and only 10 percent are illiterate (see LALS, 2000). An IDU census based on networking techniques identified only 3,300 IDUs in the Kathmandu Valley in 2001 (see FHI/New Era, 2002). HIV prevalence rates among males were nearly 70 percent and 16 percent among females. The main reason for this difference is that male IDUs frequently share syringes.

### **1.2.4 Truckers and migrants**

Cross-border migrants to India (particularly from the Mid and Far Western Regions) and truck drivers are the two other high-risk groups. HIV prevalence among groups of male migrants from Achham, Doti, and Kailali Districts who were tested in 2001 were 2.3 percent, 0.6 percent, and 10.1 percent respectively. However, migrant wives in Dadeldhura (2002) and Kailali (2001) Districts have HIV rates of well under one percent (see Pkhakadze, 2002 and Save the Children-US, 2001).

The overall prevalence rate among truckers in the Terai was 1.5 percent in 1999 (latest year available).

### **1.2.5 The National HIV/AIDS Strategy**

The final draft of the National HIV/AIDS Strategy was published in June 2002. The prevention of HIV infection among young people is a priority area. The key objectives of the strategy with respect to youth are:

- Creating a supportive policy and community environment
- Awareness and behaviour change communication
- Youth-friendly services
- Enhancing young people's knowledge about HIV/AIDS/STI in formal and non-formal education settings

The MOES has therefore a central role to play especially with regard to the development of an age appropriate, healthy lifestyle curriculum and ensuring that teachers have the knowledge, skills and attitudes to deliver this curriculum effectively.

## **1.3 THE SCHOOL SYSTEM**

This assessment focuses mainly on students and teachers at primary and secondary schools. Given the limited time that was available, it was not possible to undertake a risk assessment of the higher education sector. It is quite likely, however, that university and other tertiary education students are a higher risk group than secondary school students.

### **1.3.1 Structure, enrolments and staffing**

The structure of formal schooling in Nepal is as follows: primary Classes 1-5, lower secondary classes 6-8, and secondary classes 9-10. The official starting age for primary schooling is six years old. There were nearly 26,000 primary schools (81 percent public), 7250 lower secondary schools (54 percent public), and 4400 secondary schools (48 percent public) in 2000 (latest year available). Post-secondary education comprises of senior secondary schools (Classes 11 and 12) after which students attend university and other tertiary education institutions.

Nearly 5 million students were enrolled in primary and secondary schools in 2000. Gross enrolment ratios were 120 percent, 58 percent and 37 percent for primary, lower secondary, and secondary schooling respectively in 2000. The size of primary and secondary schools averaged 139 and 171 students in 2000. No fees are charged for primary education. Fees at public secondary schools vary considerably. At the survey schools the median fee was R.450 per annum. Private secondary schools in Kathmandu charge over R10,000.

There were 98,000 primary and 45,000 lower secondary and secondary teachers in 2000. The teaching profession in Nepal is male-dominated. In public schools, 79 percent of primary school teachers are males, 90 percent in lower secondary schools, and 94 percent in secondary schools. Another 4080 staff work for the MOES.

### **1.3.2 The Human Resources Development Strategy for the Education Sector**

A comprehensive HRD Strategy for the education sector has been recently prepared. Its key objectives include the de-politicisation of the teaching force, the establishment of an independent Teaching Service Commission as well as District and Village Education Committees. The Strategy seeks to redress deep-seated human resource management problems, most notably 'low capacity, cumbersome procedures, inadequate regulation processes, low motivation and morale, and increasing political interference and corruption'. It is noticeable though that HIV/AIDS is not mentioned at all in the 500-page Strategy document.

Teacher salaries currently absorb 91 percent of the total recurrent budget for the education sector. Urban schools are generally over-staffed while most rural schools are under-staffed.

### **1.4 THE STUDY TEAM**

A multidisciplinary team of three international consultants and three national consultants undertook the assessment. In addition, five field researchers assisted with the school survey.

#### **International consultants**

Dr. Paul Bennell, Independent Consultant, UK (Team Leader)

Ms. Annette Noten, Consultant, The Netherlands

Ms. Patricia Lim Ah Ken, Consultant, UNICEF

#### **National consultants**

Mr. Bhimsen Devkota, Faculty of Education, Tribuvan University, (Education Specialist and National Team Leader)

Mr. Khagendra Adhikary, Independent consultant (Communication Specialist)

Ms. Sunila Shreshta, Independent consultant (Social Analyst)

**Field researchers**

Ms. Poonam Adhikary  
Mrs Minerba Raj Bhandari  
Mr. Bhanu Dhakal  
Ms. Meena Karki  
Mr. Shishir Poudel  
Ms. Bhawana Subedi

**1.5 REPORT STRUCTURE**

The report is structured as follows: The study methodology is described in Chapter 2 Chapter 3 presents a HIV risk assessment of students, which focuses on the overall levels of sexual activity among secondary school students, condom use, and IDUs. The effectiveness of HIV prevention activities targeted at school children is discussed in Chapter 4. Chapter 5 presents an HIV risk assessment for teachers. The actual and likely impact of HIV/AIDS on students and teachers is discussed in Chapter 6. Finally, in Chapter 7, a series of recommendations are made about what should be done by the MOES with respect to HIV prevention and mitigation for both students and teachers.



## **2. STUDY DESIGN AND IMPLEMENTATION**

The assessment relied mainly on primary data obtained from a small survey of primary and secondary schools in three locations. In addition, key personnel were interviewed in the MOES/DOE, the Ministry of Health, Tribuvan University, United Nations and donor agencies, and non-governmental organisations (see Annex 1) and all relevant surveys, statistical data and other documentation was reviewed.

### **2.1 SCHOOL SURVEY**

#### **2.1.1 Overall approach**

The methodology for the school survey was adapted from similar HIV/AIDS impact assessments that have been recently conducted in sub-Saharan Africa (see Bennell et al, 2002). The survey consists of nine instruments, which have been carefully designed to obtain fairly detailed quantitative and qualitative information on each of the three main impact areas, (teachers, students and prevention). Special emphasis is placed on semi-structured focus groups and participatory research methods.

#### **2.1.2 School sample**

The school survey had to be completed during a four-week period from early **October to early November 2002**. It was only possible therefore to visit schools in the following three locations: the **Kathmandu Valley** and **Bankey and Ilam** Districts. The security situation was also a key factor that seriously limited the number of districts that were considered safe enough to visit. The Kathmandu Valley was selected because schools are easily accessible and this is generally regarded as one of the highest risk areas with respect to HIV. Bankey District is located in the mid-Western Terai sub-region. It is also a relatively high-risk area given its close proximity to the Indian border and its sizeable populations of FSWs, IDUs and migrants. Ilam District is located in the Eastern Hill sub-region. It also borders India, but it is not generally considered to be a relatively high-prevalence district. According to the 2001 UNDP Human Development Report for Nepal, the human development index rankings of the Bankey, Ilam and Kathmandu Districts are 44, 62, and 75 respectively.

The school survey comprised of 12 primary and 12 secondary schools. In each of the three locations, representative samples of four primary and four secondary schools were selected in consultation with the District Education Officer (DEO). It was agreed that the identity of the survey schools should not be disclosed. Half of these schools (two primary and two secondary) are in urban areas (Nepalgunj in Bankey, Ilam District Headquarters in Ilam, and Kathmandu and Baktapur in the Kathmandu Valley) and the other half is in rural areas. Given the limited time available, it was not possible to visit remote rural schools. The average distance of the selected rural schools from Ilam town is 30 kilometers and 20 kilometers from Nepalgunj.

Table 2.1: Description of school survey instruments

Instrument	Number	Information sought	Duration
Principal interview	24	Teacher and student impact and behaviour And health behaviour	60-90 mins
Health education teachers (Secondary schools)	12	HE curriculum and delivery	60-90 mins
Teacher focus groups (1 female and male/school)	48	Teacher and student impact and behaviour	90-120 mins
Student focus groups (1 female and male/school)	48	Student and teacher behaviour, health Education	90-120 mins
Teacher questionnaire (5 female and 5 male/school)	185	Personal details, experience, qualifications, Knowledge test, behaviour and other statements	45 mins
Student questionnaire (36 students/school)	750	Personal details, knowledge test, statements	45-60 mins
School statistics	24	Enrolments, repetition, dropout, teachers, fees	
Key informant interviews	50		45-120 mins

It has been agreed that the school survey will be extended to three other districts in early 2003. UNICEF has agreed to undertake this work, which will be reported on separately.

### 2.1.3 Survey instruments

The nine school survey instruments are summarised in Table 2.1 and reproduced in full in Annex 2. They were pre-tested at three schools in early October and a number of modifications were made.

### 2.1.4 Implementation

A team of four researchers (wherever possible gender balanced) visited each survey school for one whole school day. In addition, key informants in the community were also interviewed (district, education and health officials, police officers, relevant NGOs, sex workers, doctors and pharmacists). Unfortunately, there was not enough time to arrange interviews with parents and members of school management committees.

### 2.1.5 Strengths and weaknesses

In general, the school survey generated a wealth of high quality information using a range of conventional and more innovative research methods. The semi-structured focus group discussions were particularly effective in obtaining the opinions and observations of both students and teachers on what are sensitive personal issues. Considerably more detailed and more in-depth information could have been obtained if each school visit had lasted for two, even three days. Accurate information on who drop outs of school and for what reasons would have been particularly useful. More time at each school would also have allowed information on the sexual behaviour of individual teachers to be collected.

It was not possible to survey schools in any of the Far Western Districts, which have some of the highest rates of HIV prevalence in the country. However, UNICEF researchers will survey at least one, if not two, of these districts in early 2003.

### **3. STUDENT BEHAVIOUR**

This chapter provides a HIV/AIDS risk assessment of primary and secondary school students in Nepal. The risk behaviours that are of greatest concern are unprotected sex, especially with FSWs and the sharing of needles by intravenous drug users. The available information with respect to the following areas of sexual and other behaviour is reviewed: the proportion of students who have ever-had sex, the number of sexual partners, condom use to protect against HIV and STDs, sand ex with FSWs and IDUs.

#### **3.1 HIV PREVALENCE**

The weakness of HIV surveillance in Nepal makes it very difficult to establish the extent to which adolescents and youth in general are a high-risk group with respect to HIV/AIDS. NCASC reports that one-third of all HIV infection occurs in the 15-24 age cohort, but recent survey from ante-natal clinics is not available. Extrapolating this data to make HIV prevalence estimates for the total population of young people is also problematic when a high proportion are not sexually active as is the case in Nepal.

Only one primary school teacher out of 51 respondents agreed with the statement that 'some students in this school may be infected with HIV/AIDS' Among secondary school teachers, this rises slightly to eight percent. Only 17 percent and 7 percent of secondary male and female students agreed with this statement (see Tables 3.1 and 3.2).

#### **3.2 SEXUAL INTERCOURSE**

Traditional cultural values and practices in Nepal strictly forbid pre-marital sexual activity of any kind. Arranged marriages remain the norm. Young people and females in particular are therefore under strong social pressures and control from both their own families and society at large not to engage in any behaviour that adversely affects their marriage prospects. In this context, romantic relationships between boys and girls are usually clandestine. Any suspicion that a daughter is involved in a romantic relationship usually prompts the parents to arrange her marriage.

While it is generally accepted that young single people are becoming increasingly sexually active, the Demographic and Health Survey for 2001 shows that the median age of first intercourse has not changed for ever-married males and females right across the 20-50 age groups. Among females, the age of first intercourse coincides with the median age of first marriage 'implying that women's first sexual experience occurs within the context of marriage' (DHS, 2001: 105). Men, however, typically initiate sex about one year before marriage (see Table 3.3). There are no sizeable differences in age of first intercourse by ecological zone, but sexual activity starts earlier in rural areas. It is noticeable that secondary education has a relatively large impact in delaying the median age of first intercourse for females (median 16.5 years for those with no education but 19.6 years for SLC and above), but not for males.

**An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal**

Table 3.1: Primary and secondary school students agreeing with statements (percentages)

Statements	Primary		Secondary	
	Female	Male	Female	Male
Teachers teach DRH very well			89	87
Students have sufficient knowledge of HIV/AIDS	38	38	29	31
Parents do not want teachers to teach SRH			17	16
HIV/AIDS infected persons should be isolated	57	46	13	12
HIV students should be barred from school	37	44	4	4
HIV teachers should be barred from school	40	32	7	5
Teachers having love relations with students should be punished			64	59
There is sufficient information about SRH in the HPE textbooks			66	53
There are enough HPE textbooks			39	33
There should be more SRH lessons			92	92
There are regular SRH activities in the school	32	30	30	27
Students are open with their teachers about SRH issues	34	25	34	41
Some students in this school may be infected with HIV	14	15	7	17
Some unmarried students get pregnant			9	9
Some unmarried students have had abortions			8	5
Some students take drugs	10	18	36	45
Contraceptives should be provided to students			26	52
Sex education encourages encourages students to have sex			43	53
Students have easy access to SRH services			34	32
Some teachers may be infected with HIV			5	6

### 3.2.1 School survey

At the survey primary schools, many children start to become sexually aware in Classes 4 and 5. Some children write 'love letters' and 'tease' each other. But it is clear that very few have ever had sex. Two students at a primary school in Ilam did become pregnant. At another primary school in Ilam:

*'One girl from class 5 who was 15 had sexual relations with a married man who persuaded to her to have sex with him in exchange for marriage. He hid his marital status from her'*

At some primary schools, sizeable proportions of students work in private homes as domestic servants and there are quite widespread concerns about sexual abuse.

The overall level of romantic and full intercourse sexual relationships appears to be higher in Classes 8–10 of lower secondary and secondary schools. At some schools, students said that almost all students have 'love relations'.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Table 3.2: Primary and secondary school teachers agreeing with statements (percentages)

Statements	Primary		Secondary	
	Female	Male	Female	Male
Teachers teach SRH very well	46	48	66	75
Students have sufficient knowledge of HIV/AIDS	14	24	29	40
Parents do not want teachers to teach SRH	20	8	29	27
HIV/AIDS infected persons should be isolated	28	21	24	23
HIV students should be barred from school	15	0	12	15
HIV teachers should be barred from school	15	0	15	16
Teachers having love relations with students should be punished	82	83	97	74
There is sufficient information about SRH in the HPE textbooks	27	40	59	42
There are enough HPE textbooks	38	20	61	40
There should be more SRH lessons	82	96	80	73
There are regular SRH activities in the school	4	16	24	45
Students are open with their teachers about SRH issues	27	16	24	21
Some students in this school may be infected with HIV	0	4	14	10
Some unmarried students get pregnant	4	4	6	10
Some unmarried students have had abortions	0	4	0	3
Some students take drugs	0	0	11	18
Contraceptives should be provided to students	8	8	18	24
Sex education encourages students to have sex	20	16	21	36
Students have easy access to SRH services	23	4	31	33
Some teachers may be infected with HIV	4	4	9	5
Condoms should be provided to teachers	50	30	38	39

*'Petting, kissing and touching are common. About 70 percent of the boys engage in teasing the girls, using vulgar words, throwing stones or pulling hair, saying I love you and writing letters.... Love relations are frequent.'* Female secondary students, Ilam

*'About 50 percent of students of class 8, 9 and 10 have been involved in love affairs...40-45 students are involved in deep love affairs.'* Male secondary students, Bankey

*'Male and female students normally go to the love point in the tea garden and get involved in sexual activities.'* Male secondary students, Ilam

However, kissing and other overt sexual activity is rarely observed in schools. It would appear that many students at private secondary boarding schools in Kathmandu frequently watch blue movies and access other pornographic material from the Internet. At one school, male students claimed that 'more than 90 percent of students have been watching blue movies since they were 12 years old'.

Table 3.3: Median age of marriage and first sex intercourse (percentages)

	FEMALES		MALES	
	Marriage	First sex	Marriage	First sex
<b>AGE</b>				
20-24	16.8	16.9	18.7	17.8
25-29	16.9	16.9	20	19
30-34	16.7	16.8	20.1	19.1
35-39	16.6	16.8	20.3	19.4
40-44	16.4	16.7	20.1	19.2
45-49	16.1	16.6	19.9	19.2
<b>EDUCATION</b>				
No education	16.3	16.5	19.8	19.1
Primary	16.8	16.8	18.8	18.2
Some secondary	17.4	17.5	19.8	18.8
SLC and above	19.5	19.6	21.4	20.2

Source: DHS, 2001

At the end of the focus group discussions with Class 8-10 in secondary schools, students were requested to write down the answers to the following three questions: Have you ever had sex? If so, did you use a condom last time you had sex? And have you ever had an STD? 37.5 percent of male students in Ilam (9 out of 24 students) and 12 percent of the male students in Bankey (3 out of 24 students) indicated that they had had sex. Students at only one secondary school in Kathmandu were asked these questions. One out of six boys (16.7 percent) said he was sexually active. Although none of the 54 female FGD respondents indicated that they had ever had sex, interviews with teachers and students suggest that at least 15-20 percent of female secondary school students in Ilam and 5-10 percent in Bankey and Kathmandu Valley have had sex.

Time series data on levels of sexual activity among unmarried adolescents is not available. However, a survey of higher and secondary (Class 9 and 10) school students in Nepalgunj in 1996 found that 11 percent of the secondary male students had had sex, but none of the females (see University of Heidelberg, 1996).

A UNICEF survey of teenage (12-18) sexual behaviour in seven districts, which was undertaken in 2000 found that 16 percent of male school students and 5 percent of female students had had sexual intercourse. The corresponding percentages for all teenagers (both in and out of school) are 22 percent and 9 percent respectively (see Table 3.4). As with the school survey, there are very marked differences in the incidence of teenage sexual intercourse across the seven districts. For males (both in and out of school), this ranges from 53 percent in Sunsari to nine percent in Morang and Dang. As expected, the overall level of sexual activity is much higher among out of school teenagers: 33 percent of males and 15 percent of females had ever had sex.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

A survey of Class 9 and 10 students in Kailali District (which borders Banke District to the east) in mid 2002 finds that 12 percent of boys have had sex, but only 1.5 percent of girls (all of whom are married). Only 5 percent of male students reported that they had had sex during the last six months (Save the Children-US, 2002)

Table 3.4: Teenage sexual behaviour in seven districts, 2000 (percentages)

		Morang	Sunsari	Parsa	KTM	Kaski	Dang	Achham	Total
Ever had sex	Female	13	16	13	2	6	6	4	9
	Male	9	53	26	21	22	9	14	22
Multiple partners	Female	5	0	8	0	3	1	0	2
	Male	6	33	12	8	7	0	8	11
Ever had STD	Female	0	1	3	0	1	2	0	1
	Male	3	26	1	0	1	0	0	4
Use condom	Female	92	77	42	0	100	100	0	62
	Male	75	69	30	89	57	50	56	65
Ever pregnant	Female	1	2	2	0	0	2	0	1

Source: UNICEF, 2001

As will be discussed in Chapter 5, sexual relations between students and teachers also occur.

### 3.2.2 Multiple partners

Very little information could be found on the number of sexual partners among youth in Nepal. 11 percent of in and out of school male teenagers in the UNICEF survey had more than one partner, but this figure is only two percent among females. This implies that half of males and 80 per cent of females who had ever had sex are monogamous and that a high proportion of first sexual partners eventually gets married.

In Kailali District, two out of the 24 sexually active Class 9 and 10 males reported more than one partner during the last six months (1.0 percent of the total sample). Qualitative evidence from the school survey also suggests that only a few students have multiple sex partners in most schools. Compared therefore to the high HIV prevalence countries in sub-Saharan Africa, the incidence of multiple sexual partners is low in Nepal. However, the incidence of female students selling sex in return for money and other goods and services appears to be increasing. Three out of the four male secondary student FDGs and one out of four in Banke and Kathmandu mentioned this phenomenon of mainly poverty-driven transactional sex often with much older men, which has been a key factor in the spread of the AIDS epidemic in Africa. At one school, this group claimed that 10 percent of female students were selling sex to out of school male youth, including the staff of tea estates, hotel guests and visitors. The principal of a secondary school in Kathmandu stated that a 14-year old boy had been expelled because 'he used to bring girls from outside of the school to his room and charged boys to have sex with them'.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Key informants also confirmed that poor female students have a tendency to earn money by 'attracting men'. In Ilam 'many college girls who come from remote areas to study are in sexual relations for money' and 'affairs between government officers and students are common'.

*'Young girls easily get into physical relations even for small amounts of money. This is because of low status and poor economical condition' (Social worker, Ilam)*

In Nepalgunj, 10-15 of the 131 FSWs supported by one NGO are school and college students.

### **3.2.3 Post-secondary students**

Overall levels of sexual activity are likely to be much higher at post-secondary education and training institutions. This is because students are older and many are living away from home.

Over 140,000 students are enrolled at Tribuvan University and its associated colleges. Approximately one-quarter are female. The main campus at Kirtipur has about 8000 students. No KAB surveys or other research have been undertaken, but over 40 percent of male and 20-25 percent of female students are reported to be sexually active. Younger students enrolled in senior secondary (plus two) colleges are reported to be even more sexually active. The manager of one of these colleges in Kathmandu estimated that 70 percent of students, most of whom are boarders and come from relatively well off families, are sexually active. In Ilam, a doctor key informant commented that:

*'There is a garden, which is called a love garden near the college where most of the students go for romantic relation'*

The 1996 survey of students in Nepalgunj found that 43 percent of male and 6 percent of female campus students had had sex (see University of Heidelberg, 1997).

## **3.3 PROTECTED SEX**

### **3.3.1 Condom use**

Reliable information on condom use among school students and youth in Nepal is scanty. Condom use also appears to vary considerably from one district to another. Whereas all of the sexually active secondary school students in Ilam stated that they used condoms last time they had sex, the corresponding percentage for Bankey is only 33.3 percent. The UNICEF survey found that 70.2 percent of sexually active in-school male teenagers regularly use condoms compared with 61.5 percent among out of school males. However, in Kailali District, only 33 per cent of sexually active boys in the areas targeted by Save the Children US used a condom. No other type of contraception was used. Another recently completed survey shows that 74.2 percent of unmarried respondents used a condom in their last sexual encounter. Finally, ever-used condom rates were 79 percent among campus students in Nepalgunj in 1996 and 66.7 percent among secondary school students. Despite these variations, the incidence of condom



use is quite high (certainly compared with many countries in Africa), which is very encouraging. Cultural and social prohibitions on pre-marital sex are probably key factors.

According to the 2001 Demographic Health Survey, only 9.5 percent of married men aged 15-19 years used a condom during last sexual intercourse with any partner. Among married men who had ever used condoms, 2 percent first used a condom between 16-18 years, and 14 percent between 18-21 years. In total, only five percent of all married men used condoms to prevent HIV infection. Nine percent of all married males in urban areas were using condoms and 6.1 percent in rural areas. More educated married men are far more likely to use condoms (SLC and above 16.1 percent compared to 2.4 percent for those with no education).

Focus group students at the survey schools had surprisingly little to say about condom use. At some schools, principals reported that used condoms are regularly found in the school grounds. In Ilam and Kathmandu, condoms are freely available at health posts and pharmacies. But in remoter rural areas, condoms are not easy to procure.

A recent survey of condom use in the Far Western Region reports that 75 percent of condom users are unmarried male youth.

### **3.3.2 Sexually transmitted diseases**

There is no accurate data on the incidence of STDs among youth in Nepal. A key problem is that the majority of youth with STDs do not attend government clinics because access to health services is very limited and many prefer to be treated at private clinics or through pharmacies (see below). It is estimated that 200,000 episodes of STD occur annually in Nepal (see Devkota and Chhetri, 2002).

None of the 54 male student focus group respondents indicated that they had ever had an STD. Although one female student responded positively, she also said that she had never had sexual intercourse. These low rates of STD are encouraging and suggest that rates of consistent condom use are high. However, interviews with health workers in the school survey districts suggest that school students do attend clinics for STD treatment. It is difficult to obtain hard information on the numbers involved. A doctor in Banke estimated that 3-4 percent of his patients were students, mostly with STDs.

The UNICEF survey of (unmarried) teenagers reports that 5.6 percent of sexually active in-school females and 12.1 percent of male students had ever had an STD (which is three percent and one percent respectively of the total samples). Only 31 percent of boys went to a doctor and half just bought medicine. In contrast, nearly two-thirds of the affected female students went to a doctor. Similarly, 14 percent of the sexually active male secondary students in Kailali District in mid-2000 had ever had an STD (see Save the Children-US, 2002). The aggregate HIV prevalence among STI patients across the six survey sites in Nepal was 2.4 percent in 2000. This suggests therefore that at least 0.3 percent of school students who had ever had sexual intercourse could be infected. In some locations, however, this could be much higher. This includes Nepalgunj where 6.6 percent of STD patients who were tested in 2000 were HIV positive.

### **3.3.3 Pregnancy and abortion**

Fewer than 10 percent of secondary and primary teachers and students agreed with the school survey statement that 'some unmarried girls get pregnant' and 'some unmarried girls have abortions'. However, cases of mostly hidden pregnancies were commonly reported at the survey schools. At one school in Ilam where the level of sexual activity is quite high, the principal stated that 1-2 percent of students become pregnant each year. At another school in Ilam, female students reported that 'pregnancies are very famous among girls at this school'. Most pregnant students dropout of school and get married, but a significant proportion (as high as 0.5 percent of female students in the case of the above school) have abortions. These are done at private clinics and often in unhygienic conditions, which carries very significant health risks, including HIV infection. One worker at a private clinic in Ilam commented that:

*'About 20-25 couples come for abortions each year. Three-five girl students also come, but we do not deal with such cases'*

Seven percent of the sexually active female teenagers in the UNICEF survey had ever-been pregnant, which is indicative of high rates of condom use and/or infrequent sexual intercourse. This is one per cent of the sample population.

### **3.4 DRUGS and IDUs**

#### **3.4.1 Overview**

Intravenous drug users are concentrated in the 14-25 age group in larger towns, especially along the Indian border. No detailed user surveys have been undertaken, but it is widely believed that many IDUs in the Kathmandu Valley come from richer families and have attended private boarding schools.

A recent census of IDUs in the Kathmandu Valley identified 3,300 IDUs, which is considerably lower than other estimates of the IDU population (see New Era/FHI, 2001). Fragmentary evidence from NGO workers who have supported IDUs suggests that perhaps as many as five percent of IDUs are secondary school students and another 10 percent are higher education students. If this is the case, then there could be around 60 or so secondary students living in the Kathmandu Valley who are IDUs.

#### **3.4.2. School survey**

11 percent of secondary female teachers and 18 percent of male secondary teachers agreed with the statement that 'some students in this school take drugs'. The corresponding percentages for female and male secondary students are 36 percent and 45 percent respectively (see Tables 3.1 and 3.2). Drinking and various oral drugs are common among secondary school students in Ilam, but none of the survey respondents mentioned that any student was injecting drugs. However, IDU was reported at three out of the four secondary schools in Bankey. At one of these schools, male students estimated that as many as five percent of male students

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

could be IDUs, which if true would be extremely worrying. At one of the four secondary schools visited in the Kathmandu Valley, only one student was suspected.

Key informants confirmed these findings. A doctor in Bankey stated that 'many of the IDUs are school and college students'. Tidigesic and other hard drugs can be readily obtained from India due to the open boarder.

The survey of youth in Kailali District found that 90 percent of males and 93 percent of female students had never used any type of drug including alcohol and tobacco. 15 percent of respondents said they knew someone of their age who used drugs. Nearly one-quarter of the drugs reported to be in use are administered through injection, which implies that two-three percent of youth in this district are IDUs.

### **3.5 FEMALE SEX WORKERS**

At three out of the four survey secondary schools in Ilam, 5-10 percent of male students in senior classes were reported to have visited sex workers, especially in India. This percentage is much lower in Bankey (no more than 1-3 percent) and none of the respondents at the Kathmandu schools stated that students at the school visit FSWs. In Kailali District, 0.5 percent of the surveyed males had ever had sex with a FSW (four percent of those who were sexually active).

Interviews with FSW in the survey districts confirm previous research that the main clients of FSW are businessmen, military and police personnel, truckers and rickshaw pullers and are aged from 15 to 35 years old.

*'Most of my clients are officers, contractors and rich persons of the area. I charge 500 rupees for a drink and some snacks.... Some schoolboys do come to eat mo mo. Some use marijuana, tablets and alcohol' FSW, Ilam*

Where NGOs have been active, it appears that there has been considerable behaviour change among FSWs. In Bankey, all 10 FSWs who participated in the focus group discussion stated that they now insist that all their clients use condoms. A recent survey of FSWs in the Far Western Region found that 85 percent of clients use condoms.

### **3.6 MEN HAVING SEX WITH MEN**

No evidence of homosexual sex was found at the survey schools. However, recent survey evidence suggests that MSM is quite common in Nepal. Most of the men involved are married and have casual sex with other men (Pant, 2001).

## **4. HIV PREVENTION AMONG SCHOOL STUDENTS**

This chapter assesses the effectiveness of the formal curriculum and other school-based activities in ensuring that students are well informed by the causes and consequences of HIV/AIDS and have the necessary skills and attitudes that will help them avoid high-risk behaviour.

### **4.1 GOVERNMENT POLICY**

The 1995 National Health Policy on AIDS Control stressed the importance of providing HIV/AIDS education in lower secondary and secondary schools as well as post-secondary education and training institutions. To this end, the MOES with assistance from various agencies (in particular UNFPA) introduced three new subjects into the formal secondary education curriculum in 1999. These are health and physical education and population and environment (at lower secondary) and health, population and environment (at secondary).

The new HIV/AIDS National Strategy recognises that youth are now 'highly aware of the of the HIV risk, but this awareness does not necessarily translate into safe sexual behaviour'. Consequently, the national strategy 'contains elements that move beyond providing youth with basic knowledge. It also strives to strengthen the skills of young people in decision-making, communication with their partners, negotiation of sex health behaviour, and anticipation of high-risk situations. The development of a 'healthy life styles' curriculum in schools is a key objective in ensuring that the necessary skills and attitudes are acquired' (NCASC, 2002:28). However, the content and delivery of this curriculum have not yet been elaborated.

### **4.2 HEALTH EDUCATION CURRICULUM**

#### **4.2.1 Primary education**

The primary school curriculum does not include any topics on HIV/AIDS or any other area of sexual reproductive health. It is commonly argued that SRH education is inappropriate for primary school students mainly because they are too young. However, almost all primary school teachers at the survey schools agree with the statement that 'there should be more lessons on sexual reproductive health' (see Table 3.2). They give four main reasons for this.

- A high proportion of Class 4 and 5 students are adolescents and have therefore reached puberty. At the survey primary schools, 47 percent of Class 4 students and 70 percent of Class 5 students are over 10 years old. Primary schools have an important responsibility therefore to educate children with respect to basic information and understanding about adolescent sexuality.
- A large number of children do not go on to secondary education so it is important that they receive some SRH education when they are at primary school. According to EMIS statistics, these transition rates were 78 percent for girls and 81 percent for boys in 2000.
- Students do not have sufficient knowledge about HIV/AIDS (see Table 3.2.)

- Parents want schools to educate their children on these issues. Only a small minority of primary school teachers agreed with the statement that ‘parents do not want teachers to teach sexual and reproductive health topics’.

#### **4.2.2 Secondary education**

Lower secondary schools teach nine compulsory subjects. Health and physical education and population and environmental education are taught for three periods a week (out of a total of 39) and carry 50 marks each (out of a total of 700). Health, population and environmental education is one of six compulsory subjects at secondary schools (Classes 9 and 10). All compulsory subjects have 100 marks, but HPE is taught for only four periods a week (five periods for other subjects). The new HPE curriculum was introduced into schools in 1999 after a long period of preparation. The Population and Health Unit in the MOES has been primarily responsible for the curriculum design of these three new subjects.

The units and topics of these three subjects, which deal with HIV/AIDS as well as other SRH topics is summarised in Annexes 3 and 4. At lower secondary schools, students receive only very basic information on HIV/AIDS. This amounts to just three paragraphs in the textbook. However, Population and Environment as well as Social Studies have topics on family planning, early marriage, girl trafficking and high-risk behaviour (smoking, drugs and alcohol).

In Class 9, the HPE curriculum covers STDs, HIV/AIDS (including symptoms and preventive measures), but again the treatment of these topics is rather superficial. In particular, there is no further information on how HIV develops into AIDS, the information is not up to date, there are no HIV prevalence data (especially for the high-risk groups), and the description of the symptoms of AIDS is not clear. In Class 10, there is further coverage of STDs and HIV/AIDS. Topics on adolescence, substance use, alcohol, prostitution and family life are included in part two of HPE, which is an elective subject.

Class 10 Social Studies has relevant and interesting information on key issues including girl trafficking and drug abuse and is well illustrated. Facts and figures are used to explain HIV/AIDS transmission and non-transmission. The information given is accessible and user friendly. The importance of having a positive attitude towards PLWA is briefly mentioned. A short case study is presented with guidelines for discussion.

Four teacher’s handbooks are available which include information on HIV/AIDS and related SRH topics. Two of these handbooks follow an interesting approach (participatory, containing statistics etc), but it is not known how many of these books have been distributed among the teachers. None of the handbooks were found in schools taking part in the survey. A reference book originally from the Maldives has been translated into Nepali, but it has numerous shortcomings mainly because it has not been adapted to the Nepalese context.

The curriculum on HIV/AIDS and, more generally, SRH has much to commend it. SRH topics comprise a sizeable proportion of the curriculum in the three core subjects. The topic coverage is quite comprehensive. The main weakness of the curricula is that the content is not adequate, it is too content-driven, and does not focus at all on the development of key life skills, which

will help to ensure that young people in Nepal do not become infected with HIV. In key areas, not enough information is given and issues are not well explained.

Students themselves are concerned that they do not have enough knowledge about SRH and HIV/AIDS. Less than one-third of secondary student questionnaire respondents agreed with the statement that 'they have sufficient knowledge about HIV/AIDS' (see Table 3.1). The curriculum hardly deals with attitudes, beliefs and values related to HIV/AIDS. Female students would like more on the following topics: STDs, menstruation, safe motherhood and pregnancy, hygiene and care, and reproductive health. Males said that they want to know more about STDs and HIV/AIDS, condoms, 'sex psychology' and adolescence, how to behave towards PLWA, care and prevention, historical background of the disease, mother to child transmission, safe motherhood, conception, and masturbation. Students are eager to talk about these topics in an open and relaxed way. Nearly half of male students and one-third of female students indicated that there is not enough information on these kinds of issues in the curriculum. Over 90 percent said that they would like more lessons on SRH. As always, however, finding additional time in already very crowded curriculum is extremely difficult.

The quality of textbooks and other learning materials is another key issue. The textbooks are not appealing to a young audience, in particular because they do not discuss key concerns in a lively and engaging manner. The textbooks have only line drawings. And apart from the textbooks, there are virtually no other high quality supporting learning materials including wall charts, demonstration models, games, posters, and audio-visual material. Only one-third of students agreed with the statement that 'there are sufficient books on sexual reproductive health'. Health teachers also stressed the importance of having a range of interesting learning materials, which can be used to facilitate student-centred learning methodologies. A lot of excellent youth-friendly learning materials have already been developed by NGOs in Nepal.

### **4.3 CURRICULUM DELIVERY**

The common conclusion of many evaluations and other research studies is that school-based SRH education is rarely effective, particularly with respect to promoting safe sexual behaviour. The school survey also shows that secondary schools in Nepal face much the same set of problems and constraints in teaching SRH education as most other countries.

#### **4.3.1 Teacher competence and commitment**

Student and teacher questionnaire respondents at the survey secondary schools are quite positive about how well SRH is taught at the survey secondary schools. However, student and teacher focus group respondents identified a number of major concerns with respect to both teacher competence and commitment in this area.

First, very few health education teachers have undertaken the appropriate pre-service training. The main reason for this is that, although these are compulsory subjects, the Ministry of Finance has not given the MOES a financial allocation to recruit trained health education teachers on to the permanent payroll. Only one of the HPE teachers at the survey schools is properly trained. This is despite the fact that there is a plentiful supply of newly trained health

education teachers. In 2000 alone, there were over 2000 B.Ed. graduates from Tribhuvan University and its 83 associated colleges, who had specialised in health education.

This problem is further compounded by the almost complete lack of in-service training. Only four and eight percent of the teachers at the primary and secondary survey schools have attended short courses on SRH-related issues, which are typically are of only 1-2 days duration and are provided by NGOs (in particular the Red Cross, PLAN International, and FPAN).

Secondly, many health education teachers lack the confidence and necessary commitment to be effective teachers. Most of the health teachers who were interviewed readily admit that do they do not have the requisite knowledge and skills to teach the subject well. Common complaints from students are that teachers do not explain properly, are shy and 'not open', rush through or even skip the lessons, do not want to answer questions, and prefer English to Nepali words.

*'When the teacher teaches about the sex organs, all the students laugh, even if they do not understand the chapter. The teacher feels uncomfortable when the students laugh'. Male secondary students, Bankey*

Thirdly, the fact that most teachers in secondary schools are males also creates additional difficulties. Most girls cannot discuss sensitive issues with male teachers. Others complain that male teachers focus their attention on male students.

*'Girls and boys are different in the way they react to the classes: girls are often shy, but boys are open and ask many questions.' Female secondary students, Ilam.*

*'Girls cannot ask questions in front of boys students. Girls, for example, want information about the menstruation cycle. But the boys laugh and the girls feel shy.' Female secondary students, Ilam*

Female teachers are also frequently too embarrassed to teach SRH topics to mixed classes.

There are, however, a few survey schools where teachers are competent and committed. In one school in Ilam, for example, the HPE teacher asks students to write down their questions on pieces of paper. These are then read out and discussed in an open and relaxed way.

#### **4.3.2. Parental and teacher opposition**

Parental opposition to schools teaching sexual reproductive health is a major obstacle to effective learning in many countries. However, this does not appear to be the case in Nepal. Only 16-17 percent of secondary students and less than 30 percent of teachers at the survey schools agreed with the statement that 'parents do not want teachers to teach sex education' (see Tables 3.1 and 3.2).

Teachers can also object to school-based SRH, especially when they believe that providing this education encourages sexual activity among students. One in five primary and one in three school secondary teachers at the survey schools think that such a causal link exists.

### **4.3.3 The learning environment**

A supportive student-centred learning environment is essential for effective SRH and life skills training. In particular, students have to trust their health education teachers and feel confident enough to discuss sensitive personal issues with their fellow students. Such a supportive, 'student-friendly' environment does not exist in many schools. Only one-third of secondary female and 40 percent of secondary male students agreed with the statement that 'students are open with their teachers regarding SRH education (see Table 3.1). Teachers 'bad attitude' towards female students was mentioned as one of their major dislikes of school by one-third of the secondary female FGDs. Boys FGDs dislike beating, scolding, and discriminatory behaviour by teachers (see Annex 5).

The absence of any formal guidance and counseling system is also makes it more difficult for students to seek advice and support. Students receive counseling in only one-quarter of the survey secondary schools.

## **4.4 STUDENT KNOWLEDGE**

### **4.4.1 Knowledge levels**

As part of the school survey, 743 students were asked to complete a simple knowledge test about the causes and consequences of HIV/AIDS. Knowledge levels among primary students are very low. More than one-quarter of the female and male respondents gave the incorrect answer to 16 and 9 of the 20 questions respectively. However, both female and male secondary students performed very well (Table 4.1). Primary female students are slightly less knowledgeable than males. At the secondary level, these gender differentials persist, but they are much less pronounced. There are only a couple of questions, which more than half gave the incorrect answer (sharing toothbrushes and breastfeeding can result in HIV infection). There are no major differences in knowledge levels between urban and rural schools. Numerous other surveys have also found that, while general HIV knowledge among the 14-25 age group is fairly good, knowledge about STDs is quite poor. (see FHI 2001, Nepal Red Cross, 2000, UNICEF, 2001)



Table 4.1: Student knowledge test on HIV/AIDS (percentage correct answer)

Test item	PRIMARY		SECONDARY	
	Female	Male	Female	Male
Sex with a single partner helps to prevent HIV/AIDS	83	73	96	93
HIV/AIDS infection by blood transfusion	85	89	90	91
HIV/AIDS can be detected by looking at a person	56	65	90	93
HIV/AIDS infection by exchanging clothes	53	50	94	95
HIV/AIDS infection by eating together	45	51	97	98
HIV/AIDS infection by sleeping in the same room	50	61	85	95
HIV/AIDS infection by using condoms	43	45	93	97
HIV/AIDS infection by sharing toothbrush	64	63	32	30
HIV/AIDS infection by sharing soap	50	50	93	94
HIV/AIDS infection by sharing shaving blades	46	45	86	88
HIV/AIDS infection by mosquito bites	41	46	72	82
HIV/AIDS infection by taking care of infected people	55	55	92	97
HIV/AIDS infection by sharing tattoo needles	57	65	77	80
HIV/AIDS infection by pregnant mother to her child	75	78	95	98
HIV/AIDS infection by breast feeding	71	71	46	45
HIV/AIDS infection by using unsterilized needles	74	87	97	95
HIV/AIDS can be prevented by using condoms	75	85	96	97
There is no cure for HIV/AIDS	59	70	78	85
Only immoral people get Aids	69	77	92	92
HIV/AIDS can be treated by shamans and witch doctors	76	88	98	97

#### 4.4.2 Sources of information

Students at the survey schools get most of their information about HIV/AIDS from the television and radio (see Table 4.2). Most of their parents do not talk to them about the epidemic. While hardly any teachers at primary schools have provided any information, almost one-third of secondary school students indicated that their teachers are one of their three most important sources of information. Unlike many other countries, health workers are not an important source of information. Student respondents did not specifically mention peer education activities, but this is probably covered by 'word of mouth'. There are no consistent gender or location differences. It is clear though that in remote rural schools, television is unlikely to be a major information source.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Table 4.2: Most important sources of information about HIV/AIDS among students (rounded percentages)

Source	PRIMARY			SECONDARY		
	F	M	T	F	M	T
Television	85	89	87	87	83	85
Radio	74	76	75	76	76	77
Books	44	50	46	66	67	66
Health workers	1	2	1	4	6	5
Word of mouth	15	20	17	29	31	30
Teachers	3	1	2	31	30	30
Parents	3	4	3	6	4	5
Street plays	0	0	0	4	6	5

Note: Respondents were asked to indicate their three most important sources of information

#### 4.5 OTHER PREVENTION ACTIVITIES

There are a number of NGOs and other organisations that are also involved in HIV/AIDS prevention activities, both in and out of schools. However, the paucity of good quality evaluation data makes it difficult to reach firm conclusions about the overall impact and effectiveness on the knowledge and behaviour of young people.

##### 4.5.1 Non-governmental organisations

Evidence of some school-based NGO activities (street drama, competitions, video shows) in this area was found in five of the survey secondary schools (including Maiti Nepal, Family Planning Association of Nepal, and the US Peace Corps). With a few exceptions, both students and teachers welcomed these activities and would like a lot more in the future.

The Youth Department of the Nepal Red Cross Society runs the largest peer education programme in the country. Started in 1994, the programme now operates in 40 districts. A total of 2400 schools and an unspecified number of out of school youth are directly involved. Three-day training for peer educators is provided. However, a recent evaluation concludes that the programme has not been as successful as expected. In particular, peer educators need more teaching skills (see NRCS, 2001).

Save the Children US also has its own peer education programme for in and out of school in six districts. A recent evaluation has compared knowledge and behaviour outcomes among youth in both program and non-program areas in Kailali District.

Social mobilisation programmes around key HIV/AIDS issues have been promoted by Save the Children UK and US in a number of districts in the west (including Achham and Kanchanpur). Working through existing groups (especially Mother's Clubs, Junior Red Cross, child clubs), this approach supports the initiatives of volunteers to develop their own activities and materials. While some schools have been involved, teachers have not shown much interest.

***An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal***

Both NGOs believe that these programmes have had a major impact on both knowledge and behaviour. In particular, the extent of discrimination against PLWA has declined dramatically.

**4.5.2 International agencies**

UNICEF has actively supported HIV/AIDS education through its the radio programme 'Chatting with my Friend', and the television programme 'Catmandu'. Both are broadcast weekly, and emphasise life skills and 'building the capacity among young people to make informed choices'. No detailed audience surveys have been undertaken, but UNICEF believes that Chatting with My Friend has 4.5 million listeners, 90 percent of whom are living in rural areas. Since the first programme in April 1990, the programme has received an average of 125 letters per week from its listeners.

Two other UNICEF programmes- Out of School Programme for Working Children and Decentralised Actions for Children – also have HIV/AIDS education objectives.

## **5. TEACHER KNOWLEDGE AND BEHAVIOUR**

This chapter assesses the extent to which teachers in Nepal are likely to be at risk from HIV infection as a result of their sexual and other behaviour. While most principals at the survey schools felt that almost all teachers were not at risk, other respondents (students, key informants, and teachers themselves) identified a number of areas of concern, which need to be addressed.

### **5.1 TEACHER CHARACTERISTICS**

There are seven characteristics of the teaching profession, which are particularly important in determining the HIV/AIDS risk profile of this large occupational group namely: gender, age, educational attainment, marital status, geographical mobility, spouse separation, and status, power and income.

#### **5.1.1 Gender**

The evidence from African countries shows that AID-related mortality tends to be higher among male teachers. At government schools in Nepal, only 21 percent of primary, 6 percent of lower secondary, and 10 percent of secondary school teachers were females in 2000. Although these staffing gender ratios are much better at private schools, they are still very low at private secondary schools (41 percent, 11 percent, and 17 percent respectively). Only 14 percent of primary school teachers in the Far western Region are women.

#### **5.1.2 Age and location**

The younger the age profile of teaching staff, the greater the impact HIV/AIDS is likely to have on teachers. This is because HIV infection is concentrated in the age range 15-35. Table 5.1 shows that nearly two-thirds of the teachers at the survey rural primary schools were under 35 compared to less than one-third at these schools located in urban areas. Secondary school teachers have a relatively old age profile compared to other low-income developing countries. Even so, almost half of these teachers at rural schools are under 35 at both rural and urban schools.

HIV prevalence rates are typically much higher in urban areas. Thus, the higher the proportion of teachers who are working in rural schools, the lower the impact of the AIDS epidemic will be.

#### **5.1.3 Educational attainment**

The better-educated and trained teachers are, the less likely they are to become infected. Only 18 percent of Nepali primary school teachers working in government schools were fully trained in 2000. The percentages of fully trained teachers in lower secondary and secondary government schools were 31 percent and 56 percent respectively.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Table 5.1: Age distribution of teachers (rounded percentages)

**PRIMARY SCHOOLS**

Age group	Rural			Urban			ALL		
	F	M	ALL	F	M	ALL	F	M	ALL
20-24	33	24	28	0	0	0	16	19	18
25-29	13	12	13	9	38	21	20	12	16
30-34	20	24	22	18	0	11	16	19	18
35-39	20	18	19	27	25	26	20	23	22
40-44	0	12	6	36	25	32	16	15	16
45-49	0	6	3	0	0	0	4	0	2
50>	13	6	9	9	13	11	8	12	10

**SECONDARY SCHOOLS**

Age group	Rural			Urban			ALL		
	F	M	ALL	F	M	ALL	F	M	ALL
20-24	0	9	7	18	13	15	11	11	11
25-29	8	11	10	18	9	12	14	10	11
30-34	31	29	29	32	17	22	31	23	25
35-39	23	18	19	18	11	13	20	14	16
40-44	31	11	16	5	9	7	14	10	11
45-49	8	4	5	5	13	10	6	9	8
50>	0	18	14	5	28	21	3	23	17

**5.1.4 Marital Status**

The higher the proportion of married teachers, the lower the impact of the epidemic on the teaching profession is likely to be. This is because married teachers tend to have fewer sexual partners than unmarried teachers

Most teachers at the survey secondary schools are married as are primary school teachers at urban schools. But nearly one-third of teachers at rural primary schools are single (see Table 5.2). School-level statistics show that that only 7 percent of teachers at the 11 government schools were not married in contrast to 75 percent at the one private primary school that was included in the survey.

Most unmarried teachers were living with their parents or other family members.

Table 5.2: Marital status of teachers (rounded percentages)

	Rural			Urban			ALL		
	F	M	ALL	F	M	ALL	F	M	ALL
<b>PRIMARY SCHOOLS</b>									
Single	31	35	33	0	13	5	17	28	22
Married	69	65	67	100	87	95	83	72	78
<b>SECONDARY SCHOOLS</b>									
Single	0	13	10	27	13	18	17	13	14
Married	100	87	90	73	87	82	83	87	86

### **5.1.5 Geographical mobility**

The more often teachers are transferred to new schools, the higher the risk that they could become infected. Teacher transfer rates are very low in Nepal (primary 3.4 percent, lower secondary 2.2 percent, 1.5 percent secondary in 2000), which is directly linked to the high levels of politicisation and bribery associated with teacher recruitment and deployment. Teachers tend therefore to stay at the same school for all or most of their careers. While this lowers their risk profile with regard to HIV, such low levels of teacher mobility tend to seriously affect the overall effectiveness of schooling systems.

The increasing seriousness of the Maoist insurgency has resulted in some teachers leaving their schools in rural areas and moving to urban locations.

### **5.1.6 Spouse separation**

In many countries, sizeable proportions of teachers are separated from their spouses. This is particularly the case for teachers who are posted to schools in remote, rural locations and where spouses have their own careers. Lack of adequate housing and schooling for teacher's children are also key factors. Separated spouses are more likely to have extra-marital relationships and are, therefore, more at risk from HIV infection.

Spouse separation is minimal among teachers in Nepal. None of the teacher questionnaire respondents at the surveyed primary schools indicated that they were separated from their spouses. Among secondary school teachers, five percent of both female and male teachers at urban schools reported that they were living apart. School level statistics show a similar picture.

### **5.1.7 Power, status and income**

The social position and authority of teachers give them very considerable power over students. Love relations between students and teachers and sexual harassment of students by teachers are relatively common in many countries, especially in rural areas. In the context of major AIDS epidemics, such behaviour is a major risk factor. It is also argued that teachers working in poor communities are relatively well-off, which makes them more likely to engage in high-risk activities such as visiting local wine shops (bhatti) and FSWs.

## **5.2 HIV PREVALENCE**

There is no information available that can be used to ascertain likely levels of HIV infection among teachers according to age, gender, education and training, type of school, location, and marital status. It is not even possible to derive an age-adjusted prevalence rate assuming that teachers have the same risk profile as the adult population as a whole. With 108,000 teachers employed in government schools and 34,000 teachers in the private sector, it is essential that this information is obtained as soon as possible through well-established procedures of voluntary, anonymous testing of a representative sample of teaching staff.

Only 3-4 percent of the surveyed primary school teachers and 7 percent of secondary school teachers agreed with the statement that 'some teachers at this school may be infected with HIV/AIDS'. Agreement rates are only marginally higher among student respondents.

### 5.3 KNOWLEDGE OF HIV/AIDS

Both primary and secondary teachers who completed the knowledge test are well informed about the causes and consequences of HIV/AIDS (see Table 5.3). For both groups, only three out of 20 questions had less than 75 percent correct answers (sharing toothbrushes, breastfeeding, and taking care of infected people). There were no significant differences between female and male teachers and teachers at rural and urban schools. As expected, teacher knowledge levels about HIV/AIDS are much higher than for the adult population as a whole.

Teachers have obtained their information about HIV/AIDS almost exclusively from radio, television and newspapers. Only two percent and six percent of primary and secondary school teachers said that health workers were one of their three most important sources of information.

Table 5.3: HIV/AIDS knowledge test for teachers (correct answers percentages)

	PRIMARY		SECONDARY	
	Female	Male	Female	Male
Sex with a single partner helps to prevent HIV/AIDS	95	100	96	83
HIV/AIDS infection by blood transfusion	100	95	85	90
HIV/AIDS can be detected by looking at a person	100	100	83	96
HIV/AIDS infection by exchanging clothes	100	95	96	97
HIV/AIDS infection by eating together	100	100	96	99
HIV/AIDS infection by sleeping in the same room	95	100	90	99
HIV/AIDS infection by using condoms	100	95	93	100
HIV/AIDS infection by sharing toothbrush	42	43	30	26
HIV/AIDS infection by sharing soap	100	95	89	95
HIV/AIDS infection by sharing shaving blades	100	91	89	99
HIV/AIDS infection by Mosquito bites	74	63	77	79
HIV/AIDS infection by taking care of infected people	57	57	8	3
HIV/AIDS infection by sharing tattoo needles	95	95	85	80
HIV/AIDS infection by pregnant mother to her child	100	95	96	95
HIV/AIDS infection by breast feeding	31	26	30	33
HIV/AIDS infection by using unsterilized needles	95	95	96	99
HIV/AIDS can be prevented by using condoms	100	95	96	95
There is no cure for HIV/AIDS	86	81	79	87
Only immoral people get Aids	75	76	85	90
HIV/AIDS can be treated by shamans and witch doctors	100	95	100	100

## 5.4 SEXUAL PARTNERS

### 5.4.1 Extra-marital sex

The Demographic and Health Survey reports that only 2.3 percent of married men had extra marital sex during the last 12 months. Younger married men are less likely to remain monogamous (6.5 percent for the 20-24 and 4.3 percent for the 25-29 age groups). There is also some regional variation. The highest level of extra-marital sex is in the Far Western Terai sub-region (6.7 percent) (see Table 5.4). The rates for the three sub-regions covered by the school survey are: Eastern Hill (Ilam) 0.7 percent, Western Terai (Bankey) 2.0 percent, and Central Hill (Kathmandu Valley) 2.3 percent. No corresponding information on single adults is available.

Extra-marital sex appears to be much higher among migrant groups. One survey reports that 28 percent of migrant males in the Far West Region had multiple partners. Nearly one-third of non-migrants had also had extra-marital sex when their spouses' were absent. 'Women enjoy extra marital affairs in the same proportions'.

The findings of the school survey indicate that extra-marital sexual relations are not common among teachers. It is unlikely that the incidence of these relations is any higher among teachers than for the adult population as a whole. As one principal pointed out:

*'Most teachers at this school come from the local village so it is not easy for them to have affairs.'* Secondary school principal, Ilam

This highlights the importance of posting teachers to their home localities, which is a policy that MOES is pursuing for other reasons.

### 5.4.2 Female sex workers

No cases of primary school teachers visiting FSWs were reported. It is clear though that a small minority of secondary school teachers at as many as half of the survey schools have visited FSWs. Five of the male teacher FDGs mentioned that this was the case. Reported levels of male teachers living separately are generally much higher than suggested by the teacher and school questionnaire data and it is these teachers from outside the district who are seen to be most at risk.

*'Two-three teachers visit sex workers on a regular basis.'* Secondary male students, Ilam

*'10-15 percent of teachers from outside the district use sex workers.'* Female primary teacher, Ilam

None of the FSWs interviewed for the school survey indicated that teachers are an important client group. The relatively high cost involved is likely to be a major factor.



## 5.5 PROTECTED SEX

No information exists on condom use and STDs among teachers. While teachers at the survey schools are generally well-informed about condoms, most do not use them on a regular basis. For married couples, Depo-Provera appears to be the preferred form of contraception. A number of teachers commented that ‘most women take depo so condom use is not high.’

## 5.6 DRUGS AND IDUs

No cases of injecting drug use were reported among teachers either at the survey schools or other schools in the locality. However, drinking is widespread among both primary and secondary teachers, in particular in Ilam. Excessive drinking can result in “uncontrolled situations”, which can lead to high-risk behaviour.

## 5.7 SEXUAL HARASSMENT AND MISCONDUCT

Perhaps the most disturbing survey finding with respect to teacher behaviour is what appear to be fairly widespread sexual relationships between male teachers and female students at secondary schools. The incidence of these relations is particularly high in Ilam. The prevalence of this kind of behaviour is a consequence of the strong patriarchal relations in Nepalese society.

Table 5.4: Number of sexual partners among married men 2001 (percentages)

AGE	0	1	2+
15-19	95.4	4.6	0
20-24	93.4	3.1	3.4
25-29	95.7	2.2	2.1
20-39	97.4	2	0.6
40-49	99.6	0.4	0
50-59	99.4	0.5	0.1
EDUCATION	0	1	2+
No education	99.1	0.4	0.6
Primary	97.6	1.8	0.6
Some secondary	95.8	3.3	0.8
SLC and above	96.9	2.2	0.9

Source: DHS 2001

One in seven of the open-ended dislikes of school reported (on cards) by the female secondary FDGs concern ‘teacher’s bad attitude towards female students’ (see Annex 5). Five of the 12 female secondary student FDGs and 7 out of 12 secondary male teacher FDGs mention instances and examples of inappropriate sexual behaviour between teachers and students. This behaviour ranges from full sexual intercourse to touching, petting, staring, teasing etc. The following comments are typical:

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*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

*'Teachers show bad attitude towards female students. They try to feel the bra straps pretending as if they are patting their backs. They also try to put their hands under girl's skirts.'* Female secondary students, Ilam

*'Teachers blackmail students for sexual activity saying that they will pass her in her examination.'* Male secondary students, Bankey

*'Many girls dropout of school due to the relations between teachers and students.. Sexual abuse by teachers is more common in remote areas.'* Education official, Ilam

*'Many girls have sex with teachers in return for tuition.'* Social worker Ilam

*'Some teachers invite girl students to their houses and have sex with them.'* Male secondary students, Bankey

*'Some teachers have married girl students'* Secondary school principal, Ilam

*'There is a teacher at another school near here who raped a Class 5 girl. He is still teaching there'* Female secondary students, Bankey

*'Every village has a story about teacher sexual misconduct'* NGO worker, Kathmandu

*'Many girls dropout of school because of relations with teachers. They do not complain because of shyness.'* Teacher trainer, Ilam

During the last five years, six teachers at the 12 survey secondary schools had impregnated school students. The SC/US survey of youth sexual behaviour in Kailali District reports that over 45 percent of female school respondents had experienced some form of sexual harassment from males in their families and in the community. But only one boy and one girl said that this was by a teacher (0.5 percent of the total sample).

Principals at two of the survey secondary schools also cited occasions when a male teacher had facilitated quasi-commercial sexual relationships between female students at their schools and outside males.

Teachers are expected to abide by the Code of Conduct as laid down in National Teaching Service Regulations (6th amendment 2000). However, prohibition of sexual misconduct of any type is only implied by standards of high professional behaviour and is not made explicit. Teachers at three of the secondary schools had been expelled for serious sexual misconduct, but the general view is that most teachers engaging in this behaviour are not punished. Female students themselves feel powerless because 'they cannot speak openly about these teachers'.

Almost all female teachers agreed with the statement that 'teachers having illicit relations with students should be punished' (see Table 3.2). However, sizeable minorities of male primary and secondary teachers do not agree with this statement (17 percent and 26 percent respectively). Only 63 percent of male secondary teachers at urban schools are in agreement.

**An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal**

Among female secondary students, less than two-thirds agree that teachers should be punished for this type of behaviour.

## **6. IMPACT AND SUPPORT**

This chapter focuses on the actual and likely impacts of HIV/AIDS on students and teachers at primary and secondary schools. As elsewhere, it is important that the impact of HIV/AIDS on the education sector is assessed in the overall context of the very high levels of endemic poverty in Nepal.

### **6.1 STUDENTS**

There are three groups of school children whose lives are most directly affected by HIV/AIDS and whose education is therefore potentially at greatest risk: children who are HIV positive, children in households with sick family members, and children whose parents or guardians have died of AIDS. The extent to which the education of these children is adversely affected depends heavily on the level of physical and emotional support they receive from the extended family, the school, the community (including NGOs) and central and local governments.

The school survey found virtually no evidence of any student who has been directly affected by HIV/AIDS. At one school only, it was reported that there is a student whose parents are living with AIDS. This is not surprising given the still very low rates of HIV prevalence in Nepal.

However, a key informant in Bankey District did point to the growing number of children who are directly affected by the epidemic. Fifteen needy children in Nepalgunj currently receive scholarships from a local NGO. There is also some fragmentary evidence from districts in the Far Western region (in particular Achham) that the education of a small number of children has been seriously affected as a direct consequence of HIV/AIDS (see below).

Around one-third of children born to infected mothers are HIV positive. Since most die before they are five, even in countries with very high HIV prevalence rates, only tiny numbers of primary school students are infected. Anti-retroviral drugs can cut the level of mother to child transmission by one-half.

Even though there has been little or no impact to date, HIV/AIDS could seriously affect the education of many more children should HIV prevalence rates increase significantly over the next five-ten years. It is essential therefore that the MOES carefully monitors the impact of the epidemic on the education sector. The key areas of concern with respect to student impact are: the size of the orphan population; enrolment, repetition, drop out and absenteeism rates (particularly among females); discrimination against students whose households are directly affected by HIV/AIDS; and the overall level of support by MOES and other agencies to disadvantaged children and youth.

#### **6.1.1 The orphan population**

No direct census or household survey data exists on the parental status of children in Nepal. The Children on the Brink demographic modeling exercise for all AIDS-affected countries estimates that 9.4 percent of Nepalese children aged between 0–14 years have lost one or both parents (see Table 6.1). However, two-parent orphans account for only 0.4 percent of the child

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

population. It is also important to emphasise that these orphan projections are subject to wide margins of error<sup>1</sup>.

According to the Children on the Brink estimates, most of the 13,000 'AIDS orphans' in 2001 were paternal orphans. There were 1,000 two-parent AIDS orphans.

Table 6.1: Children on the Brink orphan estimates 2001-2010 ('000)

Year	Pop 0-14	Total orphans	AIDS orphans	Maternal orphans			Paternal Orphans			Two parent orphans		
				AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total
2001	9656	835	14	2	357	359	11	502	513	1	36	37
2005	10420	825	26	5	343	348	22	488	510	2	31	33
2010	11247	804	45	9	321	330	38	465	503	3	26	29

Source: Children on the Brink, 2002

Table 6.2 shows the parental status of students at the survey schools. None of the 750 students were two-parent orphans. The incidence of single-parent (maternal and paternal) orphans was 3.0 percent and 4.4 percent respectively among female and male primary school students and 7.7 percent and 6.4 percent for female and male secondary school students. The ratio of paternal to maternal orphans is very high. For a number of reasons, these are not directly comparable with the estimates of the incidence of orphan children in the 0-15 age group presented in the Children on the Brink report. The fact, however, that no two-parent orphans are enrolled at these schools suggests that these children face major problems with their education (see below).

### 6.1.2 Enrolments and enrolment rates

Reliable data on never-enrolled children, enrolments, repetition and dropouts is essential in order to monitor any future impacts of the AIDS epidemic. According to EMIS data, the gross enrolment ratio for primary education was 108.4 percent for females and 119.8 percent for males in 2000. However, using the 6-10 population estimates from the 2001 Population Census, the female GER is markedly lower (100.6 percent compared to 122.6 for males).

Table 6.2: Orphan students (percentages)

	PRIMARY		SECONDARY	
	Female	Male	Female	Male
Paternal orphan	2.4	2.9	6.7	4.9
Maternal orphan	0.6	1.5	1	1.5
Two-parent orphan	0	0	0	0

<sup>1</sup> The 2002 Children on the Brink report states that its estimation methods are in 'broad agreement with survey-based data for total orphan numbers, but 40-100% higher for maternal and two parent orphans'. It is these two types of orphans whose education is usually most affected

It is widely believed that HIV/AIDS adversely affects the education of girls more than boys. This is mainly because girls are expected to shoulder a greater burden of the (home-based) care of sick family members and to take over more of the productive and other household activities of the deceased. EMIS statistics indicate that the percentages of female students were 44.0 percent in primary schools, 41.5 percent at lower secondary schools and 40.6 percent at secondary schools in 2000. At the government schools in the school survey, however, female students tend to out-number male students.<sup>2</sup> The main reason for this is that much higher proportions of boys attend generally better performing private schools. The increasing privatisation of education provision in Nepal could therefore have an adverse impact on gender equity.

### 6.1.3 Repetition, dropout and absenteeism

MOES statistics on repetition and dropout rates are inconsistent with the limited amount of household survey data that is available (see Tables 6.3 and 6.4). The data from the Demographic and Health Survey is likely to be more accurate than EMIS data<sup>3</sup>. This is mainly because information on schooling is collected directly from households. Principals often have imperfect information on student dropouts. According to the 2001 Population Census, for the 10-14 age group, 71 percent of females and 82 percent of males are students. The corresponding figures for the 15-19 age cohort are 41 percent and 57 percent respectively (see Table 6.5).

Dropout rates at the survey primary schools since the start of the 2002 academic year are 4.9 percent for female and 6.0 percent for male students. The corresponding figures for secondary schools are 3.6 percent and 4.0 percent respectively. It is important to note however that all but one of the 10 government secondary schools in the survey have relatively numbers of students enrolled in Classes 1-5 i.e. they are combined primary and secondary schools. The cumulative repetition rates for all 10 classes at these schools are much lower than aggregate EMIS statistics (females 17.8 percent and males 17.1 percent).

Table 6.3: EMIS and DHS primary school repetition rates 200-2001 (percentages)

CLASS	1	2	3	4	5	TOTAL	Total exc Class1
<b>Females</b>							
EMIS	41	16.7	12.6	12.9	11.1	94.3	53.3
DHS	34	9.2	8.1	6.8	5.8	63.9	29.9
<b>Males</b>							
EMIS	42.4	16.4	12.8	13	10.5	95.1	52.7
DHS	31.6	10.1	7.1	6	6.4	61.2	29.6

Source: EMIS and Demographic and Health Survey 2001

<sup>2</sup> Primary schools: rural 54 percent and urban 53 percent and secondary schools: rural 53 percent and urban 51 percent.

<sup>3</sup> The 2000 BCHIMES survey estimates the dropout rate for primary school children (aged between 6-15) to be only 3.5 percent (3.3 percent boys and 3.7 percent girls). The dropout rate at urban primary schools is 2.1 percent compared to 3.6 percent at rural schools.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Table 6.4: EMIS and DHS primary school dropout rates 200-2001 (percentages)

CLASS	1	2	3	4	5	TOTAL
<b>Female</b>						
EMIS	14.3	5.1	4	1.2	12.9	37.5
DHS	1.7	1	1.7	2.3	2	8.7
<b>Male</b>						
EMIS	13.1	6.2	5.5	5.9	13.2	43.9
DHS	1.2	1.5	2.1	3.2	3	11

Source: As table 6.3

Table 6.5: Student and marital status of adolescents (percentages)

Age group	Female			Male		
	In- school	Out of school		In-school	Out of school	
		Married	Unmarried		Married	Unmarried
10 to 14	71	1.8	27.2	81.6	0.8	28.2
15 to 19	41.3	33.9	24.8	56.7	12.9	30.4

Source: Population Census 2001

Ever-repeated and ever-dropped out rates for orphan and non-orphan students attending the survey schools are presented in Tables 6.6 and 6.7. Given the small numbers of orphans in the sample, caution has to be exercised in drawing any firm conclusions from this data. However, it does appear that one-parent orphans repeat and dropout more than students with two parents. While male orphans repeat more than female orphans at both primary and secondary schools, there are no major gender differentials with respect to dropouts at either type of school. What is interesting though is that absenteeism rates for one-parent orphans in secondary schools are much lower than for two-parent students (see Table 6.8). This is also the case for paternal orphans at primary schools and absenteeism rates for maternal orphans are the same as for two-parent students. Research in Africa shows that orphans have very strong incentives to attend school (see Bennell et al, 2002).

Table 6.6: Percentage of orphan and two-parent students who have ever-repeated a class (rounded percentages)

	PRIMARY				SECONDARY			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
Paternal orphan	3	0	4	75	11	45	9	67
Maternal orphan	1	100	2	0	2	50	3	67
All orphans	4	25	6	50	13	46	13	58
Both parents alive	114	28	128	34	164	40	155	41

Overall absenteeism rates for both primary and secondary students are relatively low. The BCHIMES report also concludes that school absenteeism is not a major problem among



*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

children in Nepal. According to this survey, 83 percent attended school during the previous three days with no gender differences. However a study of dalit children in four districts in the Eastern region found that only 42 percent of girls and 55 percent of boys had primary school attendance rates of 75 percent or higher. For dalit children at secondary school, the corresponding rates were 55 percent girls and 50 percent for boys. The main reasons for student dropout are wage and household labour (see UNESCO, 2001).

Table 6.7: Orphan and two-parent students who have ever dropped out of school (rounded percentages)

	PRIMARY				SECONDARY			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
Paternal orphan	4	25	4	25	14	36	10	20
Maternal orphan	1	0	2	50	2	50	3	100
All orphans	5	20	6	17	16	43	13	38
Both parents alive	165	4	133	3	207	4	186	8

Illness accounts for at least half of all absences at the survey primary and secondary schools. At primary schools, housework and personal work are the other main reasons. While there are no significant differences gender differences among primary school students, household work is relatively more important among secondary female students in rural areas, but the reverse is the case in urban areas (see Table 6.9).

Table 6.8: Absenteeism rate among students (percentages)

	Primary	Secondary
Paternal orphan	1	5.2
Maternal orphan	8.4	3.4
Both parents alive	8.4	11.6

Notes: Percentage of total student-days absent during the last two weeks of school.

The MOES classifies 12-13 per cent of primary school students as being 'disadvantaged' compared to only 3-4 percent among secondary school students. This provides a strong indication of the extent to which children from poor families are under-represented in secondary schools.

#### 6.1.4 Discrimination

The main conclusion of a recently completed assessment of HIV/AIDS and orphans in Nepal is that orphans suffer from high levels of discrimination (UNICEF, 2002). The main reason given by the report for this is that orphans are held to be personally responsible for the deaths of their parent(s). Since orphans are not treated like other children, the report contends that orphans are much less likely to attend school. However, no empirical evidence is presented to support this assertion. It is clear though that, without appropriate education and support, AIDS orphans and

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

children in AIDS-affected households will almost certainly face very high levels of stigmatisation and discrimination. In Achham District, for example, it has been reported that a sizeable proportion of children whose parents have died from AIDS-related illnesses are no longer attending school (see Save the Children-UK, 2001).

Table 6.9: Reasons for student absences from school (percentages)

**PRIMARY SCHOOLS**

Reason	Rural			Urban			ALL		
	Female	Male	ALL	Female	Male	ALL	Female	Male	ALL
Illness	51	51	51	47	52	50	50	51	51
Housework	32	31	32	42	43	43	35	35	35
Outstation	2	2	2	5	0	3	3	1	2
Personal work	15	16	15	5	5	5	12	13	12

**SECONDARY SCHOOLS**

Reason	Rural			Urban			ALL		
	Female	Male	ALL	Female	Male	ALL	Female	Male	ALL
Illness	53	48	51	55	60	58	54	57	56
Housework	33	45	38	32	27	29	32	32	32
Outstation	3	6	4	5	4	4	4	4	4
Personal work	13	0	7	7	9	8	9	6	8

Levels of discrimination against people living with AIDS (PLWA) are very high in Nepal. PLWA in Kanchanpur have been forced to live outside and households and communities have refused to cremate those who have died of AIDS-related illnesses. While teachers at the survey schools appear to be much less discriminatory in their attitudes towards PLWA, there is still a sizeable minority who have these kinds of attitudes (see Table 3.2). Whereas very few secondary students agreed with the discrimination statements, almost half of the primary school students felt that PLWA should be isolated and infected students and teachers should be barred from schools (SEE Table 3.1). A survey conducted by the Red Cross Society of Nepal in 2000 also found that only 45 percent of Class 7-12 students who were questioned in six districts showed a positive attitude towards children with HIV/AIDS.

**6.1.5 Support for children directly affected by HIV/AIDS**

The MOES programme 'Support for Vulnerable Children' is supposed to award three bursaries of R.250 each to disadvantaged students attending public schools per annum. According to EMIS, MOES provided 388,00 scholarships for disadvantaged students in 2000, which was 7.8 percent of total enrolments. Around 28 percent of the total registered 'disadvantaged' students did not receive any assistance. No other government support is targeted at poor children as such. In particular, there is very little institutional care for disadvantaged orphans or other needy children in Nepal. There are a total of 88 children homes accommodating around 3250 children.

Governments should assist all PLWA with home-based care when it is needed. However, the HIV/AIDS Situational Analysis for Nepal concluded in 2000 that 'care and support virtually

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

non-existent at implementation level' (p46). Since then some NGOs and UN-agencies have begun to provide care and support for to PLWA. Without adequate support, it is likely that the education of children who are required to look after sick family members could be seriously affected, and some may even dropout of school altogether.

Most schools are not sufficiently child-friendly to be able to support children affected by AIDS or the many other children who are needy. In rural areas, teachers generally know the parental status of their students, but this is less so in urban schools.

## **6.2 TEACHERS**

To date, no teacher at the survey schools appears to have been directly affected by HIV/AIDS, both with regard to individual HIV infection or other household members. Nor is there any other secondary evidence that indicates any teachers are or have been either sick with or have died from AIDS-related illnesses.

No information exists on HIV prevalence among teachers or any other occupational group in Nepal (apart from truckers/transfer workers and female sex workers).

### **6.2.1 Mortality**

Data on teacher turnover and attrition were collected for the first time by EMIS in 2000. This includes teachers who have resigned, retired, been transferred, and 'expired'. A total of 196 government teachers (152 primary, 28 lower secondary, 16 secondary) were reported to have died in that year, 0.2 per cent of the total employed (see Table 6.10) and 11 percent of all teacher attrition in that year. The mortality rate among secondary teachers was nearly 40 percent lower than for primary teachers. The geographical pattern of teacher mortality does not match the known geographical distribution of HIV infection in Nepal, which again suggest that teachers have not been directly affected. Data on mortality by gender and cause of death is not collected.

Table 6.10: Mortality rates for teachers in 2000 (deaths/'000)

Region and Zone	Primary	Lower	
		Secondary	Secondary
<b>Eastern</b>			
Mountains	1.9	0	0
Hills	1.6	1.3	2
Terrai	2.2	1.5	0.7
<b>Central</b>			
Mountains	1.2	2.6	3.1
Hills	2.9	0.8	1
Terrai	3	4.8	1.5
Valley	1.8	2.6	1.2
<b>Western</b>			
Mountains	2.5	0	0
Hills	1	0.9	1.1
Terrai	2.4	0	3
<b>Mid-Western</b>			
Mountains	3.3	0	0
Hills	2.5	1	0
Terrai	2.1	3.1	0
<b>Far Western</b>			
Mountains	0.5	0	0
Hills	1	3	0
Terrai	2.2	2.3	0.7

Source: EMIS

There was no mortality or turnover among teachers at the 11 public primary schools surveyed. Among the 10 public secondary schools, the teacher mortality rate was 1.3 percent (3 deaths), the attrition rate (deaths, sickness, retirements, resignations) was 2.6 percent, and the turnover rate (attrition plus transfers and in-service qualification upgrading) was 5.2 percent. Information on the teacher deaths was not obtained, but they were not AIDS-related.

It is not possible to compare teacher mortality with the mortality rates for the population in general and other major occupational groups. Census mortality data for 2001 has not yet been fully analysed and is unreliable since deaths are under-reported by at least 40 percent.

### 6.2.2 Teacher absenteeism

Any significant increase in HIV infection among teachers will, in the absence of life-prolonging anti-retroviral drugs, eventually result in corresponding increases in teacher morbidity and absenteeism. The productivity of teachers (especially women teachers) who have to look after affected family members could also be adversely affected. It is important therefore to monitor carefully teacher absenteeism over the coming years. Teacher absenteeism is much lower in primary than in secondary schools (see Tables 6.11).

Table 6.11: Teacher ever-absent and absenteeism rates (percentages)

	EVER-ABSENT		ABSENTEEISM RATE	
	Female	Male	Fem ale	Male
Primary	16.7	10	1.4	1.5
Secondary	31.6	21.8	4.5	4.2

Source: School survey

### **6.2.3 Prevention and support**

There is no 'AIDS in the workplace' programme for teachers in Nepal. Consequently, no HIV/AIDS activities have been organised for teachers or any other MOES staff as part of a comprehensive, ministry-wide programme..

## **6.3 FUTURE IMPACT**

### **6.3.1 Teachers**

It is very difficult to project with any degree of accuracy HIV prevalence and AIDS-related mortality rates. UNAIDS and NCASC have recently published a study, which has three possible HIV infection 'scenarios' for the period up to 2005: low stable with 55-60000 people with HIV up to 2005, low moderate growth with almost 120,000 people infected by 2005 and moderate growth with about 180,000 cases by 2005.

The only accurate way of making robust projections of the epidemic on teaching staff is to test a random sample of teachers in order to establish what HIV prevalence actually is in this particular occupational group (see recommendations). Without this information, big assumptions have to be made about current and likely future prevalence in order to generate projections of likely impact. If the overall adult prevalence rate increases to 1.0-1.6 percent by 2005 (in accordance with the low and moderate scenarios), and it is assumed that teachers have the same HIV prevalence rate as the population as a whole (which is quite probably not the case) then around 1,100 to 1,800 of the currently employed teachers could become infected. Without medical intervention and, in particular, the provision of anti-retroviral drugs, the median time between infection and death is likely to be around 7-8 years in which case AIDS deaths among teachers will average between 200-250 per annum up until 2010.

### **6.3.2 Orphans**

The 2002 Children on the Brink report estimates that there will be 45,000 AIDS orphans in Nepal in 2010. Population projections based on the 2001 Population Census have not yet been made but, assuming no increase in the 0-15 age group, this would mean that AIDS orphans will account for approximately 0.5 percent of this population in 2010. There will be around 3000 two-parent AIDS orphans (0.03 percent of under-15 year olds). However, the total numbers of one and two-parent orphan populations are projected to fall to 833,000 and 29,000 respectively by 2010 (see Table 6.1).

## **7. ENSURING A COMPREHENSIVE STRATEGIC RESPONSE**

To date, HIV/AIDS has had virtually no perceptible impact on schooling in Nepal. However, the limited evidence that is available does suggest that HIV infection is increasing quite rapidly. It is essential, therefore, that decisive action is taken to ensure that both students and teaching staff do not become infected in the future. Experience from Africa and elsewhere shows just how quickly HIV/AIDS can become a major epidemic that, once it has taken hold, is extremely difficult to contain. The real opportunity for the education community in Nepal is that, if appropriate steps are taken now, this potential disaster can be avoided. MOES has a central role to play in the implementation of the National HIV/AIDS strategy, both as the body responsible for the education of over five million young people and far the largest employer in the country.

This final chapter outlines a set of number of recommendations, which collectively add up to a comprehensive but realistic HIV/AIDS strategy for the education sector. If properly implemented, these measures will ensure that the very serious threat posed by HIV/AIDS is effectively contained.

### **7.1 HIV PREVENTION AMONG STUDENTS**

As noted earlier, the National HIV/AIDS Strategy emphasises the key role of school and other education institutions in the prevention of HIV infection among young people. The recent NCASC submission to the Global Program for AIDS also highlights the need for effective HIV/AIDS education in both primary and secondary schools.

It is widely accepted that schools should teach children about HIV/AIDS and provide the knowledge and skills needed to avoid high-risk behaviour. However, it is also the case that there are very few successful school-based AIDS education programmes, especially in low-income developing countries. This is mainly because schools are already heavily overburdened, have chronic shortages of resources, and teachers are frequently poorly trained and motivated. Not surprisingly therefore principals and teachers are often reluctant to take on the additional responsibilities, in an area, which many feel, should be left to parents and other individuals in the community. To be effective, therefore, HIV/AIDS and SRH education must be very carefully designed and properly resourced.

#### **7.1.1 Primary education**

There is a strong case for the introduction of family life and sexual reproductive health education in Classes 4 and 5 of the primary education cycle. Key topics should include parent-child relations, child-child relations, sexual reproduction, body organs, puberty/ physical development, menstruation, causes and consequences of HIV/AIDS, and simple life skills. Clearly, these topics have to be dealt with in an appropriate way, but children in these classes should be provided with this information.

It is recommended that, as part of the health or social studies curriculum, one period per week is devoted to sexual and reproductive health education in both Classes 4 and 5. One teacher in

each of the 21,000 public primary schools should receive short, intensive in-service training at Teacher Resource Centres. The MOES will probably need assistance for the training of trainers.

### **7.1.2 Secondary education**

It is essential that at least one trained health, population and environment education teacher is in-post at every secondary school in the country. Both lower secondary and secondary school students should also benefit from good quality life skills education and all key adolescent sexual reproductive health topics should be treated in a lot more depth. It is recommended therefore that a comprehensive review of health education is undertaken as soon as possible. Considerably more emphasis should be given to SRH education in the lower secondary classes and high quality, youth-friendly learning materials should be available in all schools. There may also be a need for separate SRH classes for female students, which are taught by properly trained female teachers. Finally, it is recommended that a comprehensive needs assessment of school-based peer education is undertaken.

Both the up-coming Teacher Education and the Second Secondary Education Sector Projects have ambitious objectives for improving the competence of primary and secondary school teachers in Nepal over the next five years. It is important therefore that the staff development needs of health and population educators are fully incorporated into both projects.

### **7.1.3 Tertiary education**

Given the paucity of information on the sexual and other high risk behaviour of students attending post-secondary education and training institutions, it is recommended that a comprehensive KAB study is undertaken of these students.

## **7.2 AIDS IN THE WORKPLACE**

Even though HIV prevalence levels are still very low, it is essential that MOES has a comprehensive AIDS in the Workplace programme. At this stage of the epidemic, the main priorities are to monitor carefully the HIV situation among staff and to ensure that everything is done to prevent HIV infection among teaching staff. This programme should be based on the best practices that have been developed elsewhere and recommended by the International Labour Organisation.

### **7.2.1 Risk assessment**

There are almost 150,000 schoolteachers in Nepal and probably another 20-25,000 teaching staff at other, post-secondary training and education institutions. It is very important therefore that the MOES, as the major employer, has accurate and sufficiently detailed information on the incidence and pattern of HIV infection among staff. This is not only essential for planning purposes, but also in order to design effective HIV prevention programmes. It is recommended therefore that a representative sample of teachers is tested for HIV. There are now well established procedures for this. Testing would be done on a purely voluntary and anonymous

basis. Teachers at selected schools would merely be asked to provide a saliva specimen and the only information that would be collected is their age group, gender, type of school, and district. Testing is completely blind, which means that, under no circumstances, will the results of individual tests be disclosed to the teacher or anyone else. The overall findings of the survey should be made public and principals should discuss these findings with their staff. Testing should be done by a specialist organisation with proven expertise in this area. Contracting an overseas firm to do the testing will be costly, but this information is essential.

It is also recommended that additional information on teacher deaths is included in the EMIS school questionnaire, in particular a gender breakdown and reasons for mortality.

### **7.2.2 HIV prevention**

Most teachers have only a rather superficial understanding of the causes and consequences of HIV/AIDS. It is important that this knowledge is deepened and teachers are made fully aware of the dangers of high-risk activity. It is recommended therefore that a high-quality Teacher Handbook on HIV/AIDS and related SRH issues is prepared and distributed to every teacher in both public and private schools as well as other education and training institutions. Similar handbooks have been produced in other countries (most recently South Africa). The distribution of the Handbook should also be accompanied by in-service training. A reasonable target is that at least one teacher from every school should attend a one-day workshop over the next three years.

Teachers should also be encouraged to go for voluntary testing and counseling if they are concerned about their HIV status.

### **7.2.3 Sexual misconduct**

The school survey raises serious concerns about sexual misconduct of male teachers in secondary schools. While only a small minority of teachers engages in such behaviour, the MOES should take urgent action to deal with it. It is recommended therefore that the current code of conduct for teaching staff is reviewed and revised in order to ensure that effective rules, regulations and disciplinary procedures are established, especially with respect to all forms of sexual misconduct.

## **7.3 SUPPORT FOR STUDENTS**

Very few children have been directly affected by HIV/AIDS. It is important though that schools do all they can to support these children. Three areas are particularly important. First, it is recommended that MOES issues a clear policy statement with regard to discrimination against both students and teachers who are directly affected by HIV/AIDS. Secondly, schools should, where necessary, provide additional support for children who have been orphaned as a result of AIDS. It is important though that AIDS orphans are not targeted as a separate group, but receive the same assistance as any other disadvantaged or needy student. Serious consideration should also be given to the establishment of a formal system of guidance and counseling and principals should be encouraged to identify and monitor the performance of all



children who are in especially difficult circumstances. Prompt referral to the appropriate agencies is also important.

And third, additional information on students should be collected. In particular, the EMIS school questionnaire should request information on the parental status and living arrangements of students. Robust surveys of school dropouts should also be undertaken on a regular basis.

#### **7.4 AN HIV/AIDS MANAGEMENT PROGRAMME**

These recommended actions should form the basis of a comprehensive action plan. Appropriate organisational and management structures are required in order to ensure that this plan is effectively implemented. It is recommended therefore that a high-powered HIV/AIDS Technical Committee is established in MOES, which has overall responsibility for HIV/AIDS management programme throughout the education sector. The Secretary MOES should chair the Committee and its members should be drawn from senior management in all the key divisions in the Ministry (in particular Teaching Service Commission, planning, curriculum development, and teacher training). Representatives from the university, private schools, NGOs involved in peer education and other HIV prevention and support activities, and other key ministries and public agencies (in particular NCASC) should also be invited to sit on this committee.

The experience from other countries clearly shows that part-time HIV/AIDS Focal Point Coordinators usually lack the authority, time and resources to be able to implement HIV/AIDS action plans and other interventions in the education sector. It is essential therefore that a full-time HIV/AIDS Coordinator is appointed. She should report directly to the Secretary and the HIV/AIDS Technical Committee.

The success of the National HIV/AIDS Strategy depends critically on a coordinated multi-sectoral approach to both HIV/AIDS prevention and mitigation. It is essential therefore that all HIV/AIDS activities in the MOES are carefully coordinated with the activities of other key organisations at both the national, district and village level. In particular, MOES staff should actively participate in District AIDS Control Committees where these have been established.

Much will depend on the commitment of District Education Officers. As a first step, it is very important that they are briefed about the main findings and recommendations of this impact assessment. It is recommended therefore that a two-day workshop for all DEOs is organised in early 2003.

Table 7.1 summarises the Action Plan and budget for the key activities. These are further elaborated in Appendix 6.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Table 7.1: The Action plan and budget for the AIDS Management Programme for the Education Sector

Component	Activity	Target Group	Unit	Target	Unit Cost (Rs.)	Total cost (Rs.)	Duration	Provider
1. Teacher Hand book / Resource Book (color-average type)	1.1- Existing Materials Review / Messages or text design	Consultants	person	45 days	1000.00	45000.00	15 days	MOES/DOE
	1.2. - Layout design	Computer designer	person	1 week	4000.00	24000.00	1 week	MOES/DOE
	1.3-Printing	Press	pc	30000	200.00	6000000.0		MOES/DOE
<b>Sub-total</b>						<b>6090000.00</b>		
2. Teacher Orientation on HIV/AIDS	2.1 Production of Teacher Training Module/Curriculum	Consultants	person	3 person	1000.00	18000.00	1 week	CDC/DOE
	2.2 Resource persons for TOT	Resource Persons	person	300 person	2,000	600000.00	2 days	MOES/DOE
	2.2 Training of trainers	Trainees	person	750 person	4000.00	3000000.00	2 days	MOES/Coordinator
	2.3 Teacher Training	Teachers	person	26000	500.00	13000000.00	2 days	DEOs/MOES
<b>Sub-total</b>						<b>16618000.00</b>		
3. DEO's Orientation	3.DEO's orientation	DEOs	person	75	7550.00	566250.00	2 days	MOES/Coordinator
<b>Sub-total</b>						<b>566250.00</b>		
4.VCT	4.1 VCT test	Teachers	person	50000	1000.00	5000000.00	-	MOES/Coordinator
	4.2 Analysis and Reporting	Consultants	person	-	-	300000.00		
<b>Sub-total</b>						<b>5300000.00</b>		

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

## 7.5 DISSEMINATION WORKSHOP

The first draft of this report was discussed by the key stakeholders at a one-day workshop held at Dhulikhel on 8 January, 2003. Around 200 participants attended from the MOES, other key Ministries, NGOs and donors as well as school managers, teachers and students from local students. Working groups reviewed all aspects of the reports. Their recommendations are presented at Annex 7. There was broad agreement among the workshop participants concerning the recommendations and Action Plan proposed in this report.

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**ANNEX 1**

**PEOPLE INTERVIEWED**

Dr. Laxmi Bilas Acharya  
Program Officer-Research  
HIV/AIDS Prevention and Control Program  
*Family Health International*

Mr. Madhav P. Adhikary  
President, Nepal National Teacher's Association  
Kumaripati, Lalitpur

Mr. Laxmi Raman Ban,  
Director, National Health Education and Information Coordination Centre  
Ministry of Health

Mr. Keshav Bhattarai,  
President, Nepal Teacher's Association  
Dhumbarahi

Ms Divyakala Bajimaya  
Under Secretary  
Sports Section  
Ministry of Education and Sports

Mr. K.P. Bista  
National Coordinator, Health Sector Development Programme  
Ministry of Health

Ms. E. Cai Cai  
Consultant  
Life Skills Education Project  
UNICEF

Ms Tara Chhetri  
HIV/AIDS Program Officer  
Save the Children, US

Mr. Pralhad Dhakal  
Advocacy Programme Officer  
Save the Children, UK

Dr. Michael Hahn  
UNAIDS Country Programme Advisor

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Dr. B.B. Karki  
Chief Planning Division  
Ministry of Health

Mr. Tekendra Karki  
Deputy Director, Primary Education Division  
Department of Education

Mr. Vishnu Karki  
Statistics Division,  
Ministry of Education and Sports

Mr. Badri Khanal  
Executive Director  
Nepal Red Cross Society

Ms. Laxmi Khatri  
National Center for Educational Development (NCED)  
Department of Education

Professor, Dr. Nahendra Bahadur Maharjan  
Dean  
Faculty of Education  
Tribuvan University

Dr. Shyam S. Mishra  
Acting Director  
National Center for AIDS and STD Control (NCASC)  
Ministry of Health  
Teku

Mr. Bill Musoke  
UNFPA Representative to Nepal

Mr. B.B. Pant  
Program Officer  
Family Health International

Mr. Gajendra Lal Pradhan  
Deputy Director  
Secondary Education Development Center  
Department of Education

Dr. B.K. Ranjit  
Chief Population Education Unit/Population Education Project

**An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal**

Department of Education  
Mr. Deepak Sapkota  
Executive Director  
Central Child Welfare Board  
Ministry of Women, Children and Social Welfare

Mr. Shiv Prasad Satyal  
Director General  
Curriculum Development Center  
Department of Education

Ms. Bunu Shrestha.  
Population Education Project  
Ministry of Education and Sports

Mr. Harka Prasad Shrestha  
Deputy Director  
Curriculum Development Center  
Department of Education

Mr. Rajaram Shrestha  
Deputy Director  
Secondary Education Development Center  
Department of Education

Ms. Ismene Stalpers  
Associate Expert on Social Protection  
ILO.

Mr. Laba Prasad Tripathi  
Joint-Secretary  
Ministry of Education and Sports

Dr. S.R. Upreti  
National Health Training Centre  
Ministry of Health

Dr. Klaus Wagner  
WHO Representative to Nepal



*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

**People interviewed in Kathmandu, Lalitpur, Bhaktapur, Bankey and Ilam districts.**

Mr. R. N. Acharya  
Secretary, Nepal Red Cross Society  
Ilam district

Mr. Janardan Adhikari  
Chief District Officer  
Ilam district

Mr. Dipesh B.C  
Coordinator  
SEEAP Nepal  
Bankey district

Ms Bishnu Dahal  
Social Worker  
Ilam district

Dr. Peaus Dhakal  
Medical Officer  
Ilam Hospital

Mr. Hom Dhakal  
Coordinator  
Maiti Nepal  
Ilam district

Mr. A. Gautam  
Local pharmacist.  
Bankey district.

Mr. Dharma P. Gautam  
Journalist  
Ilam district

Mr. Bala Ram K.C  
District Education Officer  
Kathmandu

Mr. B.R. Khatiwada  
Health Coordinator  
Namsaling Community Development Center  
Ilam district

**An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal**

Mr. Kedar Koirala  
Project Manager  
Family Planning Association of Nepal, Ilam

Mr. Shobha Chandra Mishra  
District Education Officer  
Ilam district

Ms. Indira Ojha  
Women Development Officer  
Ilam district

Mr. Cholendra Kumar Pandit  
District Education Officer  
Bankey district

Mr. Om Pratap Rana  
Social Worker  
Bankey district

Mr. Amrit Rai  
Assistant Health Worker  
Ilam district

Ms. Usha Rawal  
Women Development Officer  
Bankey district

Ms. Srijana Shah  
Branch Manager  
Family Planning Association of Nepal  
Bankey district

Dr. G. Raj Shakya  
STD Specialist  
Bheri Zonal Hospital  
Bankey district

Mr. Gopaljee Shrestha  
Local Development Officer  
Ilam district

Ms. Leela Shrestha  
Social Worker  
Ilam district

**An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal**

Ms. Sharada Shrestha  
Master Trainer  
Science Education Development Unit  
Ilam district

Mr. BaliRam Prasad Singh  
District Education Officer  
Lalitpur

Ms. Maya Sitaula  
District Education Officer  
Bhaktapur

Mr. Tej Jung Thapa  
District Superintendent of Police  
Ilam district

Mr. Yuddha P. Vaidya  
Intellectual  
Ilam district

Mr. Nir Wagle  
Coordinator  
General Welfare Pratisthan  
Bankey district

**ANNEX 2**

**SURVEY INSTRUMENT**

**SCHOOL STATISTICS**

Name of school.....

1. Total current enrolments for each grade

Grade	Female	Male
1	.....	.....
2	.....	.....
3	.....	.....
4	.....	.....
5	.....	.....
6	.....	.....
7	.....	.....
8	.....	.....
9	.....	.....
10	.....	.....
TOTAL	.....	.....

2. Total number of students who are currently repeating a grade? Female..... Male.....

3. Total numbers of students who have dropped out since the start of this school year i.e. May 2002? Exclude students who have transferred to other schools.

Female ..... Male .....

4. Number of teachers at the school

Total number of approved posts: .....

Currently in-post

	Trained female	Trained male	Untrained female	Untrained male
Full-time	.....	.....	.....	.....
Part-time	.....	.....	.....	.....

Number of approved HPE posts: .....Actual number in-post:.....

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

5. How many teachers who were teaching at this school at the end of the last school year (i.e. in May 2002) are no longer at the school? Female.....Male.....

Transferred to another government school .....

Resigned to take up job in the private sector .....

Retired.....

Went for further studies .....

Long-term sickness.....

Died.....

Other reasons.....(specify)

6. What fees or other levies do students pay at this school?

Maximum R.....Minimum R.....perschool year

Does this school currently receive any financial or other kind of support from any outside organisations (eg. NGOs, Rotary)? Yes/No. If yes, from whom and how much?

Organisation(s).....

R.....

## Secondary Student Questionnaire

This is not a test. Your honest and important answers will help HMG to prepare educational policy as well as develop favorable knowledge and attitude among students. Please do not write your name. Your answers will be kept confidential.

Class:

Age: (Completed years)

Sex: Male

Female

Ethnicity:

Religion:

Marital Status:

Married

Unmarried

Mother's Educational Status:

Mother's Occupation:

Father's Educational status:

Father's Occupation:

1. Are your parents alive?

Yes No

If no: Only mother Only father Both

2. Who do you live with during your term leave?

Parents Mother's home Father's home Relatives Others.....

3. Have you ever repeated a class?

Yes No

If yes how many times?.....times

4. Were you absent in the school for the last two weeks?

Yes No If yes how many days were you absent?

5. Please give reason for each absence:

Reason of absence for the first time:

Reason of absence for the second time:

Reason of absence for the third time:

6. Have many times have you ever dropped out?(For more than one months)

Times..... Not Dropped out

7. If you had dropped out, what are the reasons?

i.

ii.

iii.

8. Please give main three sources of information about HIV/AIDS for you.

An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

Please read the statements given below and put the tick mark ( ) in the box you think is the right answer :-

S.N.	Statements	Yes	No
1.	Having sex with only one sexual partner is the way of protecting from HIV/AIDS.		
2.	HIV/AIDS can be transmitted from blood transmission.		
3.	You can know a person suffering from HIV/AIDS by looking also.		
4.	HIV/AIDS can be transmitted by the following ways:		
	a. By sharing cloths with HIV/AIDS infected persons.		
	b. Eating together with HIV/AIDS infected persons.		
	c. Sleeping at the same room with HIV/AIDS infected persons.		
	d. Sharing toilets with HIV/AIDS infected persons.		
	e. Sharing toothbrush with HIV/AIDS infected persons.		
	f. Sharing soap with HIV/AIDS infected persons.		
	g. Sharing blades with HIV/AIDS infected persons.		
	h. From mosquito bites.		
	i. Taking care of HIV/AIDS infected persons.		
	j. Sharing needles with HIV/AIDS infected persons for tattoo.		
6.	HIV/AIDS virus also can be transmitted by HIV/AIDS infected mother through;		
	a. Mother to the unborn baby or after baby.		
	d. Breast feeding.		
7.	Sharing unsterilized syringe with HIV/AIDS infected persons is also the cause of transmission of HIV/AIDS.		
8.	Using a condom helps prevent HIV/AIDS.		
9.	There is no cure of HIV/AIDS.		
10.	Only immoral people get the HIV/AIDS virus.		
11.	Some traditional healers can cure HIV/AIDS		

### Primary Student Questionnaire

This is not a test. Your honest and important answers will help HMG to prepare educational policy as well as develop favorable knowledge and attitude among students. Please do not write your name. Your answers will be kept confidential.

Class:

Age: (Completed years)

Sex: Male

Female

Ethnicity:

Religion:

Marital Status:

Married

Unmarried

Mother's Educational Status:

Mother's Occupation:

Father's Educational status:

Father's Occupation:

9. Are your parents alive?

Yes No

If no: Only mother Only father Both

10. Who do you live with during your term leave?

Parents Mother's Father's home Relatives Others.....

11. Have you ever repeated a class?

Yes No

If yes how many times?.....times

12. Were you absent in the school for the last two weeks?

Yes No If yes how many days were you absent?

13. Please give reason for each absence:

Reason of absence for the first time:

Reason of absence for the second time:

Reason of absence for the third time:

14. Have many times have you ever dropped out?(For more than one months)

Times..... Not Dropped out

15. If you had dropped out, what are the reasons?

i.

ii.

iii.

16. Please give main three sources of information about HIV/AIDS for you.

Part 2: Knowledge test same as secondary students



An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

Please read the statements given below and put the tick mark ( ) in the box you think is the right answer :-

S.N.	Statements	Disagree	Don't Know	Agree
1.	Students of this school have full knowledge of HIV/AIDS.			
2.	Persons with HIV/AIDS should be kept separately (especially in hospital).			
3.	HIV/AIDS infected students should not be allowed to come to school.			
4.	HIV/AIDS infected teachers should not be allowed to come to school.			
5.	Extra curricular activities on SRH are frequently conducted in the school.			
6.	Students in this school can put their SRH problems openly to the teachers.			
7.	There are some possibilities of students being infected by HIV/AIDS in this school.			
8.	Some students of this school use drugs.			

At the end, please would you suggest/comment anything about SRH and HIV/AIDS?

An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

Please read the statements given below and put the tick mark ( ) in the box you think is the right answer :-

S.N.	Statements	Disagree	Don't Know	Agree
1.	Students of this school have full knowledge of HIV/AIDS.			
2.	Persons with HIV/AIDS should be kept separately (especially in hospital).			
3.	HIV/AIDS infected students should not be allowed to come to school.			
4.	HIV/AIDS infected teachers should not be allowed to come to school.			
5.	Extra curricular activities on SRH are frequently conducted in the school.			
6.	Students in this school can put their SRH problems openly to the teachers.			
7.	There are some possibilities of students being infected by HIV/AIDS in this school.			
8.	Some students of this school use drugs.			

At the end, please would you suggest/comment anything about SRH and HIV/AIDS?

### Teacher Questionnaire

The factual, real and significant answers you give will enable us to prepare more effective educational policy and strategy, in future. You should not write your name. The answers you give will be kept quite confidential

Age (year):- Gender:- Female .....Male.....  
Nationality:- Religion:- .....  
Educational qualification:- .....Trained.....Untrained

Marital Status:- Married Unmarried divorcee Widow/widower  
Standard taught:- married Unmarried  
Secondary ( ) Lower Secondary ( ) Primary ( )  
Present domestic system:-.....  
Single Husband/Wife together Other (please mention).....  
Subject taught:-  
Teaching experience years,.....  
Teaching experience years in this school.....  
In which class do you teach?

1. Have you ever gone through any in service training on the subject of sex and reproductive health? If any please mention:-

Serial No	Type of training	Training institute	Duration	Year of Training

2. Mention there media form among the media of information you get about HIV/AIDS:-

1  
2  
3

3. Were you absent at your school with the last one month.

Yes.....No.....

If absent, for how many days?

4. If you were absent mention the reason for your absence each time:-

1  
2  
3

5. How do you pass your time on holiday? Please mention

What is your opinion about he statements given below?

An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

Parts 2 and 3 (knowledge test and statements) same as secondary student questionnaire

An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

**Principal Interview**

**Personal details**

Age..... Sex..... m/f ..... married/unmarried.....  
Living arrangement.....  
Years at the school.....

**Knowledge and impact of HIV/AIDS**

What do you know about HIV/AIDS?  
How do you look at the problem of HIV/AIDS, in general?  
Do you know of the problems of HIV/AIDS in your area/district ?  
Has it affected other schools and student?  
Has your school been affected ?  
What is your view about the future, could it be a problem in your school ?  
Are you aware of any government activities or plans regarding HIV/AIDS?  
What do you think about people with HIV/AIDS?

**Student prevention**

Who in your school is responsible for teaching about health and HIV/AIDS in your school ?  
(health teacher, others, health personnel, social worker)  
What are the topics?  
Does it cover all the necessary information?  
Are teachers committed?  
What materials are used?  
What materials are lacking?  
What could be done to improve the availability of materials?  
Has the teacher been trained or prepared to give sex education?  
Is the teacher willing to give the lessons?  
Does he actually give the lessons?..... If not, why?  
What do you think about the health/sex education curriculum?.  
Would you be interested to improve the health education programs in your school such as:  
Support to teachers, other  
What additional (outside the department of education) support have you received so far in the  
field of health/AIDS and from whom: teacher training, funds, materials, other

**Student behaviour**

What are your concerns regarding the behaviour of students in your school in general? Ask to  
indicate the most urgent problems. If he/she mentions sexual behaviour we continue the  
discussion. If not, we have to probe.  
Are some of your students in the school engaged in love relations or in sexual relations?  
Can you guess how many ( a majority, only a few, or more and more)?  
At what age boys are getting sexually active (explain) in this area/in this village?  
At what age girls are getting sexually active?

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Cover the following points in the discussion:

pregnancy  
visits to sex workers  
abortion  
use of condoms  
knowledge about condoms  
access to condoms  
teasing of girls  
do you know of students with SRD problems  
are parents concerned about these things  
drugs and IUD  
(do you think this is a problem for students; an issue in the community)  
can you see trends (changes) in behaviour comparing to the past

**Teacher behaviour**

How many of the teachers are married.....unmarried.....

living with their families.....living separately.....

Do you have any worries regarding the sexual behaviour of the teachers ?

Cover the following topics:

recreational activities  
visits to sex workers  
knowledge about condoms  
use of condoms  
harassment to female teachers/girls  
relation with girl students  
drinking  
drug  
STD

have teachers ever been expelled from school, reasons...

Do you see any changes in their sexual behaviour (trends)?

What can be done to change risky sexual behaviour of the teachers

**Student impact**

Do you know of parents of children who are sick for a long period (estimate) or have died (estimate)?

How many children are absent from school (period, last month ) or have not been successfully completing school?

Is the school helping needy (poor, orphan etc) students ?

What type of assistance is given?

Are other organizations giving help to needy students of your school (social workers, NGO/s, health people etc, VDC)

What type of services are given? (materials, counseling, emotional support, health)

How would you react if one of your students has HIV/AIDS ?

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

**Teachers posts**

How many teachers posts have been approved for this school?

How many have been actually filled up?

Are there any vacant posts among those teachers who are involved in the sex education/life skills curriculum?

**School management committee**

Is there a management committee in your school....

What activities have been set up last year.....

In what way could we support the management committee to improve the health/sex education in your school?

**Communication with the Ministry of Education**

I am very satisfied with the information I received so far, both timely and accurate

I am somewhat satisfied with the information wick I received

I am neither satisfied nor dissatisfied

I am somewhat dissatisfied

## **STUDENT FOCUS GROUP**

Separate female and male groups. Class 5 in primary, Class 7-8 in lower secondary, and Class 9-10 in secondary. Randomly selected. Maximum of eight per group. Target time around 90 minutes.

### **Step 1: Getting started**

5-10 minutes.

Introduce yourselves. Explain purpose of visit and why you want to get their honest and frank views. Stress confidentiality (teachers will not be told anything!). No names, not a test etc. Put them at their ease. We are not from the Ministry of Education. Encourage them to ask questions about the group discussion. Get them to write their first names on sticky labels. Do not bother to record their names- just the classes and ages. Tell them that you will be give a pen/sweet to all students who fully participate.

### **Step 2. Likes and dislikes**

15 minutes.

As them to write on separate cards, the three things they like most about school and the three things they most dislike. Allow 10 minutes for group discussion and 5 minutes to discuss their cards.

### **Step 3: Student behaviour and prevention**

Approximately 50 minutes.

Ask the group to discuss on their own what they know about HIV/AIDS. Get them to write on cards with felt-tip pens the different ways in which people can become infected with HIV. After 15 minutes review what they have written and give them the cards with behaviours that they have not mentioned: Checklist- romantic and full sexual relationships, sex workers/visiting cab restaurants and tea shops, drugs/IDUs, drinking, condom use, relationships between students and older men (including teachers). Give them another 5-10 minutes to discuss these.

Go through all the cards with them. For each one, ask to what extent do students (both primary and secondary) at schools in their locality engage in this particular behaviour?

For primary students, ask them if they have any SRH education at school. We know they don't, but we want to know if they would like some SRH education while at primary school.

For secondary school students, discuss with them what they like and what they dislike about SRH/family life education at their school. See what they say and then quickly go through anything that has not been mentioned. The key areas are:

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

- curriculum content. Topics that are covered, depth of coverage, time).
- curriculum delivery/pedagogy. Teacher commitment/interest and competence.
- learning materials (textbooks, posters, etc)

What AIDS education and other SRH activities have they participated in at school? Eg visits by NGOs, extra-curricula activities (clubs), essay competitions, etc.

Finally, discuss with them what schools and other organisations (NGOs, clinics, etc) should do in order to prevent students from becoming infected with HIV.

**Step 4: Teacher behaviour**

Mainly for secondary students. Approx 10 minutes.

Ask the group if teachers in their area are behaving in ways that might expose them to HIV infection. Show them all checklist cards of high-risk behaviours that are not mentioned. Discuss these with them.

**Step 5: Sexuality activity questions**

Ask them if they would answer three questions in complete privacy and confidentiality about their sexual activity. Make sure they are sitting well apart from each other. Hand out one-page questionnaire.

**Step 6: Wrap-up**

Is there anything else you want to tell us before we finish? (There often is!). Discuss. Thank students and distribute pens/sweets.

## **TEACHER FOCUS GROUP**

Separate female and male groups in each school (5 per group). For secondary schools, make sure that no HPE teachers are in the group. Target time 75 minutes.

### **Step 1 Introduction**

Explain purpose of survey. Stress the potential seriousness of the threat posed by HIV/AIDS and government commitment to take effective action now. Stress confidentiality. Ask if they have questions.

### **Step 2. Student behaviour.**

20-25 minutes

Ask group to discuss on their own (for 10 minutes) their main concerns (if any) about the sexual behaviour of female and male students at schools in their locality. Write each of these on a separate card. Discuss these with them. Refer to checklist for any behaviours that have not been mentioned: level of sexual activity (romantic relationships/kissing and full intercourse), sex workers, drugs/IDUs, drinking, condom use, relationships between students and older men. (10-15 minutes).

For the secondary school group, what are their estimates of the percentages of male and female students who are 'sexually active'(i.e full sexual intercourse)?

### **Step 3. Student prevention**

15 minutes

How adequate/effective is sexual and reproductive health education (including topics on HIV/AIDS) at their school? Primary school teachers will say that nothing is taught. But ask them if SRH should be included in the primary school curriculum. If so, what and when?

For secondary group, briefly discuss:

- student attitudes
- content (topic coverage, depth, time)
- teacher attitudes/commitment and competence
- learning materials
- role of head teacher

Are there any other SRH-related activities in the schools? (clubs, peer educators, involvement of NGOs, etc).

What role should schools play in SRH education?

What could be done to improve the teaching of SRH education in schools?



## **HPE TEACHER INTERVIEW**

Usual introduction. Target time 45-60 minutes

1. Without mentioning names, do you know anyone or any family who have been directly affected by HIV/AIDS in this area? How many FSWs and IDUs are in this area?
2. How adequate is student knowledge about HIV/AIDS and, more generally, sexual reproductive health?
3. Are there students at schools in this locality who are likely to be a risk of becoming infected with HIV? (Checklist of risk behaviours: sexually active, not using condoms, multiple partners, sex workers, drinking, drugs, IDUs)
4. Do you provide any counselling or other support with regard to SRH education at this school?
5. How adequate is SRH education in this school. Focus on the health education curriculum of the subject HPE? Open-ended question. Key areas to be discussed:
  - What is taught. Is content adequate, well-written and clear, interesting for the students?
  - Learning materials. Textbooks, teacher handbooks, teaching aids (posters, audio-visual, etc)
  - What are student attitudes to SRH education? Would they like less/same/more?
  - Do HPE teachers in this area have the necessary knowledge and skills to be effective health education teachers? What in-service training have you received?
  - What are headteacher and teacher attitudes to SRH education?
  - What are parent attitudes to schools teaching SRH education?
  - What SRH education and other SRH services are provided to young people by other organisations in this area? How adequate?
6. What should be done to improve SRH education at schools? Go through the above bulleted topics. What is the appropriate role of schools in teaching SRH education? What could be done to get parents more involved?
7. Are some teachers in this area at risk of becoming infected with HIV?
8. Any other issues that we have not discussed?

**DEO INTERVIEW**

**COMPLETION FORM  
DISTRICT EDUCATION OFFICER**

1. Not interested in names but, how (if at all) has HIV/AIDS directly affected students in this district?

.....  
.....  
.....  
.....

teachers in this district.....

.....  
.....  
.....  
.....

2. To what extent are students engaging in behaviours that might put them at risk of becoming infected with HIV?

open-ended response.....

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

then ask about specific behaviours

Sexual activity (romantic relationships and full intercourse):.....

.....  
.....  
.....

Multiple relationships.....

.....  
.....  
.....

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Unprotected sex - use of condoms

.....  
.....  
.....  
.....

Drinking: .....

.....  
.....  
.....  
.....

Drugs/IDUs.....

.....  
.....  
.....  
.....

Sex workers.....

.....  
.....  
.....  
.....

3. How effective is SRH/life skills education in secondary schools?

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

Specific issues

Teacher availability.....

.....  
.....  
.....  
.....

### ANNEX 3

#### **Health Education Curriculum: Analysis of SRH topics covered in the lower secondary and secondary school curriculum**

##### **Lower secondary schools**

The review and analysis of the contents on sexual and reproductive health (SRH) and HIV/AIDS incorporated into the school level curriculum revealed that SRH topics are included in classes 6-8. The three subjects reviewed in the class six and seven are Health and Physical Education, Population and Environment Education, and Social Studies. Contents on introduction to H/A, its transmission, causes, symptoms and prevention are included in Health and Physical Education curriculum in both these grades. There is nothing on Population and Environment Education in class six. However, few information on abortion and woman issues are given in the class seven Population and Environment Education curriculum. There are a few lines about smoking, alcohol, drug use and girl trafficking in class six Social Studies. The lessons on social studies seem that contents on SRH could be integrated into it. Similarly, the review of the existing textbooks as well as curriculum of the Population and Environment Education, science, social study and Health and Physical Education in the class Eight revealed that information on Reproductive System, H/A, drug use and STIs are given in the Health and Physical Education Curriculum.

##### *Secondary schools*

Core subjects on Health, Population and Environment Education, Science and Social studies and the elective subjects on Health and Physical Education were reviewed for analyzing the curriculum contents. The Health, Population and Environment Education Curriculum consisted information on reproductive health, family life education, safe motherhood, adolescence, reproductive system, need for sex education, introduction to STDs, causes, modes, symptoms and preventive measures of STDs and H/A. There is no mention about how HIV develops into AIDS. Moreover, the background information is not up-to-date, the sign and symptoms and preventive measures could be improved as well. As compare to other core subjects, which gets 5 period a week carrying 100 marks, EPH has been provided with only 4 periods a week. The contents on STDs and H/A such as introduction, mode of transmission, symptoms and prevention, adolescence, substance abuse, alcohol, prostitution and family life education are included in the physical education Curriculum, the elective subject in class ten. However, the symptoms of H/A could be improved and information on condom included into the same textbook.

More interestingly, the social study curriculum which is a core subject given avenues for incorporating issues on girl trafficking, drug abuse, and well illustration with figures/drawings on facts and figures, transmission and prevention of H/A with adolescent friendly presentation. There is an attitudinal aspect regarding non –discrimination to PLWAs. Case studies are given over there, which is followed with discussions.

### **Teacher handbook and resource materials**

Though there is no any SRH related contents in the primary level curriculum, there is a session on H/A in the fourth 2.5-month. Primary Teacher Training curriculum on Environment Education (In-service teacher training package). The Teacher Resource Material for lower secondary level Health Education and H/A (In-service Teacher Training) is quite a useful reference material for the teachers. It includes contents elaboration for different grades, role of teacher on H/A, pedagogy on H/A, Model Lesson plans, H/A statistics and some pictures. How to teach H/A is a new element in the resource book. 1600 copies of this resource book has been reproduced but it is yet to be distributed to all the schools in the country.

In Environment, Health and Population Education of the secondary level manual for the Master trainers and a Teacher's Handbook have been developed. These manuals are in line with the curricular contents incorporated in the curriculum and textbook of the same subject. The teacher's Handbook also comprises mark sheet that goes with the Trainer's Handbook and uses participative teaching method.

In addition to these reference materials, The Population Education Project Coordination Office, MOES has translated a SRH related document borrowed from Maldives. It would be more useful if it was adapted in Nepalese context. There is no information on the extent of its distribution.

### **Suggestions**

Conclusions from the analysis of the curricular contents and resource materials reveal that the contents are more knowledge based. They cover many of the cognitive aspects of H/A. However, there is an ample room for incorporating following areas of SRH and H/A in the curriculum, textbook, reference materials and training manuals in the future.

#### *Knowledge*

- High risk behaviors that cause HIV infection and ways of risk reduction /elimination
- Preventive measures that reduces the risk of unintended pregnancies.
- Methods of obtaining testing and counseling to determine HIV status.
- Methods of proper condom use

#### *Attitudes/Beliefs/Values*

- Understanding of the personal, familial, societal and cultural values and standards
- Understanding of discrepancies in moral code
- Positive attitudes towards alternatives to intercourse
- Responsibility for personal, family and community health
- Understanding of the fears that surround HIV/AIDS/STI
- Encouragement to peers, siblings and family members to take part in HIV prevention activities.
- Understanding of leadership role to support the HIV prevention program
- Understanding of the social stigma towards PLWHAS, and their care and support

### ANNEX 3

#### **Health Education Curriculum: Analysis of SRH topics covered in the lower secondary and secondary school curriculum**

##### **Lower secondary schools**

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##### **Secondary schools**

Core subjects on Health, Population and Environment Education, Science and Social studies and the elective subjects on Health and Physical Education were reviewed for analyzing the curriculum contents. The Health, Population and Environment Education Curriculum consisted information on reproductive health, family life education, safe motherhood, adolescence, reproductive system, need for sex education, introduction to STDs, causes, modes, symptoms and preventive measures of STDs and H/A. There is no mention about how HIV develops into AIDS. Moreover, the background information is not up-to-date, the sign and symptoms and preventive measures could be improved as well. As compare to other core subjects, which gets 5 period a week carrying 100 marks, EPH has been provided with only 4 periods a week. The contents on STDs and H/A such as introduction, mode of transmission, symptoms and prevention, adolescence, substance abuse, alcohol, prostitution and family life education are included in the physical education Curriculum, the elective subject in class ten. However, the symptoms of H/A could be improved and information on condom included into the same textbook.

More interestingly, the social study curriculum which is a core subject given avenues for incorporating issues on girl trafficking, drug abuse, and well illustration with figures/drawings on facts and figures, transmission and prevention of H/A with adolescent friendly presentation. There is an attitudinal aspect regarding non –discrimination to PLWAs. Case studies are given over there, which is followed with discussions.

### **Teacher handbook and resource materials**

Though there is no any SRH related contents in the primary level curriculum, there is a session on H/A in the fourth 2.5-month. Primary Teacher Training curriculum on Environment Education (In-service teacher training package). The Teacher Resource Material for lower secondary level Health Education and H/A (In-service Teacher Training) is quite a useful reference material for the teachers. It includes contents elaboration for different grades, role of teacher on H/A, pedagogy on H/A, Model Lesson plans, H/A statistics and some pictures. How to teach H/A is a new element in the resource book. 1600 copies of this resource book has been reproduced but it is yet to be distributed to all the schools in the country.

In Environment, Health and Population Education of the secondary level manual for the Master trainers and a Teacher's Handbook have been developed. These manuals are in line with the curricular contents incorporated in the curriculum and textbook of the same subject. The teacher's Handbook also comprises mark sheet that goes with the Trainer's Handbook and uses participative teaching method.

In addition to these reference materials, The Population Education Project Coordination Office, MOES has translated a SRH related document borrowed from Maldives. It would be more useful if it was adapted in Nepalese context. There is no information on the extent of its distribution.

### **Suggestions**

Conclusions from the analysis of the curricular contents and resource materials reveal that the contents are more knowledge based. They cover many of the cognitive aspects of H/A. However, there is an ample room for incorporating following areas of SRH and H/A in the curriculum, textbook, reference materials and training manuals in the future.

#### *Knowledge*

- High risk behaviors that cause HIV infection and ways of risk reduction /elimination
- Preventive measures that reduces the risk of unintended pregnancies.
- Methods of obtaining testing and counseling to determine HIV status.
- Methods of proper condom use

#### *Attitudes/Beliefs/Values*

- Understanding of the personal, familial, societal and cultural values and standards
- Understanding of discrepancies in moral code
- Positive attitudes towards alternatives to intercourse
- Responsibility for personal, family and community health
- Understanding of the fears that surround HIV/AIDS/STI
- Encouragement to peers, siblings and family members to take part in HIV prevention activities.
- Understanding of leadership role to support the HIV prevention program
- Understanding of the social stigma towards PLWHAS, and their care and support

*Skills*

- To identify and seek health services and information on sexuality and H/A and seek help against risk of H/A transmission
- To communicate messages about HIV prevention to families, peers and members of the family
- To build a personal value system independent of peer influence
- To discuss sexual behavior and other personal issues with confidence and positive self-esteem
- To assess the risky sexual behavior and negotiate for less risky alternatives
- Empower girls to be able to negotiate about sex

*B.Ed. Health and Physical Education curriculum*

The Faculty of Education has offered Health and Physical Education courses in the Proficiency Certificate, Bachelor and Master degree levels. In the Proficiency certificate level, Health and Physical education has been provided with 300 marks. The certificate level course has not been updated/revised for the last 25 years. Therefore, it does not include any specific topics on SRH.

In the three-year Bachelor of Education programme, Health and Physical Education is offered as a specialization subject and it comprises six different specialization subjects, two electives and one interdisciplinary/allied subjects. In addition, there are two communication skill development courses each with 200 marks and four foundation courses carrying 400 marks on pedagogy. A topic on Reproductive Health Education has been included in the Foundation of Health Education and Basic Health Science Courses. The former course also covers contents on STIs and HIV/AIDS as well.

Contents on Sexual and Reproductive health and HIV/AIDS and STIs are also covered well in the Population Education courses, which is also one of the main specialization subjects in the Three Year's Bachelor Programme. Environment Education has also been offered as a specialization subject in this level of education. Thus there are three fields of specializations in the Bachelor in Education programme that offers Health, Population and Environment Education related pre-service training to the prospective teachers. These prospective teachers are supposed to be recruited as the secondary level Health, Population and Environment Education teachers.

In the Master's in Education (M.Ed.) programme, the structure of the curriculum consists mainly of the core and specialization areas. The core, specialization and elective courses 30,65% and 5% of the weight respectively. The specialization in Health Education has offered a course on Foundation of Population Education and Reproductive Health, which is more important in providing the practical and in-depth knowledge in SRH education. The pre-service teacher educators are provided with the knowledge and skills required being a higher secondary and or higher education teacher.



## **HIV/AIDS AND THE SCHOOL CURRICULUM**

Students' Textbooks grade 6-10

### Grade six.

*Health and Physical Education.* Core subject. 50 marks. 3 periods (45 minutes) a week.  
Chapter 1: Reproductive health: male and female reproductive system.  
Chapter 4: introduction to HIV/AIDS, its transmission and prevention, symptoms; precautions syphilis and gonorrhoea.

*Population and Environment Education.* Core subject. 50 marks. 3 periods a week.  
Family planning, women issues, child mortality.

*Social Study.* Core subject. 100 marks. 5 periods a week.  
Chapter 3: girl trafficking (limited information).

### Grade seven.

*Health and Physical Education.* Core subject. 50 marks. See grade six.  
Page 73: introduction to HIV/AIDS, transmission, symptoms, prevention and treatment.  
(information not complete).

*Population and Environment Education.* Core subject. 50 marks. See grade 6.  
Chapter 7: information on early marriage and family planning.

*Social Study.* See grade 6.  
No information on HIV/AIDS and sexual reproductive health.

### Grade eight.

*Population and Environment Education.* Core subjects. 50 marks. See grade six.  
Chapter 11 (p. 98-105): family planning, legalization of abortion, women issues.

*Science Education.*  
Contains no information on HIV/AIDS and sexual reproductive health.

*Social Study.* See grade six.  
A sentence on the role of the Ministry of Health in STD and HIV/AIDS programs.

*Health and Physical Education.* See grade six.  
Chapter 4: male and female reproductive system, menstruation, HIV/AIDS and STDs. p.67:  
drug use.

### Grade nine.

*Health Population and Environment Education.* Core subject. 100 marks. 4 periods a week.

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

Chapter 6 (p.130-144): concept of reproductive health, adolescence, reproductive system, need for sex education.

Chapter 8 (p.177-178): introduction to STD's, causes, modes. Symptoms and preventive measures of syphilis, gonorrhoea and HIV/AIDS.

(information lacking on how HIV develops into AIDS, background information is not up to date, sign and symptoms of HIV/AIDS not clear and the information presented on prevention of HIV is very limited).

*Health and Physical Education.* Elective subject. 100 marks. 4 periods a week.  
No information on HIV/AIDS.

*Social Study.* Core subject. 100 marks. 4 periods a week.  
p. 60: role of various clubs in the development of Nepal. Example of a local NGO engaged in the control of drug abuse.

Grade ten.

*Health Education.* Elective subject. 100 marks. 4 periods a week.

Chapter 1(diseases): STD's, HIV/AIDS: introduction, modes of transmission, symptoms (needs revision) and prevention (no information on condoms).

Chapter 3 (p. 59): adolescence, substance use, alcohol, smoking, STD's and prostitution.

Chapter 4 (p.71): family life education and family planning, delayed marriage, birth spacing and family planning methods.

*Health Population and Environment Education.* Core subject. 100 marks. 4 periods a week.

Chapter 1: family life education: early marriage and family planning (limited information).

Chapter 5(p.98): safe motherhood, prevention of STDs, drugs, alcohol and HIV/AIDS (information limited).

*Social Study.* Core subject. 100 marks. 4 periods a week.

Chapter 4 (p.54): under social evils: girl trafficking, drug abuse. Two full pages with figures and drawings which include facts and figures on HIV/AIDS, transmission and non-transmission, charts, non-discrimination towards people living with AIDS. Use of case study. Youth friendly presentations.

## ANNEX 4

### **Resource Materials and handbooks on HIV/AIDS.**

#### For Teachers

##### Primary school level.

National Center for Educational Development (NCED). Department of Education.  
Fourth 2,5 month Primary Teacher Training. Weightage: 1 hour/90 credit.

Introduction of HIV/AIDS, symptoms, how does AIDS transfer and does not transfer, diagnosis and high risk behaviour.

##### Lower Secondary school level.

Curriculum Development Center (CDC). Department of Education. In-service training.  
Teacher resource material for lower secondary level.  
1600 copies printed. Not yet distributed.

Introduction to HIV/AIDS, role of the teacher on the basics of HIV/AIDS teaching, lesson plans, statistics and pictures. How to teach is a new element here. Does not include information or lessons on attitudes and life skills.

##### Secondary school level.

Secondary Education Development Project (SEDP). Department of Education.

Training of trainers manual on EHP for secondary level (4 week training, 100 sessions).  
Session (3 hrs.) on (non)communicable diseases, including STDs and HIV/AIDS.  
2 sessions (3 hrs.) on smoking, drug use and alcohol.  
Session(1.30 hrs. on adolescence.  
Session (3 hrs.) on the reproductive system)  
Session on the concept of reproductive health.  
Worksheets use participatory teaching methods.

Teachers' handbook class 9and 10. EHP.  
Very similar to the trainers' manual.  
Only available for participants of the training.

#### **For Students**

##### Higher Secondary school level.

Population Education Project. Coordination Office.

Reference material for higher secondary level students. Translation of a book developed in the Maldives. No information available on how many students have received a copy of the book. It would be more useful if it was adapted to the Nepalese context.

ANNEX 5

SUMMARY OF STUDENT FOCUS GROUP DISLIKE CARDS

PRIMARY SCHOOLS

S.N.	Disliking factors for not coming to schools	Girl student in FGD	Boy student in FGD
1.	Cannot finish home work	5	3
2.	Load of household work	3	1
3.	Lack of stationary, books, pen, pencil etc.	1	1
4.	Hugging, touching, using bad language, pulling hair by teachers	4	1
5.	Sickness and lazy	5	-
6.	Poor facilities and poor sanitation	-	6
7.	Frequent absentees and transfer of teachers	-	3
8.	Lack of sports and game facilities in schools	-	1
9.	Using bad and vulgar language, quarreling by students	-	7
10.	Lack of time for entertainment and traveling outside city, visiting relatives	2	1
11.	Beating by teachers, scolding and punishment	1	3
12.	Angry with parents	1	-
13.	Don't want to study	1	-
14.	Long vacation in the school	1	-
15.	Disturbances from the out-of-school boys	-	1

## SECONDARY SCHOOLS

S.N.	Disliking factors for not coming to schools	Girl student in FGD	Boy student in FGD
1.	Not completing homework	1	2
2.	Burden of household work	3	-
3.	Sickness, lazy	3	-
4.	Poor economic condition of parents	3	1
5.	Over-crowded classes	-	2
6.	School located in far distance from home	1	1
7.	Teachers bad attitude towards female students (Hugging, touching, using bad language, pulling hair, starring etc)	4	1
8.	Beating by teachers, scolding and punishment	-	3
9.	Discrimination by teachers to weak and intelligent students	1	4
10.	Teachers favoring female students	-	1
11.	Poor facilities and poor sanitation at school	1	4
12.	Frequent absentees and late coming of teachers in the class room	-	2
13.	Lack of sports and game facilities in schools	-	1
14.	Teachers feel shy in delivering SRH classes	-	2
15.	Teachers not teaching properly/carelessly	2	1
16.	Teasing boy-girls	1	2
17.	Fighting between students/bad friends circle	1	2
18.	Girl students involvement in sex selling	-	1
19.	Girl student not very closed to boy students (shy)/ falling in love with outside girls		2
20.	During menstruation period	1	-
21.	Disliking of writing love letters from boys	1	-
22.	Disliking bad behaviors of boy friends	1	-
23.	Carelessness of parents	1	-
	Total	25	32

ANNEX 6

**ACTION PLAN FOR THE PROPOSED AIDS MANAGEMENT PROGRAMME FOR THE EDUCATION SECTOR 2003 - 2006.**

	Activities	Time frame	Responsibility	Implementation	Outputs	Budget needed
1	Training one teacher at every public primary school in Nepal.	year 1 year 2	MOES	Resource Centres	21000 teachers primary schools trained (in-service)	Yes
2	Introduction sexual/reproductive health into primary education cycle.	year 1/2/3 2005	MOES	Curriculum Dev. Board DEO	HIV/AIDS information/ life skills orientation available for students class 4/5.	No
3	Review of health education curriculum secondary schools.	year 1	MOES	Curriculum Devel. Board	Recommendations improvement health education curriculum secondary schools.	No
4.	Develop additional teaching materials secondary schools.	year 2	MOES	Curriculum Dev. Board/ input by NGO's	Youth-friendly learning materials developed and distributed to every public primary and secondary school.	Yes
5.	Develop and distribute teacher handbook on HIV/AIDS and SRH.	year 2	MOES	Sec 4	Handbook for every teacher	Yes
6.	One day workshop for teachers of secondary public schools( 1 teacher per school).	year 1/2/3	MOES	Resource Centres	Teachers trained.	Yes
7.	Newsletter for teachers (primary/secondary/public and private ? how many per school ?).	Quarterly basis	MOES	NGO's/DEO/trade unions	Every school in Nepal receives a newsletter on a regular basis.	Yes
8	Risk assessment school teachers HIV/AIDS. (number of tests ?)	year 1/2/3	MOES	Min. of Health	Representative sample of teachers is tested on HIV.	Yes
9.	Include relevant HIV/AIDS related data on teachers and students in EMIS school questionnaire.	year 1/2/3	MOES	Statistical Department	Information on causes of mortality teachers /gender breakdown available. Information on parental status and living arrangements students and	No

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

					school dropouts collected.	
10	Review of current Code of Conduct for teacher staff regarding sexual conduct.	year 1	MOES	MOES	Rules, regulations and procedures related to all forms of sexual misconduct established.	No
11	Policy statement discrimination against students and teachers with HIV/AIDS	year 1	MOES	MOES	Policy statement issued by MOES against discrimination HIV/AIDS.	No
12	KAB study sexual behaviour students post-secondary education in different regions in Nepal.	year 2	MOES	MOES/N GO's	Baseline data available on sexual behaviour students post-secondary. Recommendations on prevention programs.	Yes
13	Feasibility study on current peer education programs for school students run by NGO's.	year 2	MOES	MOES/N GO's	Analysis and recommendations on possible integration in the school system.	Yes
14	One-day workshop for District Education Officers.	year 1	MOES	MOES/N GO's	75 DEOs briefed and informed about HIV/AIDS issues and activities MOES.	Yes
15	Support to HIV/AIDS orphans.	year 2	MOES	MOES/D EO	Policy on support formulated, approved and ready for implementation.	No
16	Establish HIV/AIDS management committee.	year 1 year 2 year 3	MOES	MOES	High-level management committee formed, chaired by the Secretary, members from key divisions, other ministries, NGO's, and private schools.	Yes
17	Appointment HIV/AIDS Coordinator	year 1 year 2 year 3	MOES	MOES	Full-time HIV/AIDS coordinator available and responsible for action plan, support to HIV/ADS committee, representing MOES in various fora, communication DEO's and schools.	Yes.

ANNEX 7

PROPOSED ACTION PLAN DEVELOPED BY WORKSHOP PARTICIPANTS

Group 1: Male students

S.N.	Activities	Justification	Expected out puts
1.	-Introduce SRH education from Class 4-5 - Include more contents in lower secondary and secondary level	- Start of adolescence - Sex education is good to give from young age	- Life skill based education will be received
2.	Encouragement for peer education	To communicate information freely in between friends	To explain problems
3.	Self learning materials production and distribution (chart, posters, hand book, audio-visual, cartoon)	No enough text content in text book Easy to understand	Good knowledge
4.	Extra curriculum activities (essay computation, Street drama, workshop, debates, seminar)	To get good knowledge on SRH education in a more effective manner	" "
5.	Youth Union in school and out of school youth	Youth awareness	Youth awareness
6.	Teachers Training in remote area too	Improvement in teacher training	To improve teachers training in effectively
7.	Discussion program in between teachers, and students	Develop knowledge of SRH for all people	Openness in relation
8.	Knowledgeable activities in village and in city (Radio and T.V.)	To increase knowledge of SRH issues	To increase knowledge of SRH education



*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

**Group 2: Female students**

S.N.	Activities	Justification	Expected out puts
1.	Establishment of Youth Club	<ul style="list-style-type: none"> <li>- To create a open environment to discuss among school and out of school youth</li> <li>- To inspires youth</li> </ul>	<ul style="list-style-type: none"> <li>-To get knowledge of STI and sex/ RH education</li> <li>- To get away from bad company</li> <li>- Get opportunity for the youth of school and out of school</li> </ul>
2.	Revision of SRH education	Knowledge of pregnancy and abortion	<ul style="list-style-type: none"> <li>- Get clear information</li> <li>-</li> </ul>
3.	Development of IEC materials (Posters and pamphlets with male and female organs)	<ul style="list-style-type: none"> <li>-Easy to understand for uneducated</li> <li>-Knowledge of organs</li> </ul>	<ul style="list-style-type: none"> <li>- Can be prevented from the diseases</li> <li>- Decrease in mother and child mortality</li> </ul>
5.	Peer education program	Can talk openly	- Can be more effective to impart awareness
6.	Counselling	Helps to solve physical and mental problems of adolescent	- It helps to provide family health education
7.	HPE subject teacher	Quality education	Can understand easily
8.	Life skill based education	<ul style="list-style-type: none"> <li>-Extra curricular activities</li> <li>-Involvement of parents</li> </ul>	<ul style="list-style-type: none"> <li>-It makes curiosity in students 0</li> <li>-This helps to get practical education</li> <li>-Create positive attitude of parents</li> </ul>
9.	SRH education from Class five	To impart knowledge on SRH	<ul style="list-style-type: none"> <li>-This helps students to create awareness on SRH</li> <li>-It helps to remove gender discrimination</li> </ul>

*An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal*

**Group 3: Primary School Teachers**

S.N.	Activities	Justification	Expected out puts
1.	Interaction between teacher students and parents	To cerate awareness	- Change in behaviour
2.	Incorporate simple SRH curriculum in class 4 and 5	Starts adolescent age and they became curious	- Basic awareness increases
3.	Training package and training to teachers on HIV/AIDS	To increase efficiency of teachers	- Teachers will be committed to teach SRH competently
5.	Production of IEC materials and conduct extra curricular activities, based on gender equity	Effective and efficient methods	-Sustainable learning methods for continuity -Fruitful for society

**Group 4: Secondary School Teachers**

S.N.	Activities	Justification	Expected out puts
1.	Provide SRH education -Basics in Class 4 –5 -Existing course of Class 9 and 10 should be given in Class 6- 8 - More specific and comprehensive course in Class 9-10	-According to the age level of students	- Create awareness in HIV/AIDS diseases
2.	Teachers training and supervision	Teacher training is important to make them efficiency	- To get right education in right way
3.	Learning materials (Posters, pamphlets, booklets, video show	Easy to give knowledge in effective way	- To make understand to the students
4.	Extra curricular activities (Game, debates, Peer group, quiz etc.	Can participate with excitement	Can get knowledge easily
5.	Develop slogan like " Good teachers Good students Good conduct Strong nation"	To create national feeling	Can create strong population

**Group 5: District Education Officers and Regional Education Directors**

S.N.	Activities	Justification	Expected out puts
1.	Incorporation of SRH education in curriculum a. Basic in class 4-5 b. Comprehensive in Lower secondary c. Cause and effective in secondary	<ul style="list-style-type: none"> <li>- General knowledge</li> <li>- Starting and adolescent age</li> <li>- Mature and responsible</li> </ul>	<ul style="list-style-type: none"> <li>- Students will be knowledgeable and change in behaviour</li> <li>- "</li> <li>- "</li> </ul>
2.	Teachers training a. Update in teachers training package b. Develop TOT SRH/HA c. Training Package to HPE Teachers	-Development of knowledge skill and confidence of teachers	Effectiveness in teaching
3.	Community mobilization a. Interaction between teachers and parents b. Coordination among SMCs,VDCs and NGOs/CBOs	Sharing ideas, coordination and cooperation developed	<p>Identification of the problem and its solutions</p> <p>-Active participation in the programs</p>

An Assessment of the Impact of HIV/AIDS on the Education Sector in Nepal

**Group 6: Technical Group (CDC, NCED, SEDC, NFEC, DEC, GEMC, FOE/TU, Life skills group)**

S.N.	Activities	Justification	Expected out puts
1.	Policy Review a. National AIDS Policy Linkage b. Community involvement including SMC c. Teaching Method d HPE Teacher recruitment e. Teacher Training	To update the activities	Need-based curriculum and Text-books
2.	Implementation of Life skills based Education a. Parents, involvement in community awareness b Self-learning materials and other materials c. Peer-based education d. Use of Health workers and Resource persons	Behaviour change  -To support school activities  -To get more information  To explore available resources	Linkage of Education with available services e.g. Health workers  Better teaching-learning  Local resource mobilization
3.	Monitoring and Evaluation: Training of School supervisors and Resource persons Appoint a focal person in DEO	Content-based evaluation	-