Nepal Red Cross Society/Norwegian Red Cross

HIV/AIDS and Reproductive Health Programme

Final Evaluation

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November 2004

Edited and prepared for web publishing by the International Division of the Norwegian Red Cross. September 2005

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
BCC	Behaviour Change Communication
BCN	Baun, Chetri, Newor – high cast ethnic groups
CBFA	Community Based First Aid Programme
CDP	Community Development Programme
DACC	District Aids Coordination Committee
DDC	District Development Committee
DEO	District Education Officer
DP	Development Partners (INGOs, Donors)
FGD	Focus Group Discussion
FHI	Family Health International – American NGO
GIPA	Greater of Involvement of People Living with HIV/AIDS
HIV	Human Immunodeficiency Virus
HM	Head Master
HMG/N	His Majesty's Government of Nepal
ICRC	International Committee of the Red Cross
IDU	Injecting Drug User
IEC	Information, Education and Communication
IFRC	The International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organization
JRC	Junior Red Cross
MCTC	Mother to Child Transmission
MGR	Magar, Rai, Gurung – ethnic groups
MSM	Men who have Sex with Men
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
NRCS	Nepal Red Cross Society
PE	Peer Education or Educator
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
RSA	Rapid Situation Assessment
SARNHA	South Asia Red Cross/Red Crescent Network on HIV/AIDS
SDC	Swiss Development Cooperation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
SPSS	Statistical Program for Social Scientists
SW	Sex Worker
TOT	Training of Trainers
TS	Teacher Sponsor (teacher responsible for JRCS activity in the school)
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee

Study team

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Executive summary

This evaluation study uses both qualitative and quantitative methodologies. It was carried out for Nepal Red Cross Society (NRCS) who has been implementing HIV/AIDS and Adolescent Reproductive Health Programme in seven districts in Nepal with financial and technical assistance from the Norwegian Red Cross (NRC). The programme was implemented from 2000 to 2004. For the purpose of the study three districts (Rasuwa, Gulmi and Rautahat) were selected for primary data collection with wide range of people (School youth, teachers, community members, and government officials). Field study was conducted by a team consisting of national and international professionals during the month of November 2004.

The objectives of the study were as follows;

- A general assessment of projects achievements in terms of capacity building at local communities, reduction of vulnerability around HIV/AIDS among target groups, effectiveness (including Cost-effectiveness), sustainability and advocacy.
- A general assessment of capacity building at the district chapter, sub chapter level of NRCS and the community
- An assessment of the degree of coordination and collaboration with relevant agency of the government, NGOs and INGOs

Major findings

The HIV/AIDS and adolescent reproductive health programme is primarily targeted at school youth. The programme was implemented in collaboration with schools, using a Peer Education approach. Red Cross District Chapters were responsible for day to day management of the programme for which a full time Field Coordinator was assigned. Red Cross Head Quarters (HQ) provides continuous support, guidance, coordination and other input for the programme implementation.

Qualitative and quantitative data indicated that the overall knowledge and attitude related to HIV/AIDS and reproductive health is very good both among the Peer Educators and other students, with some exceptions. Many can express correctly the route of HIV transmission as well as ways to prevent the transmission. Teacher Sponsors (teacher responsible for Junior Red Cross activity in the school), Peer Educators, radio and magazines are the main sources of information for many young people. Knowledge on reproductive health is also high, and a majority of youth are confident of their ability to manage physical and emotional changes occurring during the adolescent period.

Youth at schools feel empowered through the communication and other skills developed, and information received, during Peer Education training. Risk behaviour is reported to be insignificant among the youth and sex trade is thought as urban behaviour only. Although sharing on HIV/AIDS outside the school is less frequent, youth have demonstrated that they have discussed HIV/AIDS and reproductive health issues with non school youth too. Being a Peer Educator for many is a matter

of pride and has received high regards from their co-students and village people. However the evaluation team felt that students regard HIV/AIDS studies with no more respect than any other topic, like geography or English. Most of them see it as relevant to “others”, and not to themselves. Nonetheless, many young people wanted to continue their association with the Red Cross, but such opportunity is often limited in a rural setting. Furthermore, Peer Education is an interactive and a continuous process which is often lacking in the schools. Evidently, youth as direct beneficiaries is well achieved, but youth as vehicle for change not fully achieved.

Similarly, in all programme districts, women’s groups are either purposely formed around HIV/AIDS education or HIV/AIDS activities were integrated to existing women’s group. Among the women’s groups the level of knowledge, confidence and activities varied a lot. In Gulmi a group was formed only of Dalit women for conducting HIV/AIDS activities and training. If only one particular group is targeted for HIV/AIDS activities, there is a danger in creating a stigma for that particular group.

Gender balance was maintained while selecting Peer Educators, but a majority of Teacher Sponsors are male. Many teachers see no difference in teaching female or male students despite the realisation that there are more social restrictions for girls than for boys. The Red Cross organisation as a whole is male dominated and stakeholders have mixed views about it. More coordination and linkage is suggested for better programme implementation.

The Red Cross has comparative advantage in implementing activities in the field in the current political context. In the current programme districts, Red Cross has no problem in conducting field activities. Youth and teachers also feel safe being associated with the Red Cross. In addition to this, since the programme is implemented through existing structures i.e. schools and teachers, no additional cost is required to set up and maintain the structure.

Implementation of projects like the HIV/AIDS programme, while building the image of the Red Cross, has been successful in reactivating junior youth circles. In programme districts many new Junior Red Cross Societies are formed and renewed. This process is believed to have significantly contributed in promoting Red Cross philosophy. Moreover, a cadre of trained teacher is formed who would perform their responsibility with renewed motivation and added skills. Clearly, all this has strengthened the overall capacity of Red Cross in implementing HIV/AIDS programme.

Despite careful financial monitoring, there is room for improvement in the overall programme monitoring – more specifically in the follow-up of the Peer Education process. It is important to keep track of any changes in the behaviour of youth. The standardised programme management has certain advantages, but room for innovation and flexibility is necessary to address the diverse need of different districts.

Since the programme is implemented by the school at the front line, some parts of the programme – if not all – is expected to be continued by the Red Cross trained Teacher Sponsors in the respective schools even after the completion of project input. With the renewed motivation and new skill acquired through the HIV/AIDS programme, Teacher Sponsors and headmasters are confident to continue some elements of the HIV/AIDS and reproductive health programme. Some support from Red Cross is however expected by all for the continuation of the programme. Red Cross HQ officials and district members have said that HIV/AIDS is a high priority, and have expressed their willingness to continue the programme even after the completion of the project. However, the alternative plan and resources required for this is often lacking both at HQ and at District Branches.

Recommendations

Definition and application of the Peer Education approach needs to be redefined, making the process more interactive and continuous. This is a good opportunity for the Red Cross to establish a firm working modality on Peer Education for school youth and community youth.

Gender equity and equality within the wider context of NRCS institutions at policy and other levels is a major concern. The problem must be given serious consideration, enabling more female members to join the executive committee at the central and district levels. More specifically, there is a need for sensitisation workshops among district chapter members, teacher sponsors, peer educators and their target group, on gender equity and what it means in practice.

The HIV programme appears to be an isolated activity in the districts, despite the fact that number of different events (Junior Red Cross meetings, HIV/AIDS orientation) are held at the same time with the same group of youth within a different programme (e.g. Community Based First Aid Programme, Community Development Programme). This opportunity to integrate HIV/AIDS activities into other programmes should be taken maximal advantage of.

It is essential to develop a monitoring system which not only keep track of activities but also assess the results.

Linkages between this project activity and the South Asian Red Cross/ Red Crecent Network on HIV/AIDS (SARHNA) and other stakeholders are not visible, although informal relationships and consultations appear to exist. The existing opportunity to strengthen the linkage needs to be capitalised.

Exit plans need to be developed from the outset of the projects so that District Chapters and Schools can be oriented and prepared towards this in order to develop a plan for the continuance of the project after withdrawal of external funding. Having an exit plan does however not mean complete termination of all activities and relationships – it is to move to the next stage of development.

Conflicts of different natures and magnitude are likely to remain as a part of the development cycle. While designing the future intervention conflict situations therefore needs to be taken into consideration, and conflict management should be a cross cutting issue in all fields and training activities – including Peer Education training at the school level.

In the current situation, the Government is developing a school curriculum in order to integrate life skills and reproductive health in an extensive way in the schools. NRCS has been in the forefront of the in-school approach, and should be proactive in planning changes to their programme. If the programme in the schools will be taken care of by the teachers directly through the government support in the future, NRCS might want to look at ways for reaching the out-of-school youths, those who drop out, or other vulnerable groups.

1. Introduction

This evaluation study was carried out for Nepal Red Cross Society who has been implementing Adolescent Reproductive Health and HIV/AIDS Programme in seven districts in Nepal with financial and technical assistance from Norwegian Red Cross. The programme was implemented from 2000 to 2004. A baseline study was also carried out in 2000 to establish a benchmark and draw information to design specific approach to address the situation of youth and adolescents.

1.1 Context

1.1.1 Young people

About 40% of the population in Nepal are below 20 years of age and 32% are Adolescents. According to the World Health Organisation (WHO) definition, people between 15-25 years old are youth, while those between 10 and 19 years of age constitute adolescents. The transition from childhood to adulthood between the age of 10-19 is characterised by changes in physical, mental and emotional health. Desire for experimentation, inquisitiveness and action are some the inherent characteristics of the youth in this age group. At this age, adequate and appropriate information, skills and support are needed for the youth to take right decisions that affects their lives.

1.1.2 National HIV/AIDS situation

According to the Joint United Nations Programme on HIV/AIDS, UNAIDS, Nepal has now been categorised a country with a "concentrated epidemic" in which the HIV/AIDS prevalence consistently exceeds more than 5% in one or more sub-groups. The prevalence among the general adult population is currently low (0.5%), but an increasing prevalence is noted in several groups: Sex Workers (SW) in Kathmandu 17.3% (Family Health International, FHI, 2000) which was 2.7% in 1997, Injecting Drug Users (IDUs) 40.4% nationwide, 68% in the Kathmandu Valley (National Centre for AIDS and STD Control, NCASC, 2002), and 10% in certain migrant population is a matter of grave concern (See also Box 1 for additional information). Moreover, the vulnerability for rapid transmission of HIV/AIDS in Nepal is increased manyfold by pervasive poverty (40% of the population below the poverty line with an annual income of less than Rs 4400), coupled with a low literacy rate, gender inequity, labour migration, girl trafficking and increasing sex trade.

In addition to this, the current conflict has further added to the vulnerability – resulting in massive labour migration and displaced population, broken family and social structures, increased numbers of orphans and loss of caretakers, loss of income and decreased access to productive assets.

Box 1: HIV/AIDS situation

	Data	Date
Reported HIV Cases Reported AIDS Cases Estimated number of adult and children living with AIDS Estimated adult and children mortality due to AIDS	4680 854 60,018 2,958	Jan 2005 Jan 2005 End 2002 2002
HIV prevalence		
IDUs (Kathmandu) Female SWs (Kathmandu) Patients with STI (Sexually Transmitted Infections) Blood donors ANC	68% 15.61% 0.7-6.6% 0.28-0.48% 0.2%	2002 2002 2002 2002 2002
Source: NCASC (www.ncasc.gov.np)		

1.1.3 Working environment

The NRCS programme implementation responsibility lies with the District Chapters and the Field Coordinator appointed to supervise the programme. They are theoretically answerable to the local chapter, not to the Red Cross headquarters. The NRCS charter states that the District Chapters are autonomous in terms of its management, programme implementation and resource mobilisation. In addition, the schools in which the programme is being implemented lies under the Education Ministry – and are therefore not obliged to communicate with the Red Cross. In such a situation the Red Cross cannot put pressure on schools or invite the teachers for training and other activities without consent of District Education authority. In other words, programme implementation is heavily influenced by the system which is outside the Red Cross purview. The challenge therefore is to establish a good coordination and working environment, which is often best done informally, to implement the programme at the district level.

1.1.4 Comparative advantages of the Red Cross

In the current conflict situation, Red Cross has certain comparative advantage (credibility, humanitarian philosophy, neutrality, locally managed, modest and well accepted at local level) over other organisations. This allows it to operate even in the most severely conflict affected areas. People also feel safe to be associated with the Red Cross in such armed conflict situations. Furthermore, the local chapter is managed by the locally elected body, creating a strong sense of ownership.

Moreover, many teachers particularly from Gulmi expressed that the role of Junior Red Cross (JRC) as a movement teaching democracy is also vital in the current political situation. Through their JRC election, voting and selecting candidates, they learn important democratic skills, norms and values.

Since the programme is implemented through existing structures i.e. schools and teachers, no additional cost is required to set up and maintain the structure.

2. Methodology and Objectives

Both qualitative and quantitative methodologies were used in the study, as specified in the Terms of Reference (TOR). For the primary information, basically, participatory tools were applied. In particular, focus group discussion and interaction with respondents and key informants (like peer educators, health service providers, school headmasters, parents, teacher sponsors, Red Cross representatives, and opinion leaders) and in-depth interviews were used. Documents review and observations/visits at schools and local communities were also among the methods used. Meetings, interviews and discussions with NRCS officials including chapter and sub-chapter members, local authorities, International and National organizations working on district level were also carried out to collect information.

Quantitative methodology was used primarily to assess the knowledge, attitude and behaviour of school-attending adolescents in the age bracket of 13 – 19 from class eight to ten. Although the questionnaire was already pre-tested, some adjustment had to be made in one of the questions in the structured questionnaire after the first field visit as student did not fully understand it. Quantitative data thus collected were entered and analysed using Statistical Program for Social Scientists (SPSS) analysis package by an independent data analyst who was not a member of field visit team.

Qualitative data were collected to assess the effectiveness of the programme, capacities, benefits and management issues, from wide range of people (students, local leaders, government officials, donor agencies).

2.1 Objectives of the study

The objectives of the evaluation were as follows;

- A general assessment of projects achievements in terms of capacity building at local communities, reduction of vulnerability around HIV/AIDS among target groups, effectiveness (including Cost-effectiveness), sustainability and advocacy.
- A general assessment of capacity building at the district chapter, sub chapter level of NRCS and the community
- An assessment of the degree of coordination and collaboration with relevant agency of the government, NGOs and INGOs.

2.2 Sample

Out of seven districts in which the programme was implemented three districts were selected for the study purpose. The three districts purposively selected were Rautahat (Tarai, with Tarai inhabitants), Gulmi (Mid hill with mixed population), and Rasuwa (Northern mountainous district with specific ethnic majority). Moreover, the three districts were geographically located in three different parts of the country. In each district 20% of schools were selected for a self-administered questionnaire survey and a total 30 students were randomly selected from class 8, 9, and 10 in each sample school to fill in the self-administered questionnaire.

For qualitative data collection, sample and tools used were as follows

Tools	Sample population	Sample size
Focus Group Discussions	Peer Educators	2 cluster in each districts with 8-10 Peer educators
In-depth Interview	Headmaster and Teacher Sponsor	In each visited schools
Interactive meetings	Red Cross District chapters members, District AIDS Coordination Committee (DACC) , district authority	As available
Observations	Local library, query box, local pharmacy	In all visited schools.

2.3 People met

Following categories of people were met during field study for Focus group discussion, In-depth interview and or interactive meetings (See Table 1: below).

Table 1: People met

	Gulmi	Rautahat	Rasuwa	Total
Boys (Peer Educators)	12	9	7	28
Girls (Peer Educators)	8	10	6	24
Total (Peer Educators)	20	19	13	52
Women group members	9	10	9	28
Parents/community people	12	13	16	41
DACC members		2	3	5
Dist. Chapter members	7	6	9	22
Red Cross HQ Officials				7
Teacher Sponsors	8	5	6	19
Headmasters	8	5	5	18
Stakeholders (Kathmandu)				10
Total	64	60	61	**202**
Quantitative questionnaire	223	205	156	**584**

Beside this, 584 students participated in self administrated questionnaire whose profile is as follows (See Table 2: and Table 3: below). Among the respondents, the majority are from Baun, Chettri and Newar group, a privileged group who have better access and control over many productive resources. In second category Magar, Rai, Gurung who are mainly habitants of mid hills. In Tarai the high caste people is the largest group (10%) compared to other caste group (6%) in the same area. The representation of Dalit and low caste group is very minimal (4.1%). This is the reflection of social hierarchy prevailing in the country where access to productive resources is not uniform to all.

Table 2: Number of students by district

Districts	Number	%
Rasuwa	156	27
Gulmi	223	38
Rautahat	205	35
Total	**584**	**100**

Table 3: Respondents' profile

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
Mean age (years)	15.90		15.0		15.09		15.33.	
Sex								
Male	96	62	106	48	89	43	291	**50**
Female	58	37	113	51	107	52	278	**48**
Missing	2	1	4	2	9	4	15	**3**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Ethnicity								
BCN Group	56	35.9	180	80.7	65	31.7	301	51.5
MGR Group	89	57.1	23	10.3	19	9.3	131	22.4
Tarai high caste	1	0.6	0	0.0	60	29.3	61	10.4
Tarai other caste	0	0.0	0	0.0	35	17.1	35	6.0
Muslims	0	0.0	0	0.0	7	3.4	7	1.2
KDL group	2	1.3	10	4.5	13	6.3	25	4.3
Missing	8	5.1	10	4.5	6	2.9	24	4.1
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Religion								
Hindu	67	43	217	97	180	88	464	**79**
Buddhist	77	49	2	1	14	7	93	**16**
Christian	8	5	0	-	0	-	8	**1**
Muslims	1	1	0	-	8	4	9	**2**
Missing	3	2	4	2	3	1	10	**2**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Education								
Class 8	39	25	73	33	49	24	161	**28**
Class 9	57	37	70	31	79	39	206	**35**
Class 10	58	37	71	32	74	36	203	**35**
Class 11	0	0	2	1	0	-	2	**0**
Class 12	0	0	4	2	0	-	4	**1**
Missing	2	1	3	1	3	1	8	**1**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**

Marital status								
Married	5	3	0	-	4	2	9	**2**
Unmarried	148	95	219	98	188	92	555	**95**
Missing	3	2	4	2	13	6	20	**3**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**

Note: BCN = Baun, Chettri, Newar; MGR = Magar, Gurung, Rai, Sherpa, Lame; KDL = Kami, Dami, Lohar

2.4 Limitation and constraints

Districts selected for the study varies significantly with each other in many respects i.e. geographical distribution, stages of development and presence of development activities, population composition, socio-economic status and effects of conflicts, therefore generalisation of data and findings is not possible.

The Red Cross Districts Chapters were responsible for the selection of the sample schools for the study, the selection criteria and process followed in the districts varied. The schools performing best or with a location easily accessible from the district headquarters appeared to have been selected for the study. Similarly, the school teachers in the respective schools selected the 30 students for the self administered questionnaire. Personal bias of the school teacher may have influenced the selection. Likewise, despite orientation to the students before administering the questionnaire, some youth have skipped certain questions and did not put any tick mark on it, therefore many ‘missing values’ were observed while analysing the data. This ‘missing’ was interpreted as the students sole interest and rights not to disclose that particular piece of information to the evaluation team.

The evaluation team was perceived and treated more as a Project Identification Mission in Gulmi district with many social functions and gathering which is likely to have influenced the way information was shared and the way the evaluation team interacted with the local beneficiaries and stakeholders.

Time limitation (tight schedule) for the study was further aggravated by two major holidays, which meant performing Focus Group Discussions (FGD) and interviews in late hours and beyond the normal working hours. It also affected the travel days.

The security situation in the country was rather tense at the time of the evaluation, and the team had to adapt travel days and the school visits at the districts according to security needs as well.

3. Study Findings

3.1 Knowledge and Awareness

Good knowledge on HIV/AIDS was found among the Peer Educators who have received focused training of 1-3 days duration. They can express correctly the route of transmission and ways to prevent the transmission. They know about Sexually Transmitted Infections (STI) and have also actively talked to other youngsters.

Many youth have access to radio where message about HIV/AIDS and other health issues are discussed. Many youth said that they also find newsletters and magazines as a useful source of information beside their text books. Sometimes illiterate members of the community accuse them of immorality. They would like to have the query box in their school functioning so that they can ask and respond different questions that is difficult to ask openly in the class.

The result of the questionnaire (Table 4: below) also indicate high level of awareness among the students from class 8-10 in the sample schools. For many students both the teachers and the peer educators are good sources of information.

Knowledge on reproductive health (Table 5: below) particularly the understanding of the reproductive organs is high. The majority of youth are aware about changes occurring during the adolescent period and do not feel worried or embarrassed when wet dreams (64%) or menstruation occur (63%). This is quite a positive result of the programme among the youth who otherwise would normally worry or feel embarrassed during such happenings.

3.2 Empowerment

Empowerment is assessed in terms of their ability to talk and share openly and frankly on the issues of HIV/AIDS and Reproductive Health (RH).

It was found that Peer Educators (PE) and teachers are confident to talk and share freely and openly about HIV/AIDS and RH issues. During the FGD with the PE, the youth were very open to share their concerns, lessons learned and their motivation to work as PE. They also expressed that they receive high regards from their co students and village people. At times they are considered as role model for good student. Beside, the regular forum (JRC meeting every last Friday of the month) is now being used to discuss not only the JRC issues but also on HIV/AIDS and related issues. This has greatly enhanced the youth’s confidence and skills. Moreover use and sale of condom (Table 6: below) in the area was reported to have increased, but who are the users and how it is used is not know.

Beside this, in all programme districts women groups are either purposely formed around HIV/AIDS education or HIV/AIDS activities were integrated to existing women’s group. In Rauthat existing women group are provided with HIV/AIDS orientation where as in Gulmi and Rasuwa new women groups were formed and training provided. In Gulmi a group is formed only from Dalit women and provided with HIV/AIDS training. It is seen that if only one particular group is targeted for

HIV/AIDS activities, it is likely to create stigma to that particular group. Such targeting was justified by the local field coordinator as the group is prone to infection (because of their sexual behaviour) therefore programme is targeted to them.

However, evaluation team felt that students take HIV/AIDS just like another topic like geography or English. Most of them see it as relevant for “others”, and not themselves. Some youth in Gulmi who are planning to study in Kathmandu after finishing the grade 12, did not foresee that they would get into situations away from home that might cause risk behaviour.

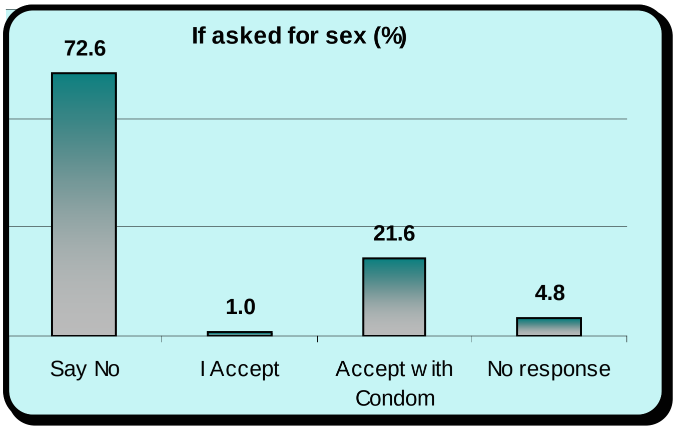
3.3 Risk behaviour of youth

While looking at the risk behaviour and free time activity, youth who participated in FGD and questionnaire, do not report any behaviour that can be termed as risky behaviour (Table 7: below). Almost all are non smoking, and no alcohol users. About six students reported of using drugs, and ten students reported that they look for sex worker in their free time but it is difficult to assess whether they mean by it and have fully understood the meaning of drug. The most popular free time activity for youth is watching cinema.

Many Teacher Sponsors (TS) felt that students got the information when they had developed a risky behaviour already. Many people also talked about the social change, with transition from a traditional society to the modern world. Inaccessible areas now have electricity and TV, people look at movies, commercials, the young people want modern clothes and most of them want to leave the country. As poverty increases the vulnerability for HIV transmission, this should be reflected in the programme designing as well. One TS said that information alone does not work well; it must be linked to income generation for the poor

When asked what they would do if proposed for sexual intercourse, the majority (72.6%) say they would refuse such proposal. 21.6% said that they accept having sex when using a condom. Although the students theoretically know how to get hold of condoms, it is not clear whether they would refrain from sex if condom is not available.

Box 2: If asked for sex



Perception and sexual practices among the youth in Table 8: below indicate that early sex and premarital sex is not very common. A small proportion of youths (6-7%) expressed that premarital sex is acceptable. The majority (17%) are in the view that sexual practices are likely to starts after the age of 20. About 4% of youth admitted they have had sex with their friends and this figure is in line with the data in 0 above where 21.6% of youth have expressed that they accept the request for sex with condom.

In some districts, where pre marital sex is more common, people said that it was not unusual that unmarried girls were using Depo Provera as contraceptive[1]. Whether a woman using such injectable contraceptive would insist of condom use with a partner is not known from our field study.

It was a common perception in the study areas that commercial sex work did not take place there at all. That was seen as a city phenomenon only. Although in Rasuwa district, many are aware that in certain parts of the districts girls were trafficked to Indian brothel.

3.4 Attitude and Behaviour

During the focus group discussion a responsive attitude was observed towards the issues of differences between boys and girls. In other words PEs were usually responsive to each other irrespective of the sex. Moreover, the self respect and self esteem of PE was found to be very high. “We were at times considered as a role model of a good student[2]”. As for the HIV/AIDS problem, many student see that HIV/AIDS is a problem for all people in the society (See Table 9: below in annex 8.4), although quite a few (19%) respondents see it as the problem of sex workers and migrants (12%).

Peer educators also have gained high respect from the community members and co students. But the adult attitude towards condoms is mixed (0 below). There is some fear among the adults that condoms promote immoral act or promiscuity.

[1] Example HM Gulmi District
[2] A student at Nilkantha Secondary School, Rasuwa

Box 3: Condoms and morality

Many teachers, including Teacher Sponsors, ostensibly shared how comfortable they are in teaching difficult topics like sex and sexuality in class after receiving trainers training from Red Cross. They also shared that now students can talk about condom use, are familiar about its advantage and can obtain condoms if needed. “Now in our community the occurrence of unwanted pregnancy or pre marital pregnancy is rare or virtually non existent, which used to be a serious problem in past” (Headmaster of Secondary School, Jibjibe, Rasuwa). Women used to suffer the most from the social stigma caused by unwanted pregnancy, making living in the society virtually impossible for the women. Social stigmas, branding such women as immoral and as witches were among the social responses to unmarried mothers. It now seems to be quietly accepted in the society that because of availability and use of condom such incidence is not surfacing. In other words sex outside marriage appears to be accepted indifferently. All these changes are attributed to condom use and availability of abortion facility relatively easily.

Condom promotion does face challenges, however. One example is how a health worker at a nearby government health facility complained to the headmaster of the school that some of the school boys from higher classes would regularly drop by the health facility to pick up condoms from the “condom box”. The headmaster took this complain very seriously as he saw this as promoting “immoral behaviour” among the students, which might distract them from their studies. The accused students were immediately summoned to the office and pocket searched for condoms. When condoms were found in their pockets, they were warned not to repeat this again. They were advised that they have not reached the point where they should be using condoms, and that this (*sex before marriage*) is immoral. The teacher proudly said to the evaluation team that after this event no such complain was heard again (*meaning that he was able to stop his students from performing an immoral act*).

This is a typical social response in Nepalese society when talking about condoms. Condoms, sex and morality are so inextricably linked that condom promotion often faces double standards from many people.

Clearly, simple training and technical knowledge alone is not enough to de-link the use of condoms from social (moral) values.

The attitude towards people living with HIV/AIDS, however, appeared generally positive among the respondents both in the FGDs and questionnaire (Table 10: below in Annex). FGD participants have not yet met any HIV positive persons, though they have heard or read about HIV positive person. In some areas teachers knew about girls coming back from work in India, and they were sick, and suspected that it was related to HIV/AIDS when they died. Some expressed their interest to meet the positive people and learn more from him/her to understanding more about HIV/AIDS. However, some TSs mentioned that they were unsure of how they would react, and in spite of their knowledge might be a bit cautious to be in close contact with a HIV positive person. But that they were not sure how they would react if they met any.

Most of the students and teachers in the schools report that they do not know any person with HIV in the community, and that it is only speculation. However, a TS in Rautahat told that they knew of two people with AIDS in the community. Lots of men from this area are labour migrants to Punjab (India). One man died after coming back, and later the widow fell sick. At an early stage there were negative attitudes, but then a PE went to the house for education. They arranged for the widow to be tested at the lab, and she tested positive.

Members of a women's group had heard that they can live up to 10 years after getting HIV. They expressed that this is not different from other aspects of normal life, as nobody knows about life and death anyway[3].

It is an interesting observation in Table 10 below: the majority was of the opinion that HIV status should be disclosed without citing any specific reason for their answer. The most positive aspect here is that only 2% suggested separate the HIV positive person from other people.

The higher cast students do not reach the lower cast youngsters with information. Given the fact that there were only 4.3% Dalit respondents in quantitative study (see Table 3: above), the views express do not necessarily represents the view of Dalit group. Besides, their number in the school is so low that neither they are selected as Peer Educator nor they have received any focused orientation. These are quite sensitive issues and Red Cross should give due emphasis to make the programme accessible to all caste group irrespective of their schooling status.

Box 4: Cultural Sensitivity

Cultural insensitivity
Rasuwa district is very close to Kathmandu both in terms of its economic activities and physical distance (six hours drive from Kathmandu). Tamang is the dominant ethnic population after Baun/Chhettri/Newar (BCN) group, but only five Tamangs from the district have completed their Bachelors Study.

There are 29 Secondary/lower Secondary Schools and good number primary schools all over the districts. Almost all the teachers except in Primary Grade are from the BCN group and mostly from other districts (Nuwkot, Lamjung, Gorkha, Kathamndu).

Tamang culture and marriage practices are different than that of other groups, which primarily gives rights of choice to women when it comes to marriage and access to parental property. Marriage practices, as summarised below are of particular interest for many.

If a boy or his parents see a girl that might be suitable for marriage, the first step is simply force the girl to elpe and keep her for some time in the family. During this period, the girl is given enough opportunity to understand the family, assess the suitability of the

[3] Women's Group member in Rautahat and Gulmi during FGD

boys and the whole family. In such a process, the girl and the proposed husband may have sexual intercourse and exchange of gifts. After undergoing this process, at the end, if the girl did not find this family suitable for her marriage, she could inform her family (or the family would find it out eventually) who would come and take her back home. On getting back in the family and society, she would be accepted without any prejudices, stigma or blaming her as *bigreko keti (immoral girl).* She could live her life as normally and can get married with any suitable boy she may find later. A small ritual might be performed to *purify* her.

This practice of the Tamang community is normally seen as bad practices by Baun/Chhettri/Newar teachers and government workers as they see this as promoting promiscuity and sexual indiscipline. This practice, as the BCN group sees it, is on the one hand promoting sexual immorality and on the other, spreading diseases like STIs and HIV/AIDS. Often the BCN group makes fun of this and try to sexually exploit the Tamang women.

This insensitive attitude and behaviour of those who are occupying key positions in schools and government offices towards a culture that has given liberty to women and no social stigma attached to the decision of women, unlike in the culture of the BCN group where a girl would be ostracized and become an outcast if such behaviour was found. The Tamang wedding practice is in some aspects more a democratic process and the most liberal attitude of the society towards honouring and respecting the decisions of women.

The attitude towards the Tamang women amongst teachers and government workers, is an obstacle to the empowerment of women and a development towards a stigma and discrimination free society - particularly for people living with HIV/AIDS.

3.5 Gender

Like many organisations in Nepal, NRCS also has male majority in decision making level. For example, the Central committee consists of four women and 26 men. As such, NRCS may be a reflection of the Nepalese society where “women traditionally have a lower status than men and gender inequality is deeply rooted”. More boys than girls receive education, women generally work longer hours than men, and men have better access to services, - including health services.

Among the teachers in higher secondary schools, we did not meet any female teacher sponsors, and in the lower secondary schools very few. However, among the informants in our study, it is a tendency to under communicating the importance of differences in status between males and females. This is particularly important when the main focus of the project is adolescents in their puberty.

The TS’s usually say that there is no difference in approach towards the male or female students and that they teach the children in the same way. “*There is no difference in teaching female or male students. We give the same information in the same class room*[4]”

[4] Interview with a male TS in Gulmi district

There is no problem in lower secondary school, as the students follow instructions and are disciplined. But there might be a difference in their understanding. Generally, the girls are shy and the boys are not, they may even be bold or rude. Still, sometimes TS divide the class in a female and a male group, to facilitate a freer discussion. They also emphasise that the teaching in these topics has passed through a change process from taboo, shyness and shame to openness and confidence. However, they seem to believe that the puberty is more difficult for females than males. In all the three districts, less female than male students continue beyond grade five in school, and traditions may keep a female student at home during her menstruation period.

Male TS also acknowledge that the social environment places stronger restrictions on females, and what it is possible for them to take part in, and some of them feel that this makes it more difficult for a female to be a TS or even a PE. “Females are dominated, they have more housework. They are restricted in movement, while boys move more freely. Many girls do not get the permit to visit another Red Cross programme. Only girls from a few progressive families are able to make such visits.

PE experiences in fulfilling their role are mainly positive, they gain respect from their fellow students, and often from their parents and teachers as well. This increases self esteem and confidence. However, as Nepal is an hierarchical society, this is also reflected in the PE group. It is more difficult for younger PEs to approach the older ones, and the male students tend to listen to female PEs. The male PEs does not respond that the female students do not want to listen to them. “The peer educators do not have problem in talking to boys or girls, but the boys are shy in talking to the girls[5].

3.6 Leadership

The process of JRC formation, orientation to the youth and JRC activity within and outside the schools provides opportunity for youth to improve their skills including the leadership skills. Every year the executive committee of JRC is elected in the school when students leaving school hand over their responsibility to the newly formed committee.

The HIV/AIDS programme has further added to their exposure. Peer Educators are selected mostly from among the JRC members. PEs are provided with various training and orientation either in district headquarters or outside. The added value of such training is the opportunity for the youth to develop networks with likeminded students groups. At times the PE is asked to teach a class during their free lessons, so that he/she can share views and ideas to their fellow students.

3.7 Communication Skills

Many PEs reported talking about HIV/AIDS in the community and outside the school in informal settings. Many PEs said they mostly interact with school students than outside fellows. In schools also it is more like a group teaching than one to one

[5] Female PE Rautahat district

talking. Peer Education is not like group teaching even though it is done by a Peer Educator. PEs are not shy to talk to others about HIV/AIDS and reproductive health issues. Prior to three days training they were not confident and comfortable to share their reproductive health problem to others. Many PEs expressed that they face a number of problems like parents disapproving of talking about HIV/AIDS, sex and sexuality, condom and so on; tricky questions from co students; difficulty in talking with higher age group; and lack of updated information.

The majority of respondents also reported that the teacher explains properly while teaching about HIV/AIDS and Reproductive Health issues by using different methods. Likewise many students seem to have talked about HIV/AIDS and related issues with friends and quite a few found the PEs are cooperative (see Table 11: below). It is however interesting to note that the majority of students (68%) have not visited any health post, whereas 66% reported that condoms ate readily available at the health post (see Table 6: below). Clearly, the students assume that condoms are available there even if they have not visited the health post.

3.8 Organisational Development

Implementation of HIV/AIDS and reproductive health programmes in the districts has contributed in many ways in organisational development of the Red Cross, both at district and central levels.

3.8.1 Stakeholders view

Stakeholders do have wide range of views and perceptions about the work of the Red Cross in the field of HIV/AIDS.

“NCASC would have liked to participate in this evaluation”[6]. NRCS has its own credibility, with networks, leaders and access to the communities. All NGOs should coordinate with the authorities to avoid duplication and get maximum output of the resources. The NCASC director had visited some of the JRC in the school and was impressed by their knowledge! For community based programs to work, they have to be comprehensive. Every age group, every ethnic group and both men and women have to be represented.

NANGAN (National NGO Association Against HIV/AIDS) see that NRCS work against discrimination by spreading correct messages. NRCS was involved at a very early stage and always come to the meetings. They play a vital role for the development of information, education and communication material. Where other agencies have a bad reputation for misusing funds (Dollar farming) NRCS is highly respected, especially in the time of conflict they bring the good NGOs into the limelight. Nepal plus (Organisation of HIV Positive People) however are not much aware about Red Cross activities. But they were positive to the fact that NRCS worked through the schools, and in rural areas. Most agencies work in the cities, as it is more difficult working in the rural areas.

[6] Director NCASC

Policy Project (USAID supported) is aware about NRCS activities like Condom Day, Mobilisation of Youth Circles, mandate by the government for blood transfusion and screening of blood. The strength of the Red Cross lies in being present at grassroots level and having access to people everywhere. They know about stigma and discrimination, and mobilise the community for tolerance for people living with HIV/AIDS.

The International Federation of the Red Cross, IFRC, believes that NRCS plays a leading role in national activities like condom day. The mainstreaming process has started within the organisation, and the departments are discussing how to improve integration. The conflict affects the HQ staff ability to monitor projects.

UNAIDS had hardly any idea about what NRCS is doing and wondering if NRCS knows what others are doing[7]. Coordination is needed, otherwise all interventions are fragmented. When it comes to protection, girls have zero chance of buying condoms. In addition to knowledge, they need empowerment, life skills and ability to say NO to peers. The objective is to give the correct knowledge. If the objective is behaviour change, this is wrong. We (UNAIDS) have a PE approach. Be a part of it. We have to move on in a coordinated way.

Swiss Development Cooperation (SDC), however, has different views about the Red Cross. They worry that NRCS is seen as an organisation for the elite, because traditionally only those economically better off could give their time, and were therefore able to be members of the Red Cross. It needs to evolve into a pluralistic and inclusive organisation by making enough provisions through which those who are excluded would find an entry to the organisation[8].

3.8.2 Image building

The image of the Red Cross as a Disaster Relief Organisation is now gradually expanding and people have seen the Red Cross genuinely committed for the cause of improving human life. It was general coherence in the perception that programmes relating to HIV/AIDS are on line with the Red Cross' humanitarian principles. The HIV/AIDS is seen as a humanitarian disaster, and this is fitting in well in the overall programme.

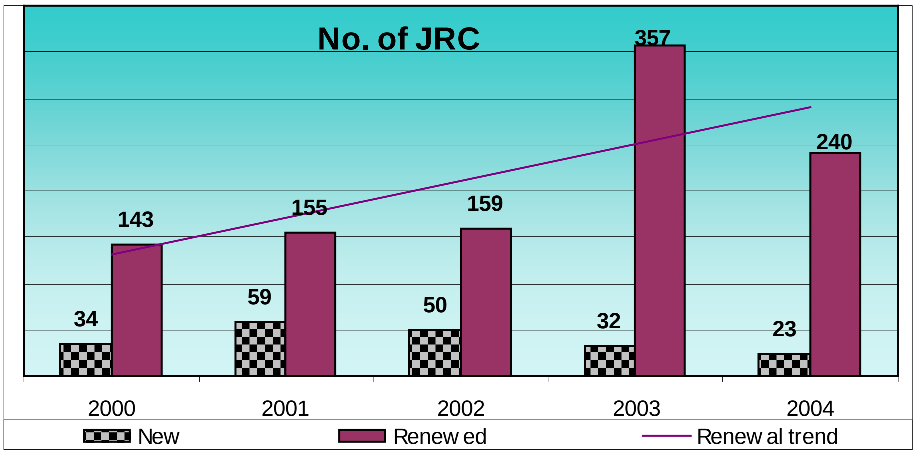
HIV/AIDS has a high priority in NRCS. The National Strategy is well established in the NRCS. A wide coverage is a high priority, but still many districts do not have external support. It is a dilemma on wide coverage versus high quality. The HIV/AIDS problem in Nepal is too big for one agency. Obviously the Government should be in the lead. But NRCS should be one of the few major actors in this field. NRCS can reach the communities through their extensive and well established network[9].

[7] UNAIDS representative during in depth discussion
[8] SDC representatives during in depth discussion
[9] View expressed by the DR during in depth discussion.

3.8.3 Formation of JRC

A number of new JRC have been formed and many old ones have renewed their affiliation (see 0 below). The foundation of the Red Cross as an institution is JRC through which Red Cross values and principles are propagated and volunteers are prepared to take an active role in Red Cross movements. Various projects implemented through the Red Cross District chapters reactivate the JRC and promotes Red Cross philosophy amongst the youth and others.

Box 5: JRC formation



3.8.4 Human resources

A good number of trained cadres on the HIV/AIDS issue are now formed in programme areas. HMs are generally motivated and allow the TS to carry out Red Cross supported activities. Similarly, Red Cross staff both at the district and central level has received training, attended various workshops within and outside the country, and have access to information. All this have contributed in creating a strong human resource base in the Red Cross. The challenge is to utilise this created human resource by creating opportunity to involve them.

District chapter members are trained and involved in project management, and there is an increasing realisation among the volunteers that a more *"professional approach is required at all levels, an altruistic and charity concept alone is not adequate if Red Cross truly wants to embark on development discourse*[10]*"*.

The Teacher Sponsors are mainly men. In general they report that they have personal motivation for the task as TS. They report that their teaching style has improved in quality following the RC training, they feel more comfortable in teaching often complex subjects like HIV/AIDS, reproductive health, sex and sexuality. Many TSs are very dedicated. Several of them started their RC career as a member of JRC, and is doing what they see as a humanitarian duty by being a TS. School and the teachers are very trusted and respected institution especially for illiterate parents. They trust and respect very much what goes on in the school.

[10] Red Cross Central Committee Member during in depth discussion at Chitwan

Most TS expressed need for regular support and supervision from the Red Cross. "After the initial TOT we are not contacted or visited by the district or central Red Cross people[11]".The role of TS as perceived by them varied a lot, many felt that their role is to receive and follow the instruction from Red Cross while other felt that they are to share knowledge with the students. Some TS (Rautahat) believe that mandatory HIV/AIDS testing is necessary to prevent further transmission of the disease.

Time management at times has become very difficult for TS, as their priority is to complete the prescribed course and prepare the student for exam. Therefore other activities get a lower priority.

4. Operational issues

4.1 Capacity

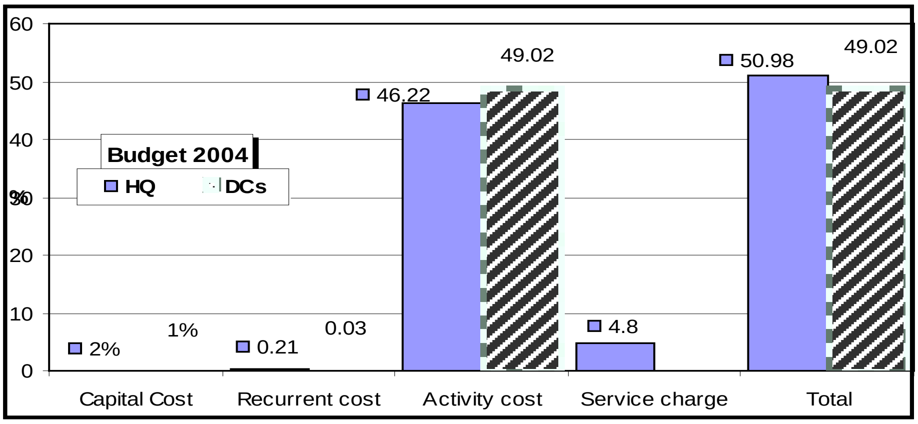
The capacity to manage the HIV/AIDS programme can be divided into three levels; school level, District level and HQ level.

At the school level, the local JRC, including headmasters and TS, appears to have a minimum capacity to run and continue the Peer Education programme through the Junior Circle Mechanism. In the seven districts, as for the human resources, large numbers of TS have received TOT; many headmasters have participated in one day seminars, and district Red Cross chapter members have participated in central level planning and other events. All this should provide sufficient basis to carry out the programme with minimal external support from Red Cross HQ. But at the district level lack of adequate fund raising skills and opportunity; dedicated staff and volunteer for HIV/AIDS related activities and presence of other competing priorities would make it difficult to sustain HIV/AIDS programming. Apart from this, a critical awareness on gender, sex and morality as well as an appreciative and empathetic attitude needs to be further strengthened.

Looking at the budgetary allocation pattern, the total resources available from NRC seems to have been distributed almost equally between Central and District management. Although activity costs are a little higher at the district level, capital costs, recurrent costs and service changes are only available for HQ. For the programme whose ultimate focus is at the district level, the budget pattern appears to be biased towards HQ.

[11] TS in Rautahat (Bastipur Secondary School) and Rasuwa (Nilkantha Namuna secondary school, Jibjibe)

Box 6: Budget allocation pattern 2004



During internal discussions with officials at HQ and Districts, there is an interest to move beyond awareness raising activity to more complex activities like care and support. The existing capacity of the Red Cross needs substantial improvement to move beyond awareness raising activities in the complex area of HIV prevention and care.

4.2 Sustainability

The programme is subtly linked with JRC at the school. Therefore, theoretically, as long as there is JRC in the school, this educating process should continue. Many headmasters are positive and have seen the benefit of the affiliation with the Red Cross both for the student and the school – particularly in the present armed conflict situation – though their understanding about the role and responsibility of Teacher Sponsors is limited. Therefore, the headmasters and the TS are willing to continue the activities.
It was envisioned that once TS are trained; they would include PE as regular extra curricular activity in the school annual calendar. Even if the cost of organising a two-day PE training at the school level is very minimal, most schools are not able to afford this amount. Moreover the schools are not allowed to raise additional funds due to Nepal Communist Part (Maoist) pressure, therefore the resource base of many schools is very poor at the moment. JRCs do not have any funding source except the little amount collected as and when required for any specific activities. Senior executives in the districts (except Rasuwa district) and HQ expressed that they will continue some minimal activities on HIV/AIDS and reproductive health, even if external funding is not available.However, none have developed any contingency or alternative plan towards this, making the likelihood of translating this wish into action minimal. JRCs wanted some kind of continuity from the Red Cross (District or HQ) in terms of supervision, supply of material for education, information and communication, and published material like *Yuva Chautari* and refresher training.

Sustainability needs to be seen not just as whether or not activities are continued at the school level. It is also important to see whether or not benefits are sustained and behaviour is changed among the youth to whom the programme is targeted. From this perspective, the knowledge and skills acquired by the youth are likely to remain and influence them for safer behaviour even after they graduate from the school. The most important for the youth is to have regular opportunity and mechanisms to update and reinforce their knowledge, skills and behaviour. Once the students complete their school education, the opportunity and mechanisms for updating information is often limited in a rural setting.

The Secretary General of NRCS stated that sustainability does not mean that NRCS should employ all field staff. The stakeholders have to sustain the programmes. It doesn't mean that they have to keep a large number of staff. This was compared with the drinking water project, it is the drinking water that is to be sustained, not all the staff needed to construct the pumps. So the project staff should not need to be sustained for HIV/AIDS either[12].

4.3 Monitoring and Evaluation

Activity and events are well reported, financial matters are closely monitored, but programmatic monitoring and supervision from HQ and district at the school level is weak. Many TS (Rautahat and Rasuwa) reported that visits from the Red Cross (District and HQ) are very few, they visit only during the training period. TS also said that the Red Cross district chapter do not give timely information.

During the training period for Peer Educators, pre and post test questionnaires are filled in and analysed. However, afterwards the PEs are never checked again to see whether they have any problems once they have started educating their colleagues. Beside, there is no mechanism (formal or informal) at all to measure the changes among the youth. In one case of visible risky behaviour, PEs exerted pressure on their colleague, forcing him to change his bad habit of smoking.

4.4 Programme Management

The programme approach is fairly standard to all districts. The blanket approach is good for programme implementation and management from central level, but may not be useful at the district level. For example, in Rasuwa the same 20 schools are in the programme and are receiving similar programme every year for three years. Some PEs have received the same training 3 times in last three years period.

[12] Secretary General, Nepal Red Cross Central Office – during in depth discussion

5. Lessons learned

5.1 Peer to peer

Peer Education is primarily based on the principle that a peer can interact more easily and informally with another peer in order to promote safer behaviour than teacher or any other outsiders. Peer Education has been mainstay of the Red Cross HIV/AIDS prevention programme for many years now. Red Cross has a long experience of working with school youth applying PE approach to empower the youth for safer behaviour.

The PE approach is well established for high-risk behaviour groups (SWs, IDUs) for the prevention of HIV/AIDS and behaviour change communication. Response to high-risk behaviour (CSW, IDUs, Group with multiple sex partners) in Nepal is well researched and documented, and is closely monitored through yearly behavioural surveillance. But well researched and documented experience on PE approach is inadequate when it comes to youth and the general population. Knowledge of their sexual patterns and the extent of risk behaviour is not well established.

Nonetheles, so far two major lessons have been learned - PE has been used as a “Group teaching approach as opposed to empowering approach” and as Awareness programme with “one off event” focused rather than a continuous process.

Most importantly continuous interaction between PEs and other student as well as between PE and TS is very minimal. Once the two days PE training at the school finished there was no evidence that PE were regularly met, encouraged or monitored by the TS or the Red Cross. On the whole, the school attendance of Dalit and the deprived is very low, therefore they do not get an equal share of the benefits from the school and current PE approach. They need a programme that is not school based. Nevertheless, there is increasing community acceptance for the youth to talk about sex and sexuality, condom use and reproductive health issues.

Youth as direct beneficiaries is well achieved, but youth as vehicle for change not fully achieved. Despite some constraints, they feel pride in carrying out the PE activities. Constraints are related to mobility (girls are not allowed freedom of movement), parents not approving of the work as PE, and lack of updated information. However, for many PEs are the source of information about HIV/AIDS and reproductive health.

Box 7: The quest for information

Excerpt of a letter from an adolescent
"I have studied manuals, booklets and *Yuba Chautari* developed by the Red Cross for adolescents and youth, which I had chance to borrow from my friend. The materials are very useful for an adolescent like me. I would like to go through all the materials in detail and want more information. Please tell me, how I can receive all the materials developed by your office. Please enter my name and address in your mailing list. I am eager to receive every piece of the published materials."

Thank you very much
Pradip Ban, Wamitaxar, Gulmi

5.2 Early in reaching youth

Government was in a process to revise its school curriculum, with the aim of changing it into a life skills based curriculum. This process is now completed and is about to be implemented throughout the country in a phased manner. Since the Red Cross has already started a HIV/AIDS and reproductive health programme based on life skill education before the government, this has already prepared many schools for new intervention. The teacher TOT is also based on this principle. Therefore, those teachers who have participated in Red Cross TOT are already aware of and skilled in the subject. When government finally introduce this system, it will be much easier for the trained teacher to implement the new curriculum. This would be an opportunity for the Red Cross to move to a different level of support and programme implementation.

5.3 Standard approach

Despite the fact that access to and flow of information, teaching/learning environment and general orientation of students and teachers varies between districts and schools, there is very little variation in knowledge, attitude and skills among the students of those schools. Clearly, the NRCS standard approach that has the same level of input has contributed to reach this situation. Even so, the standard approach has faced some problems – mainly on administrative matters (e.g. travel allowances has not bee adequate for school supervision) – and offer a limited scope for innovation and new ideas.

5.4 Comprehensiveness

Questions dropped at Query boxes and informal interaction with youth revealed that youth wanted to know more on issues related to reproductive health than just about HIV/AIDS. This includes the social dimension of sex and sexuality, social response and their own preparation (and presentation) for changes. Clearly youth demand a comprehensive mechanism which can help addressing their diverse need. Approaches that support a holistic view to HIV/AIDS, sexual and reproductive health is essential – and also in high demand among the youth. In addition to this, youth prefer to remain active and always in search of opportunity, motivation and social recognition for what they do. Many young people were worried about how they would continue working with the Red Cross after they finish school and leave junior circle.

Box 8: Query – some samples

Queries of youth

Dropped in a Query Box at Shree Nilkantha Namuna Secondary School, Jibjibe, Rasuwa

- Is STI cured if you have sex during menstruation?
- Can you get STI by being bitten by a witch?
- How do you have sex with man to man or woman to woman?
- When is puberty and why?
- Demonstrate how to use a condom.
- Can you get sexual satisfaction through animal?
- Why do female breasts grow?
- Why do not male breasts grow?
- What are the disadvantages of pre marital sex?

6. Recommendations

Definition and application of the Peer Education approach needs to be redefined, making it a more interactive and continuous process. This is a good opportunity for the Red Cross to establish a firm working modality on PE for school youth and community youth. Since the school based PE inherently is limited to reach the school attending youth, a separate arrangement needs to be worked out to intervene at the community level.

Gender equity and equality within the wider context of NRCS institutions at policy level and other levels is a major concern that needs serious consideration so that more female members can join in the executive committees at central and district levels. In addition to this, more female teachers should be promoted to join the programme as TS. This effort would greatly enhance the girls' participation there by increasing the overall impact of the programme. More specifically, there is a need for sensitisation workshops among district chapter members, teacher sponsors, peer educators and their target youth on gender equity and what it means in practice.

The HIV programme appears to be an isolated activity in the districts, despite the fact that number of different events (Junior Red Cross meetings, HIV/AIDS orientation) are held at the same time with the same group of youth within a different programme (e.g. Community Based First Aid Programme, Community Development Programme). This opportunity to integrate HIV/AIDS activities into other programmes, should be taken maximal advantage of.

Progress Monitoring mainly revolves around activity reporting. Reporting in a standard format that measures the progress against the indicator set in the programme document is necessary to ensure that project is producing the result as initially envisaged. Furthermore, there is no systematic way of monitoring the behaviour of youth. It is essential to develop a monitoring system which do not only keep track of activities but also assess the results.

For this monitoring mechanism, a two levels approach is necessary:

> Youth level or PE level to monitor the changes, even the minor ones, would be of significant value. Measuring changes not only in risk behaviour, but also on other personal behaviour such as leadership, communication skill, temperament and risk taking tendency is necessary. This kind of monitoring is best done by the youth themselves, if they are equipped with skills and tools. This should be part of the programme implementation where youth should be trained in participatory monitoring and evaluating skills and tools. This not only helps monitoring the changes; the process itself is empowering to the whole group.
>
> Secondly, monitoring at programme level also needs improvement, it should not limited to financial and activity reporting. The field coordinator should be responsible for collecting and compile data and forward it to HQ. HQ should make field visit as often as possible.

Linkages between this project activity and the South Asia Red Cross/ Red Crescent Network on HIV/AIDS (SARNHA) is not visible, although informal relationships and consultations appears to exist. Opportunities to strengthen the projects linkage to SARNHA needs to be taken full advantage of.

Distribution of information, education and communication material is weak, particularly regarding the Red Cross magazine for youth – which is very popular. Distribution from HQ to District chapter is relatively smooth but from District to the respective schools distribution is not systematic. Since this is a popular newsletter among the youth, distribution mechanism should be efficient. The District Education Officer would probably be the best channel as someone form school invariably come to this office (to collect salary or submit reports), and should be able to take back the newsletter to the respective school.

Exit plans needs to be developed from the start of the projects so that District Chapters and Schools can be oriented and prepared towards this in order to develop a plan for continuing the project after the withdrawal of external funding. Exit plan does however not mean termination of all activities and relationships – it is to move to next stage of development.

Conflicts of different nature and magnitude is likely to remain as a part of the development cycle. While designing future intervention, possible conflict situations therefore needs to be taken into consideration, and conflict management should be a cross cutting issue in all field and training activities – including PE training at the school level.

In the current situation, the Government is developing a school curriculum aimed at integrating life skills and reproductive health in an extensive way in the schools. NRCS has been in the forefront of the in-school approach, and should be proactive in planning changes to their programme. If the programme inside the schools will be taken care of by the teachers directly through the government support in the future, NRCS might want to look at ways for reaching the out-of-school youths, those who drop out or other vulnerable groups.

Annexes

Annex 1: Selected readings

Development Resource Centre (2000) A Study on knowledge, attitude and practice concerning HIV/AIDS, STDs and RH among the adolescents/youth of four districts, Gulmi, Rasuwa, Rautahat and Surkhet. Baseline survey report. Nepal Red Cross Society, Kathmandu

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Nepal Red Cross Society (1999), Project document in NORAD format (internal document).

NRCS (2003), Fourth Development Plan 2003-2007

NRCS (2004) cooperation Agreement Strategy 2004-2006

NRCS Junior/Youth Red Cross Department (2001) Programme Operational Guidelines. Nepal Red Cross Society, Kathmandu.

NRCS: Annual Reports for the year 2000, 2001, 2002, 2003 and six monthly report for the year 2004. (Internal document)

Annex 2: TOR

Terms of Reference
External Final Evaluation
HIV/AIDS Prevention and Reproductive Health Project
(25 September 2004)

1. Background:

Nepal Red Cross Society (NRCS) in co-operation with Norwegian Red Cross (NRC) has been implementing HIV/AIDS Prevention and Reproductive Health Project since 1995. The first phase of HIV/AIDS Project was implemented in Nawalparasi, Dang, Accham, Dhading, Morang, Sunsari and Jhapa district from 1995 to 1999. A project was signed between NRCS and NRC to implement project in seven districts namely, Bara, Rautahat, Dailekh, Surkhet, Gulmi, Arghakhanchi and Rasuwa from 2000 to 2004.

A baseline study was carried out in 1999 to assess knowledge, attitude and practices of adolescent/youths regarding Reproductive Health issues and HIV/AIDS. The project was designed based on the needs identified by the local adolescents/ youth and community people.

A mid term self evaluation of the Project was carried out in the month of March 2002 with the objectives of assessing whether the activities carried out under the HIV/AIDS Prevention and RH Project are directed towards meeting the objectives as laid down in the project document.

In the mid of the year 2003, NRCS and the Norwegian Red Cross agreed to expand the HIV/AIDS Prevention project in five new districts (Bhajang, Nuwakot, Parsa, Taplejung and Bhojpur) for the initial period of two years that is from 2004 to 2005, whereas it was also agreed to continue the old project districts for one year (up to December 2004) as the follow-up project.

The aim of evaluation is to determine the effectiveness, impact, sustainability and relevance of the project in accordance with the NRCS guideline and strategy.

Goal:

To improve HIV/AIDS and reproductive health situation and promote self-esteems of adolescent /youth and strengthen institutional development of Junior/Youth Red Cross.

Objectives:

- To promote adolescent/youth, and community women's access to information about HIV/AIDS, and reproductive health,
- To promote communication skills among adolescent/youth, and women groups to empower them to play active role in social decision,

- To build up institutional capacity of the Junior/Youth Red Cross and sub chapter though training and professional development activities.
- To practice planning, monitoring, evaluation and transfer in to action.

Expected Results:

- Adolescents/youth, women and community concerned at large will have accepted the HIV/AIDS issues positively,
- Adolescents/youth of the project area will have applied assertive skills of communication,
- Adolescents/youths and community women will have practiced and promoted safer behaviors regarding Prevention of HIV/AIDS,
- District Chapters will have been equipped with trainers, managerial skills to continue and sustain the project activities.
- Institutional capacity of Junior/Youth Red Cross will have been strengthened to continue major project activities,
- The Nepal Red Cross Society, National headquarters will have been equipped with capacity of collaboration and resources.

2. Coverage of the project

The coverage of the project is as follows:

Districts	No of schools	No. of communities	No of schools selected for evaluation	Women group
Rautahat*	60	4	8	1
Bara	60	4	None	None
Rasuwa*	20	5	5	1
Gulmi*	60	4	8	1
Arghakhachi	60	4	None	None
Surkhet	60	5	None	None
Dailekh	60	4	None	None

* Districts selected for evaluation. Rasuwa represents high hills, Gulmi represents hill and Rautahat represents terai. The particular schools and women groups to be identified by the District committee.

3. General Objective of the Evaluation

The objectives of the evaluations are as follows;

- A general assessment of projects achievements in terms of capacity building at local communities, reduction of HIV/AIDS vulnerability among target groups, effectiveness (including Cost-effectiveness), sustainability and advocacy.
- A general assessment of capacity building at the district chapter, sub chapter level of NRCS and the community.
- An assessment of the degree of coordination and collaboration with relevant agencies of the government, NGOs and INGOs.

4. Scope of work

The scope of work shall be a systematic and objective assessment of the design, implementation and result of the project, and more specifically focus on the following areas:

a. To assess the achievement of the project in relation to objectives and results as identified in the project design and in relation to the human and financial resources utilized.
b. To assess the relevance of the project in relation to priorities and policies from NRCS and NRC.
c. To assess the relevance and appropriateness of project strategies, approaches and activities in relation to the needs and priorities as perceived by the beneficiaries and to what extent the vulnerability of the target population has been reduced, and its cooping capacity increased.
d. To assess whether and how effectively the project has managed to address the gender issues.
e. To assess the Peer Education process in terms of mechanism, frequency and coverage by the peer educators. Also make an assessment of limitation of peer education/educators in changing the behaviour of youth.
f. To what degree has bottom-up and participatory approaches been implemented. Also make an assessment of social attitude as to how the community are supporting or hindering the behaviour changes among the youth.
g. To assess the sustainability of the projects activities, including an assessment of to what extend any changes produced by the project can continue in NRCS and in the target population after external, technical and financial support has ended.
h. To assess the present capacity of project management, centrally and decentralized, NRCS especially concerning:
- Management system and tools, such as activity plan, quarterly and annual reports etc
- Effectiveness of the project management system at central, district and community levels.

3.10 To assess to what extent national and district level collaboration has been established and degree of cooperation between different national level and district level organizations.

5. Methodology

This assessment will use both primary and secondary information. The evaluation will apply both quantitative and qualitative data. The base line survey data will be utilized as a benchmark to assess the achievements and impacts of the project. For the primary information, basically, participatory tools will be applied. In particular, participatory tools, like questionnaire schedule, focus group discussion and interaction with respondents and key informants (like peer educators, health service providers, school headmasters, parents, teacher sponsors, RC representatives, and opinion leaders) and in-depth interview for some case studies, will be carried out to collect the intended information.

Out of seven project districts, four districts will be selected purposively on the basis of geographical and socio-cultural characteristics. The four proposed districts for evaluation are Rautahat, Rasuwa, Gulmi and Surkhet.

Meetings, Interviews and discussions with NRCS officials including chapter and sub-chapter members, local authorities, International and National organizations working on district level should be performed in a participatory manner.

Details of the Key respondents:
In total the respondents of the evaluation will be as follows:
- Junior/Youth members of 6 schools x 20 peer educators in each district, and in total 480 J/RCY members.
- Teacher sponsors 6 in each district in total 24 persons
- District Chapter Volunteers and staffs (10 in each district) in total 40 persons
- Other stakeholders (District Public Health Officer 1, District Hospital chief -1, District Development Committee Chief - 1, Health post/Sub health post chief- 2, other NGOs representative - 2; in total 7 in each district.
- Community Youth(out of school) 10 in each district total 50 persons
- Community leaders and parents 10 persons in each district and in total 50 persons

6. Output
The output of the final evaluation shall be a written report containing findings and recommendations. The report should include an executive summary containing a summary of the findings and recommendation of the evaluation.

The draft report will be submitted to NRCS HIV/AIDS Prevention Project, who will send the draft report to Norwegian Red Cross Regional Coordinator (Asia Pacific) for comments. Equally, the report will be shared among departments and South Asia Regional Network on HIV/AIDS (SARNHA) for comments and feedback. Additions and comments will be sent to the Final Evaluation Team Leader where he/she will finalize the report. Then the final report submitted from the consultant will be submitted to NRC regional coordinator (Asia Pacific).

The report should be presented on the following format
- Executive summary
- Study methodology
- Findings
- Recommendations
- Operational issues
- Lessons learned
- Case studies
- Annexes, if any

7. Composition of the Study Team
Study team will be composed of 5 persons (preferable at least 2 women):
Team Leader - 1 person
Field researchers - 4 persons

Observer of NRCS - 5 persons (one from the HQs to each district and one form each district chapter)
Observer from NRC (yet to be finalized) - 1 person

8. Supporting Documents
The relevant documents to be consulted and largely dealt with for compatibility with NRCS principles and policies:

a) NRCS HIV/AIDS National strategy 2004-2008
b) Policy and Procedures of HIV/AIDS Prevention and RH programme
c) Report submitted to NORAD
d) Baseline survey reports
e) Progress reports, plans, budget and audited reports of the HIV/AIDS Prevention project
f) Mid term evaluation report 2002
g) NRCS Development Plan
h) Cooperation Agreement Strategy (2004-2006) of NRCS
i) Others: Recent evaluation reports from HIV/AIDS Prevention and RH programmes

9. Timing and Reporting
The evaluation period will be from the 1st of November till the end of December 2004.

The fieldwork will be carried out from the beginning of the 2nd week of November 2004 till the end of the 4th week of November 2004 (12 days including travelling to and from the project area and district headquarters).

Draft report will be submitted by the external consultant to NRCS, HQs and NRC Regional Coordinator(Asia) on 2nd week of December 2004. Comments, Feedbacks and suggestions will be given over the report up to the end 3rd week of December 2004. The consultant will submit the final evaluation report at the end of 4th week of December 2004.

The report will be in English and 5 copies of final reports should be submitted along with diskette to NRCS.

The actual working days for the evaluation are as follows:
5 days preparation work for field visit including orientation work to the field researchers.
12 days fieldwork in project district (3 days in each districts)
12 days travel from Kathmandu to districts to Kathmandu (two days to Rautahat, two days to Rasuwa, Four days to Gulmi and Four days to Surkhet)
7 days for the preparation of draft report
3 days for submission of comments and feedback and submission of final report

10. Budget
(to be defined)

Annex 3: People met

(Please also see Table 1: above)

Kathmandu

Red Cross

1. Secretary General, Nepal Red Cross Society
2. Member central executive committee – NRCS
3. Director, Junior youth Department
4. Team (8)- HIV/AIDS programme management

Stakeholders

5. Director, NCASC, Ministry of Health
6. NCASC
7. Country Programme Advisor, UNAIDS
8. Leader, Policy Project
9. Team (5) – NANGAN, Kathmandu
10. Nepal Plus
11. Swiss Development Cooperation, Kathmandu
12. Federation Delegates, Kathmandu

District people

13. Red Cross Members- District Chapters (Rasuwa, Rautahat, Gulmi)
14. District AIDS Coordination Committee members (Rauthat -3, Rasuwa-2)
15. Headmasters
16. Teacher Sponsors

Annex 4: Quantitative Tables

Table 4: Knowledge and source of information on HIV/AIDS

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
Heard about STIs and HIV/AIDS								
Yes	151	96.8	217	97.3	200	97.6	568	**97.3**
No	4	2.6	3	1.3	1	0.5	8	**1.4**
Missing	1	0.6	3	1.3	4	2.0	8	**1.4**
Total	**156**	**100.0**	**223**	**100.0**	**205**	**100.0**	**584**	**100.0**
Source of information								
Radio	79	19.4	116	20.1	100	16.0	295	**18.3**
TV	47	11.5	56	9.7	88	14.1	191	**11.9**
Magazine/newspapers	47	11.5	67	11.6	75	12.0	189	**11.7**
Peer Educators	87	21.3	112	19.4	98	15.7	297	**18.4**
Family members	15	3.7	46	8.0	53	8.5	114	**7.1**
Health workers	56	13.7	71	12.3	75	12.0	202	**12.5**
Teacher	71	17.4	109	18.9	132	21.1	312	**19.4**
Others(specify)	6	1.5	1	0.2	4	0.6	11	**0.7**
Total	**408**	**100.0**	**578**	**100.0**	**625**	**100.0**	**1611***	**100.0**
How HIV is transmitted								
Unsafe sex	140	24.3	207	25.6	188	25.3	535	**25.2**
Use of body piercing tools	146	25.3	202	25.0	185	24.9	533	**25.1**
Infected blood	144	25.0	201	24.9	182	24.5	527	**24.8**
Infected mother to child	146	25.3	198	24.5	187	25.2	531	**25.0**
Total	**576**	**100.0**	**808**	**100.0**	**742**	**100.0**	**2126***	**100.0**
Preventive measures								
Safe sex	145	35.0	198	34.7	186	35.1	529	**34.9**
Use of sterilised tools	121	29.2	178	31.2	161	30.4	460	**30.4**
Safe (tested) blood	148	35.7	195	34.2	183	34.5	526	**34.7**
Total	**414**	**100.0**	**571**	**100.0**	**530**	**100.0**	**1515***	**100.0**
Knowledge on symptoms of AIDS								
Fever > 1 months	141	35.2	195	34.8	178	34.4	514	**34.8**
Diarrhoea >1 months	112	27.9	156	27.9	151	29.2	419	**28.3**
Weight loss	141	35.2	199	35.5	182	35.1	522	**35.3**
Don’t know	7	1.7	10	1.8	7	1.4	24	**1.6**
Total	**401**	**100.0**	**560**	**100.0**	**518**	**100.0**	**1479***	**100.0**

Note: * Multiple answers: “missing’ = no response from the student in that particular question

Table 5: Knowledge on Reproductive Health

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
Female reproductive organ								
Testes	14	8	14	6	17	7	45	**7**
Uterus	140	82	188	85	181	78	509	**81**
Penis	6	4	6	3	10	4	22	**4**
Spermatic cord	8	5	6	3	21	9	35	**6**
Don't know	3	2	8	4	3	1	14	**2**
Total	**171**	**100**	**222**	**100**	**232**	**100**	**625***	**100**
Male reproductive organ								
Testes	62	31	75	34	113	40	250	**36**
Uterus	4	2	0	-	4	1	8	**1**
Penis	106	54	90	41	114	40	310	**44**
Spermatic cord	24	12	47	21	51	18	122	**17**
Don't know	1	1	10	5	3	1	14	**2**
Total	**197**	**100**	**222**	**100**	**285**	**100**	**704***	**100**
Changes during adolescence								
Enlargement of breast	124	19	194	21	191	21	509	**20**
Hair growth at private parts	144	22	203	22	196	21	543	**22**
Shyness	122	19	145	16	157	17	424	**17**
Moustache growth	132	20	185	20	186	20	503	**20**
Height gain	136	21	193	21	183	20	512	**21**
Total	**658**	**100**	**920**	**100**	**913**	**100**	**2491***	**100**
Feeling during menstruation								
Too much worry	4	7	18	16	21	21	43	**16**
It is natural, no worry	40	70	65	58	66	65	171	**63**
Don't know	13	23	30	27	15	15	58	**21**
Total	**57**	**100**	**113**	**100**	**102**	**100**	**272**	**100**
Feeling in wet dream								
Too much worry	14	15	4	4	12	14	30	**11**
It is natural no worry	62	67	52	51	65	76	179	**64**
Don't know	17	18	46	45	8	9	71	**25**
Total	**93**	**100**	**102**	**100**	**85**	**100**	**280**	**100**
Right marriage age for girls								

< 20 years	32	21	19	9	38	19	89	**15**
20 – 25 years	119	76	197	88	162	79	478	**82**
Missing	5	3	7	3	5	2	17	**3**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Right age for child birth								
< 20 years	34	22	31	14	43	21	108	**18**
20-025 years	110	71	160	72	138	67	408	**70**
25-30 years	9	6	16	7	11	5	36	**6**
30-35 years	0	0	4	2	2	1	6	**1**
> 35 years	0	0	1	0	0	-	1	**0**
Missing	3	2	11	5	11	5	25	**4**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**

Table 6: Availability of condoms

Variables	**Rasuwa (N=156)**	**%**	**Gulmi (N=223)**	**%**	**Rautahat (N=205)**	**%**	**Total (N=584)**	**%**
Is condom easily available in your area								
Yes	100	64	152	68	163	80	415	**71**
No	51	33	55	25	22	11	128	**22**
Missing	5	3	16	7	20	10	41	**7**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Where do you get condom								
Health post	91	77	122	75	112	52	325	**66**
Drug shop	18	15	31	19	64	30	113	**23**
Other shop	2	2	4	2	23	11	119	**6**
Peer Educator	7	6	5	3	15	7	27	**5**
Total	**118**	**100**	**162**	**100**	**214**	**100**	**584**	**100**

Table 7: Risk Behaviour of youth

Variables	**Rasuwa (N=156)**	**%**	**Gulmi (N=223)**	**%**	**Rautahat (N=205)**	**%**	**Total (N=584)**	**%**
Smoking Habits								
Yes	2	1	3	1	0	-	5	**1**
No	148	95	188	84	203	99	539	**92**
Missing	6	4	32	14	2	1	40	**7**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**

Alcohol habit								
Yes	5	3	4	2	2	1	11	**2**
No	145	93	186	83	201	98	532	**91**
Missing	6	4	33	15	2	1	41	**7**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Drug abuse								
Yes	2	1	3	1	6	3	11	**2**
No	148	95	186	83	197	96	531	**91**
Missing	6	4	34	15	2	1	42	**7**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Cinema view at free time								
Yes	69	44	68	30	92	45	229	**39**
No	83	53	129	58	111	54	323	**55**
Missing	4	3	26	12	2	1	32	**5**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Playing Card								
Yes	13	8	12	5	4	2	29	**5**
No	136	87	176	79	199	97	511	**88**
Missing	7	4	35	16	2	1	44	**8**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Look for sex partners								
Yes	4	3	4	2	2	1	10	**2**
No	140	90	175	78	201	98	516	**88**
Missing	12	8	44	20	2	1	58	**10**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**

Table 8: View on sexual practices

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
Premarital sexual relation for women								
Correct	19	12	6	3	8	4	33	**6**
Incorrect	129	83	206	92	194	95	529	**91**
Missing	8	5	11	5	3	1	22	**4**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Premarital sexual relation for men								
Correct	27	17	6	3	9	4	42	**7**

Incorrect	116	74	192	86	183	89	491	**84**
Missing	13	8	25	11	13	6	51	**9**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Age at which sexual relation is likely to take place								
Don't Know	88	56	140	63	79	39	307	**53**
< 14 years	5	3	4	2	10	5	19	**3**
14-16 years	24	15	17	8	11	5	52	**9**
16-18 years	16	10	18	8	17	8	51	**9**
18-20 years	10	6	9	4	18	9	37	**6**
> 20 years	10	6	23	10	68	33	101	**17**
Missing	3	2	12	5	2	1	17	**3**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Have you had sexual contact								
Yes	17	11	2	1	4	2	23	**4**
No	139	89	218	98	200	98	557	**95**
Missing	0	0	3	1	1	0	4	**1**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
If yes, who was your partner								
Girl/boyfriend	14	82	1	50	3	75	18	**78**
Sex workers	2	12	0	-	0	-	2	**9**
Unknownperson	1	6	1	50	1	25	3	**13**
Total	**17**	**100**	**2**	**100**	**4**	**100**	**23**	**100**
Was that sexual contact with consent								
Yes	16	94	2	100	3	75	21	**91**
No	0	0	0	-	0	-	0	**-**
Missing	1	6	0	-	1	25	2	**9**
Total	**17**	**100**	**2**	**100**	**4**	**100**	**23**	**100**

Table 9: Perception of risk groups

HIV/AIDS is whose problem	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
Our problem	108	64	137	55	135	56	380	**57**
Women's problem	4	2	3	1	14	6	21	**3**
Sex workers'	29	17	58	23	40	17	127	**19**
Drug addicts'	13	8	24	10	16	7	53	**8**
Migrants	16	9	27	11	37	15	80	**12**
Total	170	100	249	100	242	100	661*	**100**
High risk groups for HIV transmission.								
IDUs	128	26	181	28	158	25	467	**26**
Sex workers	140	29	186	28	182	28	508	**28**
Sex outside marriage	137	28	190	29	180	28	507	**28**
Migrants	36	7	58	9	65	10	159	**9**
MSM	49	10	40	6	57	9	146	**8**
Total	490	100	655	100	642	100	1787*	**100**

Note: * multiple answer

Table 10: Attitude towards PLWHAs

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
HIV status disclosure								
Should disclose	131	84	197	88	188	92	516	88
No need to disclose	1	1	3	1	4	2	8	1
Don't know	21	13	20	9	6	3	47	8
Missing	3	2	3	1	7	3	13	2
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Behaviour toward PLWHAs								
Keep in the	137	70	192	67	172	64	501	67

family with love								
Keep in rehabilitation centres	49	25	75	26	92	34	216	29
Keep separate	5	3	5	2	3	1	13	2
Don't know	2	1	5	2	2	1	9	1
Others(specify)*	3	2	8	3	1	0	12	2
Total	**196**	**100**	**285**	**100**	**270**	**100**	**751****	**100**

** No discrimination, sharing experiences of others*
*** Multiple answers*

Table 11: Quality of services and support

Variables	Rasuwa (N=156)	%	Gulmi (N=223)	%	Rautahat (N=205)	%	Total (N=584)	%
While teaching about HIV/AIDS, teacher								
Explains properly	93	49	137	44	141	52	371	**48**
Ask us for self study	10	5	21	7	15	5	46	**6**
Uses different methods	86	46	147	48	117	43	350	**45**
Other(specify)**	0	0	4	1	0	-	4	**1**
Total	**189**	**100**	**309**	**100**	**273**	**100**	**771**	**100**
Ever talked with friend about HIV								
With school mate	130	76	200	80	169	65	499	**73**
With friend outside school	39	23	48	19	74	29	161	**24**
Other(specify)***	2	1	1	0	16	6	19	**3**
Total	**171**	**100**	**249**	**100**	**259**	**100**	**679**	**100**
Behaviour of Peer Educator								
Cooperative	94	60	186	83	163	80	443	**76**
Just OK	55	35	29	13	34	17	118	**20**

Uncooperative	1	1	1	0	1	0	3	**1**
Missing	6	4	7	3	7	3	20	**3**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Ever visited Health post								
Yes	30	19	56	25	73	36	159	**27**
No	120	77	155	70	120	59	395	**68**
Missing	6	4	12	5	12	6	30	**5**
Total	**156**	**100**	**223**	**100**	**205**	**100**	**584**	**100**
Purpose of Health post visit								
Pregnancy test	2	6	3	5	17	20	22	**13**
Post partum test	3	9	3	5	8	10	14	**8**
To get information	26	79	36	65	36	43	98	**57**
For counselling	1	3	11	20	21	25	33	**19**
Other(specify)****	1	3	2	4	2	2	5	**3**
Total	**33**	**100**	**55**	**100**	**84**	**100**	**172***	**100**
Health worker's behaviour								
Cooperative	22	73	42	78	50	71	114	**74**
Just OK	7	23	10	19	20	29	37	**24**
Uncooperative	1	3	2	4	0	-	3	**2**
Total	**30**	**100**	**54**	**100**	**70**	**100**	**154**	**100**

* Multiple answers
** some time street drama and pamphlets are shown
*** Community people. friends, peer educators
****Blood check and treatment of abscess