

CHAPTER- I

INTRODUCTION

1.1GENERAL INTRODUCTION

1.1.1 GENERAL INTRODUCTION OF STIs

A. Sexual transmitted infections (STIs) are the diseases, which are transmitted through sexual contact during the carelessness intercourse. Sometimes these are also transmitted from mother to there child and through infected blood transfusion. There are numbers of STIs; each caused by a specific organism. They are most commonly passed through: vaginal and anal intercourse, mouth contact with the genitals, oral intercourse or the infected areas on the skin of infected person.

Sexually transmitted infections (STIs), formerly known as venereal diseases, more than 25 infections passed from one person to another primarily during sexual contact. STIs are among the most common infections known-more than 15 million people in the United States become infected with one or more STIs every year. The United States has the highest STIs rate in the industrialized world-roughly half of all Americans become infected with an STIs before the age of 35. Despite the prevalence of STIs, studies show that many people are unaware of their risks for contracting STIs or the serious, and sometimes deadly, health consequences that may result from an untreated infection.

Some STIs, such as gonorrhea or Chlamydia, may cause no symptoms. People who do not know they are infected risk infecting their sexual partners and, in some cases, their unborn children. If left untreated, these diseases may cause debilitating pain or may destroy a woman's ability to have children. Some STIs can be cured with a single dose of antibiotics, but many, such as acquired immunodeficiency syndrome (AIDS), are incurable. People with these diseases remain infectious to others for their entire lives.

Those most at risk contracting STIs are people who have unprotected sex-that is , sex without using a latex or polyurethane condom; those who have multiple partners; and those whose sex partners are include intravenous drug users who share needles. Studies show that Americans between the ages of 16 and 24 are at greater risk for acquiring STIs than are older adults because

younger people are more likely to have multiple sexual partners rather than a single, long-term relationship. Additionally, young people may be more likely to have unprotected sex and they may find it difficult to tell their sexual partners they are infected with STIs. Young people may also be embarrassed or unable to seek treatment for STIs. This means that they are not only more likely to pass the diseases to other young people; they also have a greater risk of suffering the long-term consequences of untreated STI.

B. HOW STIS ARE TRANSMITTED

STIs are transmitted by infectious agents-microscopic bacteria, viruses, parasites, fungi, and single-celled organisms called protozoa-that thrive in warm, moist environments in the body, such as the genital area, mouth, and throat. Most STIs spread during sexual intercourse (vaginal or anal), but other forms of sexual contact, such as oral sex, can also spread diseases.

Some STIs are transmitted in ways other than by sexual contact. Certain viral STIs such as aids and some types of hepatitis may be transmitted by contact with infected blood. For instance, viral STIs may pass between people who share infected needles, and a person can become infected from a transfusion of infected blood. Some STIs may pass from an infected mother to her child. Infection may occur before birth, when the infectious agent crosses the placenta (organ in a pregnant woman's uterus that links the blood supplies of mother and baby) and enters the baby's bloodstream. Infection also may occur during childbirth, as the baby passes through the birth canal, or after birth, when the baby consumes infected breast milk. STIs cannot be transmitted through shaking hands or other casual contact, or through contact with inanimate objects such as clothing or toilet seats.

C. COMMON STIS

The most common STIs in the United States include Chlamydia, gonorrhea, syphilis, herpes, AIDS, hepatitis, genital warts and trichomoniasis.

(i) CHLAMYDIA

According to the centers for disease control and prevention (CDC), Chlamydia is the most frequently reported infectious diseases in United States. Caused by the Chlamydia trachoma is bacterium, the disease does not produce noticeable symptoms in 75 percent of women and 50 percent of men, so an infectious often goes undiagnosed. Experts estimate that 3 million people become infected with Chlamydia each year, but according to the CDC, only about 660,000 of these infections are reported each year. People who do not know they are infected with Chlamydia may not seek medical care and they may continue to have sex, unknowingly spreading the disease. When symptoms do develop, men may experience painful or burning urination, vaginal discharge, or mild lower abdominal pain. If left untreated in women, Chlamydia can cause severe health problems. Chlamydia damages female reproductive tissue, causing pelvic inflammatory disease. PID can cause chronic, debilitating pelvic pain, infertility, or fatal pregnancy complications. Babies born to mothers infected with Chlamydia are at risk of developing eye and lung infections.

Diagnosing Chlamydia infections requires a physical examination in which a health-care provider performs a pelvic examination to collect a small amount of vaginal or penile fluid, which is then tested for the presence of Chlamydia trachoma is. New diagnostic tests that use urine samples to identify the presence of Chlamydia bacteria have become available, providing a noninvasive way to diagnose people who show no symptoms for the disease. Chlamydia is treatable with antibiotics.

(ii).GONORRHEA

Gonorrhea, caused by the bacterium noisier gonorrhea, infects the membranes lining certain genital organs. Although roughly 360,000 gonorrhea, infections are reported each year in the United States, experts estimate that closer to 650,000 people are infected annually. Like Chlamydia, gonorrhea is often symptomiess. When present; symptoms may be similar to those of Chlamydia and include burning urination and penile or vaginal discharge. Untreated gonorrhea can cause PID in women. Babies born to mothers with gonorrhea are at risk of infection during childbirth; such infections can cause eye disease in the newborn. Physicians diagnose gonorrhea by testing penile or vaginal discharge or urine specimens for urine specimens for the presence of

noisier gonorrhoea. Gonorrhoea is treated with several antibiotics, although the infection has become resistant to treatment with some drugs in past several decades.

(iii) SYPHILIS

Syphilis, a potentially life-threatening STI, is caused by bacterium *Treponema pallidum*. According to the CDC, there are an estimated 36,000 new cases of syphilis in United States each year. In the early stage of syphilis, a genital sore, called a chancre, develops shortly after infection and eventually disappears on its own. If the disease is not treated, the infection can progress over years, affecting the vertebrae, brain, and heart, and resulting in such varied disorders as lack of co-ordination, meningitis, and stroke. Syphilis during pregnancy can be devastating to the fetus, causing deformity and death, and most pregnant women in the United States receive screening for the disease in the first weeks of pregnancy so that the disease can be treated before the fetus is harmed. Syphilis is easily treated with penicillin, and the number of cases in the United States has dropped considerably since 1982. By the late 1990s, however, many urban communities experienced resurgence in syphilis cases among men who have sex with men.

(iv) GENITAL HERPES

Genital herpes is caused by infection with the herpes simplex virus (HSV). Most cases of genital herpes are due to HSV type 2. Some cases, however, result from infections with HSV type 1, a common cause of cold sores. Genital herpes causes recurrent outbreaks of painful sores on the genitals, although the disease often remains dormant with no symptoms for long periods. In the United States, one in five individuals over the age of 12 is infected with HSV type 2, and the vast majority of those infected—about 90 percent—do not know they have the disease. Blood tests can detect HSV infection, even if a person has no symptoms. The symptoms of HSV can be treated with antiviral drugs, such as acyclovir, but HSV cannot be eradicated from the body—it is incurable.

(v) AIDS

AIDS, the result of infection with human immunodeficiency (HIV), is an incurable and deadly STI. AIDS attacks the body's immune system, leaving victims unable to fight off even the mildest infections. While HIV can be transmitted by other means, sexual contact is the most common means of transmission. Women who are infected with HIV can pass the virus to their infant during pregnancy, childbirth or, less frequently, in breast milk. Treatment options for people infected with HIV include protease inhibitors, which can markedly increase survival. In spite of widespread educational and prevention programs, the CDC estimates that there are 40,000 new cases of HIV each year in the United States and that 800,000 to 900,000 Americans overall have HIV infections.

(vi) HEPATITIS B

One hundred times more contagious than HIV, hepatitis b passes from person to person through unprotected sexual intercourse with an infected person or through the sharing of infected needles or other sharp instruments that break the skin. Hepatitis b can also spread during childbirth: between 90 and 95 percent for all babies born to infected mothers get the disease during birth. The CDC estimates that 120,000 new hepatitis b infections occur each year. Hepatitis b attacks liver cells, sometimes leading to cirrhosis and cancer of the liver. In most cases hepatitis b is incurable, but arduous chemotherapy can eliminate the virus in some patients. There is a safe, effective vaccination for hepatitis b, and most states are developing or already have initiated public school immunization programs.

(vii) GENITAL WARTS

Genital warts grow on the penis and in and around the entrance to the vagina and anus. They are caused by a family of viruses known as human papillomavirus (HPV) that are transmitted during sexual intercourse. The CDC estimates that there are 5.5 million new cases of genital warts in the United States each year. Genital warts are treatable with topical medications and can be removed with minor surgical procedures. Certain types of HPV that caused genital infections can also cause cervical cancer. Regular pap smear screenings can detect cervical cancer in early stage, when the disease is easier to treat.

(viii) TRICHOMONIASIS

Trichomoniasis, caused by infection with the protozoan trichomonas vaginalis, causes burning, itching, and discomfort in the vagina in women and the urethra in men. Trichomoniasis is easily treated with a single dose of antibiotics. The CDC estimates that 5 million Americans become infected with trichomoniasis each year.

D. PREVENTION AND CONTROL

Unlike many serious diseases, simple measures can prevent STIs. The most effective prevention method is abstinence- that is, refraining from sex completely. No sexual contact means any risk of developing an STI. Practicing monogamy, in which two partners do not have sexual relations with anyone but each other, also greatly reduces the risk of spreading and contracting STIs.

Latex condoms are an effective, although not perfect, form of protection from STIs. These plastic sheaths, worn over the penis or inserted into the vagina, act as a physical barrier to organisms that cause STIs. However, condoms do not cover all of the genital surfaces that may come into contact during sex, and the possibility of transmission of some STIs, especially genital herpes and warts, still exists.

Early diagnosis and thorough treatment prevent the more serious consequences of STI infection, while halting the spread of STIs from person to person. This is most critical in STIs that do not cause symptoms, because those infected often do not know they risk infecting their sexual partners. The complete dosage of drug treatment must be completed, even if early doses of drugs appear to alleviate symptoms entirely. The infection may still persist in the absence of symptoms, leading infected individuals to unknowingly spread the disease.

Public clinics screen patients at risk for STIs in order to diagnose and treat diseases in the early stages. Clinics monitor the incidence of STIs in particular areas and contact the sexual partners of infected individuals. By identifying and treating these potential carriers, clinics are able to break the chain of STI infection. Several organizations, such as the CDC and the World Health Organization, monitor and research the prevalence and transmission of STIs on an international level in an effort to prevent local outbreaks from reaching global, epidemic proportions.

E. TRENDS IN STIS

At any time in history, the prevalence and significance of different STIs mirror changes in science and society. For example, in many countries of the world, the incidence of STIs increased during and immediately after World War II (1939-1945), when soldiers spending extended periods of time away from home engaged in unprotected sexual relations with different partners, many of whom carried STIs. When the antibiotics penicillin became widely available in the following years, the same countries experienced dramatic reductions in STIs incidence. Beginning in the 1950s, however, the incidence of gonorrhea began to rise as American sexual mores changed. Strains of the disease developed resistance to penicillin, and by the 1970s and 1980s the disease reached epidemic proportions in young adults' populations. Introduction of HIV into the human population led to an international AIDS crisis that began in the 1980s and continues to this day.

Cases of STIs are increasing, even though the use of condoms has increased since the onset of the AIDS epidemic. Public health officials that many factors are probably responsible for the increase in STIs, among them trends in sexual behavior. In the last several decades, the age at which people have sex for the first time has shifted downward, while the average number of partners a person has sex with during his or her lifetime has increased. Together, these trends increase the risk of exposure to an STI.

The HIV/ AIDS epidemic is spread through the world with ferocious speed. HIV has infected more than 60 million people worldwide. More than 20 million have died from AIDS, 3 million dying in 2000 alone. There were around 40 million people living with HIV/ AIDS at the end of 2002. Approximately 14000 new infections occur each day. More than half are among those below age 25 years. Over 95% of people living with HIV/AIDS are in low and middle-income countries. In sub-Saharan Africa, HIV/AIDS is now the leading cause of death and it is the fourth biggest killer globally. In second nations, life expectancy has been cut by more than 10 years (World Bank, 2003).

Nepal is not far from this problem. This history of HIV/AIDS pandemic in Nepal is now more than 21 years old. The first AIDS case was detected in 1988 in Nepal. Since then the infection is increasing in such a rapid rate that up to 29 February 2004, 3432 infected cases have been

reported to national center for AIDS and STI control. The government body is responsible for STD and HIV/AIDS activities in Nepal. The detected figure is only the tip of iceberg as WHO estimated the HIV prevalence in Nepal by the december2001 was37000. Now it is approximately 60000 HIV/AIDS infected cases are reported. An estimate shows that 800000 person travel across the border each year. There are also a large no of Nepali girl and women working in Mumbai alone are more than 56000. If these women return to Nepal they stand a high chance of being infected with HIV and consequently unwillingly transmit the AIDS virus to other (DNASC, 1999).

There are generally three periods when HIV enters into human body:

1. Window period: in this period when HIV virus enters into human body, generally cold cough may appear and disappear after sometimes. The virus safely settles in cell whereas man looks healthy. at this moment, it is so much risky period because it is possible for transformation of HIV virus by involving in sexual intercourse.
2. Carrier stage: although man is seen to be healthy in this period HIV virus replicate inside human body. it takes 5 to 10 years for adult and takes 1 to 2 years for child. If we check the blood, there would be presence of the HIV virus.
3. Aids: after six to 10 years period, sign and symptoms are seen. Person looks healthy until the sign and symptoms are seen physically and after checking the blood if it shows the HIV positive, then this situation is called aids.

MINOR SIGN OF AIDS

- * Persistence coughs for more than one month
- * generalized purities dermatitis
- * History of herpes zoster
- * Or pharyngeal candidacies
- * Generalized lymphadenopathy

MAJOR SIGN OF AIDS

-) Weight loss of 10 % or more of body weight
-) chronic diarrhea for more than 1 month
-) Prolonged fever for more than 1 month
-) More sweating,(UN, 1997).

1.1.2 INTRODUCTION OF DRUGS

The history of the human race is also a history of drug use. Since, earliest drug uses have been used to relief pain and control diseases. In and of itself, the use of drug does not constitute on evil. Drugs properly administered are a medical blessing. Unfortunately, certain drugs also initially penance entitling side effects, such as a feeling of euphoria a sense of feeling good, elation, serenity and power. The abuse of drug is an international problem, which affects almost every country in the world both developed and developing. The problems of drug abuse involved not only illicit but also licit and prescribed substances. Current evidence from around the world trend is the misuse of psychoactive drugs (Maskey, 2002). Drug may be defined as substance, which acts on a person's nervous system to produce changes in sensation, mood and perceptions. There is much different kind of drugs; some are legal and other like ecstasy and cannabis are not. Different drugs have different effects on people, some of these effects are more dangerous than others, injecting drugs is more dangerous than sniffing or smoking them (Maskey, 2002).

Societies in all parts of the world have used substances that suppress pain and sorrow and also provide pleasurable sensations when consumed. People take drug in different ways in different societies. Drug users frequently abuse several different type of substance. Nepal is not an exception to this phenomenon. Now heroin (brown sugar, smack), codeine, morphine and number of natural and synthetics mind altering drugs or psychotropic substances are found in common use among both young and adult Nepalese people. It is believed that Ganja, Bhang and Chores are found in religious usage in Nepalese society. People have been using these since very beginning. It has been clearly mentioned in the Hindu's religions books that the God Shiva used to smoke such drug for the meditation.

These are different types of drugs, which have different influential effects. The drugs affect the central nervous system of human body when consumed. The drugs both illicit and licit or prescribed belong to narcotic or psychotropic. Drug abuse administrates the drugs through smoking, smelling, inhaling, swallowing chasing and injecting (Dhital, 1999).

1.2 STATEMENT OF THE PROBLEM

HIV/AIDS is today most burning issue in the world and it has no any cure, preventions are the only remedied aspect of the disease. Therefore, public awareness is the most essential thing to protect from this disease. The pandemic of sexually

transmitted diseases in developing region is characterized by thigh incidence and prevalence of high rate of complication and alarming problem of anti-microbial resistance and interaction with HIV infection. It is estimated that 333 million curable cases of STIs worldwide are occurring in developing countries.

The secondary level students are vulnerable to drug abuse and STIs as they have the curiosity to test and pretend themselves the matures in the society. Prevention is the better way than have a cure. The boys and girls in their teen age might ruin their life on first testing which forms habitual in.

Since first HIV positive case in Nepal was detected in July 1988, HIV/AIDS is spreading rapidly in Nepal. In 1998, the number of HIV infected was only four. The ratio increased during the 10 years and reached 220 infected people in 1998. At present time, HIV infected persons are 2432 among them 2498 Boys and 938 Girls (NCASC, 2004). Over 13 million children currently fewer than 15 have lost one or both parents because of AIDS. The total number of children orphaned by the pandemic is forecasted to more than double by 2010 (WHO, 2002). Nepal is a multi-ethnic, multi-lingual and multi-cultural country with poor socioeconomic status. These characteristics are also found in Chitwan district. Brahman, Chhetry, and Tharu are main caste/ethnic groups in this district. Young people go to foreign countries (India, Singapore and Arabian counties) for the percent and temporary employment. Girl's trafficking and prostitution are also found in this region. When people return to own places they bring STD and HIV/AIDS. This phenomenon is extant in Bharaptur, Municipality.

Boys and Girls students of age 10 to 19 years in higher secondary level of education belong to adolescents. Adolescents can be divided into two groups early (10-14 years) and late adolescents (15-19 years). Adolescence is the transitional phase change during the period (Aacharya 1999). Adolescents are at high risky from the point of view of the transmission of STIs and fall in drugs abuse.

But at present, we don't know their level of knowledge regarding the STI's HIV/AIDS and drug use, knowledge on modes of transmission and most importantly ways of prevention. Therefore, it is necessary to conduct a research to find out their knowledge and behavior regarding STIs, HIV/AIDS and drug use.

Drugs abuse have become one of the major problems in the world, virtually no nation, state or social class remain untouched by this problem. Since it has spread over the entire planet, the problem of such drug abuse has caused millions of people to bear immeasurable costs associated with health hazards, human suffering loss of life, hindrance to the place of economic development, disruption of the social order, antisocial behavior, insecurity, violence, crime and numerous other drug related problems. Like other developed and underdeveloped countries, Nepal is experiencing tremendous problems of drug addiction and drug offences.

Drugs are taken for the relief of pain for the treatment of disease, to change mood to soporific euphoria or to find or to lose identity, to escape, to forget and to explore. In fact the abuser of licit or illicit substance is rooted deeply in every society in the world. The consequences of drug abuse have advanced the society in crucial situation. It has created many critical problems in the society and adverse consequences in public health as well as social system of the society.

Use of illicit drugs continues to expand in many countries. Propelled by a powerful economic underworld, countries in all regions of the world have experienced rapid increasing in drug use, drug injecting and subsequent HIV pandemic, which began among indicative drug user (IDUs) and moved to their sexual partners and onwards to the general community.

At mid of 70's there were only 50 drug users in Nepal (Bhandari, 1998), whereas at the end of 2000, it is estimated that there were about 50000 drug addicts in Nepal, out of which 20000 use injection and possibly about 50 percent of them are already HIV positive. At the beginning of

90s, the prevalence of HIV infection in IDUs' population was only one percent, whereas in 1991, the prevalence of HIV infection in IDUs' population was about 40 percent (G. Makey, 2002).

Adolescents are most vulnerable group for STIs and HIV/AIDS. A large proportion of adolescents in Nepal join school. The school curriculum also contains information on STIs, HIV/AIDS since some year before. But there are still many obstacles hindering the full information to adolescents. In our country, where sex education is considered as the taboo and the society and the families are not free on it, only the school curriculum may not be sufficient condition for providing information to them. The social system and family background are most important aspects influencing the level of knowledge to adolescents. Therefore, it is necessary to investigate relationship between family background and adolescent's knowledge on STIs and HIV/AIDS.

Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to I-IIV and other STIs. These include teens that are gay/exploring same-sex relationship, drug users, juvenile offenders, school dropouts, runaways, and homeless of migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis, and have limited access to health care and service-delivery systems.

A lot of international and national agencies have made attempts for understanding the sensitiveness of the problem. Since the identification of the HIV/AIDS, the governments are using the maximum strength to avoid and control the problem. But still comprehensive studies are not available that deal with problem of adolescent. This study will try incorporating the issues why the adolescents are not contributing to identify the nature of problem and to what extent they are aware of the problem and what measures do they apply for preventing themselves from the HIV/AIDS infection. This study also incorporates one more variable what the adolescent population do to prevent the society from the evil death AIDS. In Nepal, issue of reproductive health was included in secondary school curriculum from the academic year 1998/99.

In recent year HIV/AIDS has spread from urban to rural areas and a study indicate 85 percent of

this infection occur through the sexual route, 4 percent through blood transfusions and another 7 percent through drug abuse (The Rising Nepal, 1 December, 2003).

1.3 OBJECTIVES OF THE STUDY

The major objectives of the study area as follow:

- 1 To identify the socio-economic status of secondary level students of Bharatpur municipality.
2. To find out the level of knowledge on STIs and HIV/AIDS in secondary level students.
3. To identify the knowledge of drug and drug abuse.

1.4 LIMITATIONS OF THE STUDY

This study attempts to analyze the knowledge and behavior on STIs, HIV/AIDS and Drug use among secondary level students in bharatpur municipality of chitwan district. However it has certain limitations, which are listed below:

1. This study is limited only to the secondary level students of bharatpur municipality of chitwan district. Therefore, the finding obtained from this study cannot be generalized for whole nation.
2. The information for the study is obtained from the participant of that, secondary level students, which do not represent the people of other areas.

SIGNIFICANCE OF THE STUDY

The finding of this study may help the policy markers and persons working in the field of STIs, HIV/AIDS and drug prevention and control. Since it attempts to provide the level of knowledge about the transmission of STIs and HIV AIDS prevention in secondary level students, this may help for course design.

As this study also attempts to identify the sources of information of AIDS, drug and STIs, the study is of equal importance to improve the effectiveness of the media. This Study tries to assess the misconception persisting among peoples. The finding of this study may also help to adopt strategies to root out the existing wrong concepts and to disseminate necessary message through

the mass media. A person of the community is the important part of the nation should essentially possess the basic knowledge about public Health, drugs abuse and killer disease such as: STIs and HIV/AIDS. What extent of the existing perception is true and what amount of the knowledge is false must be assessed. The statistic provided by this study may be a representative of the other part of country having similar environment.

1.6 ORGANIZATION OF THE STUDY

Whole study has been summarized into seven chapters. Chapters one deals with the introduction, statements of the problem, objective and significance of the study. Review of literature-has been included in chapter two. Third chapter deals with the methodology of the study. Chapter four deals background characteristics of the respondents. Chapter five deals the knowledge of HIV/AIDS, drug use and use of condom. The following chapter six includes group discussion and public communication. The final chapter seven has been used to state finding, conclusion and recommendations.

CHAPTER II

LITERATURE REVIEW

2.1 THE GLOBAL SITUATION OF THE HIV/AIDS

As a global problem, Acquired Immune deficiency Syndrome (AIDS) has become a great and powerful symbol for the world, which has threatened in all directions. AIDS is a viral disease, like other diseases. Although Human Immune Deficiency Virus (HIV) is responsible for AIDS, it shares most of the characteristics with all known viruses. It is different from other viruses as it strikes at the body's defense cells. As a result, the immune (defense) system of the person infected with HIV gets weakened over the years.

Sexually transmitted diseases (STIs) everywhere have become a major public health problem in both developed and developing countries. On average, an estimated 685,000 people are infected every day with STIs (Mahat, 2002). Prevalence rates are apparently far higher in developing countries, where STI treatment is less accessible. In studies in developing countries, up to 18 percent of these patients have Gonorrhea, up to 17 percent have Syphilis, and up to 30 percent have Trichomoniasis. Among developing regions, STIs appear to be more common in Africa than in Asia or Latin America. In a review of Judith Wasserheit, 20 percent of women in Africa had Trichomoniasis, while the prevalence in Asia was 11 percent and in Latin America 12 percent (Mahat, 2002).

Today's youth have inherited a lethal legacy that is killing them and their friends and the whole youth. An estimated 11.8 million young people aged 15 to 24 are living globally with HIV/AIDS. Each day nearly 6,000 young people between the ages of 15 and 24 become infected with HIV. Yet only a fraction of them know they are infected (WHO, 2002).

By 2001, AIDS killed one or both parents of 13.4 million children under the age of 15. Their ranks will soon be swelled by millions of additional children that are living with sick and dying parents. The tragedy continues to worsen as the disease kills ever-larger numbers of people. By 2010, the total number of children orphaned by HIV/AIDS is expected to double, nearly to 25 million (UNICEF, 2002). HIV/AIDS has killed more people in sub-Saharan Africa than anywhere else,

and the vast majority of orphans and other children affected by HIV/AIDS are also living in this region. By the end of 2001, AIDS had orphaned approximately 995000 children in Nigeria, 989000 in Ethiopia, 782000 in Zimbabwe, 662000 in South Africa, and 572000 in Zambia (UNICEF, 2002).

HIV/AIDS is a pandemic with cases reported from every country. The current estimate of the total number of cases of HIV infection among adult worldwide is approximately 36.1 million including 1.4 million children. The United Nations Program on AIDS (UNAIDS) estimates that approximately 17.5 million adult and 4.3 million children infected with HIV have died since the beginning of the pandemic.

Within the territory of Eastern Europe and the former Soviet Union, there are 700000 estimated cases of HIV infection. This region has one of the faster growing rates of HIV infection in the world. In Armenia, there were 161 cases of HIV registered between 1988 and 1 September 2001. It is believed that the number of HIV infected individuals residing in Armenia greatly exceeds the number of officially registered cases. According to the official data, however, it is possible to determine the following trends. The large population of the HIV infected population is adult Boys (75 percent) and transmission occurred primarily through drug use and heterosexual contact. Children constitute 2 percent of the total number of HIV infected individuals in Armenia. The majority of the cases have been registered in Yerevan.

In the present time 40 million people are living with HIV/AIDS among them 37 million are adults and 2.5 million are children under 15 years. Five million people were newly infected with HIV in 2003 among them 4.2 million were Adults and 700000 were children under 15 years. Three million people died in 2003 by AIDS among them 2.5 million were adults and 500000 under 15 years.

2.1.1 AFRICAN COUNTRIES

A review of the available information on the prevalence rates of HIV infection indicates that Sub-Saharan Africa has the highest rate of HIV infection in the world. By the beginning of 1997, about 22.6 million people worldwide either had contracted HIV infection or had AIDS, about 14 million (63%) of them were in Sub-Sahara Africa (WHO, 1997). By the end of 1997, the joint of

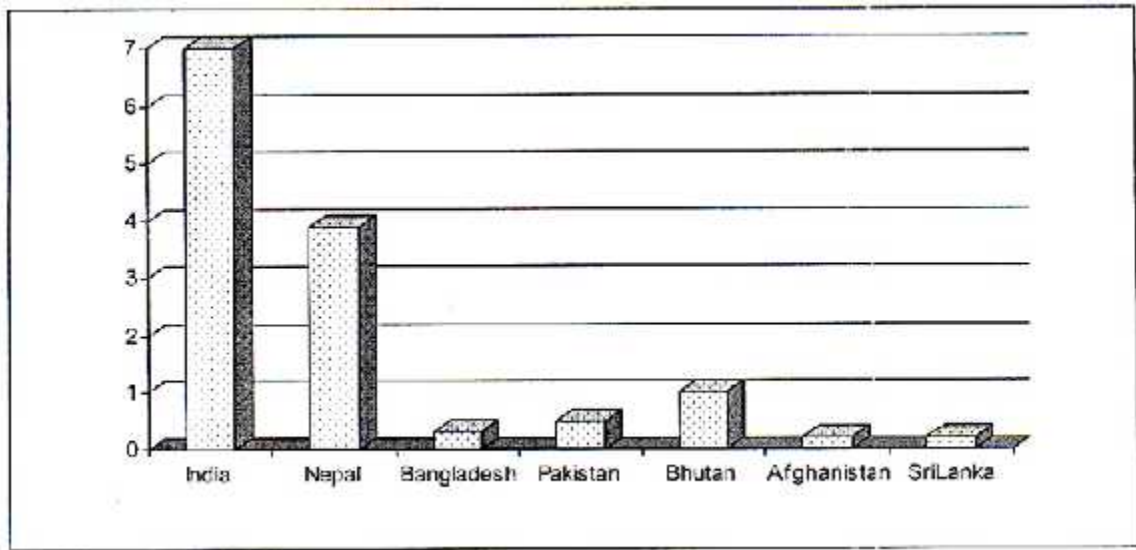
United Nation Program on HIV/AIDS (UNAIDS) had adjusted the global HIV/AIDS estimates upwards to 30.6 million. Their estimates put about 21.8 million of the HIV/AIDS cases in sub-Saharan Africa (UN Program on HIV/AIDS, 1997). In 1981, the year the AIDS virus was first identified in five gay men in Los Angeles, United States of America, about 111000 (67%) of the estimated world total of 165000 infections occurred in Africa. The annual number of infections is estimated to have passed 1 million in 1988 and from 1992 to 1995; about 1.5 million HIV infections were estimated to occur annual in Sub-Saharan Africa (UN, 1997). WHO estimates that about 6.4 million people have died of AIDS since the pandemic began in 1981 and that 74 percent of these deaths occurred in Sub-Saharan Africa (WHO, 2002).

In 12 countries of Sub-Saharan Africa at least 10 percent of population aged 15 to 49 are estimated to be infected with HIV. The majority of new infections in this region are among young people age 15 to 24. In Botswana, South Africa and Zimbabwe it is estimated that more than 60 percent of boys aged 15 today will become infected with HIV during their life time (UNICEF, 2002).

2.1.2 SOUTH ASIA

The HIV/AIDS epidemic is relatively recent in South Asia. The first case was identified in India in 1986. By the year 2000, all the countries in the region have been reported HIV infections. In general infection rates remain low in most of the countries of the region except in some states of India and among certain group at risk such as commercial sex workers and injecting drug users in Nepal and India. Despite the low prevalence, specific characteristics of the pandemic make urgent and immediate action necessary (UNICEF, 2000). It was estimated that 780000 total new infections of HIV/AIDS were in South East Asia in 2000 of which 260000 were young under the age of 25 years.. Every day 700 young people get infected and one young people are infected in every two minutes (UNICEF, 2000).

Figure 1: Adult HIV Prevalence in South Asia in Million, End of 1999



Source: WHO, 2002.

The first AIDS case in India was reported in May 1986. The infections were doubled between 1994-1998. The population infected in 1994 was 1.8 million, which reached to 3.5 million within 4 years and 3.9 million at the end of 2000. Even women with a single partner are vulnerable to HIV infection. Findings of a study in India shows that 90 percent of women infected were married and have only one sex partner. In India at least 100000 HIV positive women become pregnant every year, which could transfer it to more than 30000 babies annually (UNICEF, 2000). A study in India has estimated that for the year 1991 the loss of productivity due to AIDS in monetary cost was Rs. 1014 billion.

2.1.3 CASES IN NEPAL

Although AIDS was first recognized in 1981, in Nepal it was first identified in 1988. At present the HIV/AIDS epidemic in Nepal is believed to be at a relatively yearly stage as compared to many other countries since 1991. The National center for AIDS and STIs control (NCASC) has implemented sentient HIV surveillance in high-risk group. In 1986, the prevalence of HIV among blood donors was found to be one in 100, which is three times the rate of 1995. At the end of 1996, a total of 82 cases of AIDS and nearly 500 HIV cases were reported by ministry of health (Mahat, 2002).

Hundreds of thousands of Nepalese men seek work in India as migrant laborers, while up to 100000 Nepalese women work in India as prostitutes engaging unprotected sexual intercourse, where the prevalence of HIV infection among the general population is comparatively high (Roka, 2000).

The HIV/AIDS epidemic represents the most serious public health concern in Nepal. The data clearly indicates that HIV is prevalent in almost all parts of the country. In recent years, it has spread from urban to rural areas and as studies indicate 85 percent of this infection occur through the sexual route whereas 4 percent through drug abuse.

A large majority of cases (81%) occur in sexual active and economically productive age group of 18-19 years and one in every 4 cases reported is a woman. It is estimated that HIV infection rate among STIs infected has significantly increased. Almost 58 thousand people are infected by HIV/AIDS in the present time (The Rising Nepal, 1 December 2003).

In Nepal, 4 people infected by HIV were identified in 1988. The number rapidly increased and reached 1199 at the end of 1998. At the end of 2003, 3432 persons were infected by HIV (NCASC, 2004). In Nepal, one-third of reported HIV positive cases are women of whom 33 percent are adolescents (UNSG, 2000). According to NCASC latest report, cumulative HIV/AIDS situation of Nepal as of February 29, 2004 are listed below.

Table 1: Cumulative HIV Infection by Sub Group and Sex, Nepal, 29 February 2004

Sub-group	Boys	Girls	Total	New cases in February 2004
Sex workers	-	512	512	1
Clients of sex/STD	1984	61	2045	14
House wives	-	336	336	9
Blood or organ recipients	5	2	7	-
Injecting Drug use	469	3	472*	19
Children	36	29	60	1
Total	2494	938	3432	44

Source: NCASE, 2004.

*Mode of transmission IDU or Sexual.

Table 2: Cumulative HIV Infection by Age Group, Nepal, 29 February 2004

Age Group	Boys	Girls	Total	New cases in February 2004
0-4	20	17	37	-
5-9	16	8	27	1
10-14	9	6	15	-
15-20	142	161	303	2
20-24	518	258	776	9
25-29	667	236	903	8
30-39	885	206	1091	19
40-49	202	40	242	3
50 above	35	6	41	2
Total	2434	938	3432	44

Source: NCASC, 2004.

The actual number of HIV infection is higher than the report of National Center for AIDS and STIs control. The number HIV/AIDS infected people in Nepal have exceeded 58 thousand (The Rising Nepal, 1, December 2003).

2.2 DRUG ABUSE

2.2.1 CONCEPTS AND DEFINITION OF DRUG

The definition of the word drug proposed by the WHO refers to all psychoactive substances, i.e., "organism, may modify its perception, mood, cognition behavior or motor function". This distinction includes alcohol tobacco and solvents and excludes medicinal non-psychoactive substances (World Drug Report, 1997). WI-10 has considered alcohol and tobacco as substances rather than drugs. Drug means any chemical plant-derived substance, which can cause any person using it to experience mental, emotional or physical change (Gosden, 1987).

Drug is a substance, which by its chemical nature alters the existing nature of a person. A drug is any chemical substance that alters mood perception or consciousness and is isused to the apparent injury of the individual or society.

2.2.2 CLASSIFICATION OF DRUGS

Some socially deviant drugs abused in Nepalese society are as:

- I. Opium: Used principally by older people in rural society but also as a second choice by urban drug abusers.
- II. Morphine: Derived from opium: principally intended as a painkiller used when available by urban youth, occasionally available as liquid in medicine vials.
- III. Pethidine: A synthesized (man - made) opiate locally available only to the medical profession.
- IV. Heroin: Distilled from opium, which is 2 times more powerful. It is very expensive and available in urban areas. It is the principal hard drug abused in Nepal, mostly used by young people.
- V. Barbiturates: Sedative like sleeping pills, which can lead to physical and psychological dependence.
- VI. Aminophetamines: Stimulant drugs like Benzedrine and Dexedrine used for increasing energy and post-poniard fatigue. It can lead to psychotic reaction.
- VII. Minor Tranquilizers: Like Valium and Librium give short-term relief of anxiety can lead to physical dependence.

Bhandari has classified drug into four groups, as

- | | |
|-----------------|-------------------|
| I. Stimulant | II. Hallucinogens |
| III. Depressant | IV. Narcotics |

Depending upon strengths to intoxicate a user, the aforementioned drugs can be categorized into two groups.

I. Hard Drugs: These are strong drugs in nature and produce physical dependency in addicts and one or two doses of hard drugs make its user an addict. Its examples are morphine, and heroin (popularly known as brown sugar, smack, white powder and golden sugar).

II. Soft Drugs: These are mild in nature in comparison to hard drugs. They produce only psychological dependence in an addict. Their example includes *Ganja*, *Chareesh*, and *Maryuana* etc.

The history of humankind is also a history of man's desire in eating or drinking things that make them feel euphoric. By the time of the reign of King Hammurabi of Babylonian (2067-2025

BC), the sale and consumption of alcohol was evidently well known as he tried to regulate drinking house in Babylon (Gosden, 1987).

Archaeological evidences indicate that cultivation of drug dates back to 6000 BC. Religious and mythical use of cannabis in Indian societies was reported from about the 7th century A.D. By the end of the 19th century, drug abuse and addiction were being seen in many countries and were beginning to receive the attention of national government as a part of social responsibilities.

In Nepalese context, it is believed that *Ganja*, *Bhang* and *Chares* are important in religious context. People have been using these drugs since very beginning. It is clearly mentioned in the Hindu's religious book that God Shiva used to smoke such drugs for mediation. Though the use of opium in the form of smoke any poppy seeds in the form of food had been quite common in the past, in Nepal. It is believed that the problem of drug abuse entered into Nepal when Hippies came in Nepal at mid 60s. Brown sugar, Morphine and other hard drugs entered into Nepal in early 80s. These drugs were in the form of smoking and chasing when enforcement low started being more rigid, drug addicts started cubing drugs like psychoactive substances which were comparatively more easy to be undefended by the enforcement authorities. During early 90s, tidigistic tool place of these drugs in Nepal. It is easily available and comparatively cheap. On the other side, most of drug users are shifting their drug using modes from chasing, smoking to ineptly that possible results the transmission of HIV and other viral insertion among and from IDUs (Maskey, 2002).

2.3 DRUG AND HIV/AIDS

Unsafe drug injecting practices and sharing of needles/syringes and other injecting equipment lead to many young people being either infected or at risk of becoming infected with blood-borne viruses such as HIV and hepatitis B and C. High risk sexual behaviors often accompanying with his risk drug use further increase the chances of HIV transmission, injecting drugs can also cause many other illness among injecting drug users (IDUs).

The shift to production and distribution of high-grade heroin has resulted in the shift from the tradition of ingesting and/or inhalation of opium to injecting drugs. Moreover, when drugs become scarcer and uneconomical as a result of drug control efforts, injecting drugs ensures that

the drug is used entirely. It can further spread to the sexual partners and children of the IDUs and eventually to the community. HIV is prevalent among IDUs of 119 countries around the world. In Nepal, the HIV prevalence among IDUs has risen from 1 percent in 1999 to over 50 percent in 2002.

2.4 ADOLESCENTS AND HIV/AIDS

Early adolescence from the age of 10 to 14 is a time, when enduring pattern of healthy behavior can be established, including postponing the onset of sexual activity, which can quell the spread of HIV/AIDS (WHO, 2002). Today youths have inherited a lethal legacy that is killing them and their friends, their brothers and sisters, parents, teachers and whole models. An estimated 11.8 million young people aged 15 to 24 are living with HIV/AIDS. Each day nearly 6000 young people between the age of 15 and 24 become infected with HIV. Yet only a fraction of them know they are infected.

Adolescents, who become sexually active early and change partners frequently, are at greater risk (UNES, 1998). The HIV pandemic, which began in the late 1970s, has now affected every continent. At the end of 2003 almost 40 million world people are infected by HIV/AIDS among them 25 million people were aged less than 15 years. The main cause of transmission is unsafe sexual intercourse. Almost 80-90 percent source of transmission is unsafe intercourse (NCASC, 2003).

In a study conducted in 2000, it was found that almost all (99%) peoples have heard about HIV/AIDS and the average knowledge among students is high. Some misconceptions are also reported specially about the transmission routes of AIDS. But STIs knowledge level is less among the students compared to AIDS and condom (Roka, 2001).

A study on AIDS related knowledge in Nepal specially based on high school students was undertaken by Rayamajhi undertook the AIDS related knowledge study in Nepal specially based on high school students. He studied knowledge and attitude of HIV/AIDS among 1144 students (630 Boys, 514 Girls) studying in class ten of different government and private schools. According to the study, ninety-nine percent of the students had heard about schools. According to the study, ninety-nine percent of the students had heard about AIDS. Similarly, another KAP

study among the general rural population conducted in Nuwakot district, central region of Nepal, indicated that 71 percent of those with SLC and higher education were aware about AIDS.

In another study, students expressed rather negative attitude towards HIV infected people, which seemed surprising considering the good level of information about HIV/AIDS. The analysis of attitude towards premarital sexual relations indicated that Boys were associated with a more liberal attitude and that students who considered their religion as important were less likely to have a liberal attitude towards it.

Students in schools generally have a limited access to information about sex, sexuality and human reproduction. Incidental information that they get from their friends, magazines and mass media may even be misleading. Integrating information regarding sexuality, STIs and AIDS into the family life education course designed for school students can, therefore, be considered as a necessity. AIDS is fundamentally a development challenge intertwining issues of poverty, inequality, culture and sexuality in complex way (UNICEF, 2002).

CHAPTER- III

METHODOLOGY

This study has been confined within Bharatpur Municipality, Ward No. 4 of Chitwan district. Primary data used to meet the objectives of the study. The data for this study have been collected through field study from 104 respondents of the Study area.

3.1 STUDY AREA

Study area for this survey has been selected purposively. The study has been conducted in Bharatpur Municipality Ward No. 4 of Chitwan district it lies in the central development region, Narayani zone of Nepal. Bharatpur is capital town of Chitwan district. The area covers inner Terai. The climate of district is tropical. Its political boundary is Dhading district in the north, Nawalparasi district in the west, and Makwanpur in the east. Total population of this district was 470713 in the census 2001. This district is the common place for the people from different caste/ethnicity, religions, and occupation. Almost all type of the caste/ethnicity and religious are found and almost all types of occupational groups are available.

Bharatpur Municipality is developing municipality of Chitwan district, largely populated by various castes and ethnic groups like Brahmin, Chhetri, Magar, Tharu, etc. who possess land asset. Business, services, agriculture is the main occupation of population of this municipality. It has fertile and plane land with irrigation facility. There is no alternative occupation for the poor and marginalized groups. It is the connecting place to Nawalparasi with Mahendra highway. This municipality has well education facilities up to secondary level and several primary schools are established here. Average literacy rate of the municipality is 59 percent. Literacy rate is higher among Brahman and Chhetri castes. There is growing market area, which provides the daily need of people. It is situated at an altitude of 750 meters above the sea level. Ratnanagar municipality is situated to the east of the Bharatpur Municipality. There is a growing trend of population in this municipality. Total population of Bharatpur municipality was 470713 (237669 are Girls and 233074 are Boys) in 1991, which reached to 10920 (5643 Girls and 5277 Boys) in 2001. Population of 10-14 years age group constitutes higher (15.1%) among total population of this municipality.

3.2 RESEARCH DESIGN

This study has been conducted to identify the level of knowledge of secondary level students on STIs, HIV/AIDS and drug use with respect to their socio-economic and demographic background. Therefore, it is descriptive type of study. This study has also included in the participation of whole members of community awareness as well as frequent discussion with friends and family members.

3.3 SAMPLE SIZE

The study area Bharatpur Municipality has 36 secondary level schools. The research Carried in three schools, purposively in the academic year 2007 of 4 ward no. only. One hundred four students were selected using systematic random sampling. The complete sampling frame was constructed from the total students of secondary level of these three schools. Students were first alphabetically arranged and then systematic random sampling was used. Three schools taken for study are Balkumari secondary school, chit wan secondary boarding school and Siddhartha secondary boarding school.

Distribution of Sampling Frame

Table no- 3 Distribution of sampling frame.

Name of school	Total no of student	Selected student	Total No
Balkumari secondary school	234	54	104
Chitwan secondary boarding school	189	25	
Siddhartha secondary boarding school	62	25	

Source: field survey- 2006

3.4 METHOD OF DATA COLLECTION

This study was based on the primary data. Therefore, the selected 104 respondents were the main source of information for the study. Semi-structured questionnaire was used to collect the information. The questionnaires after selecting the particular Respondents were distributed to the completion of filling the questionnaires; they were collected on the spot.

3.5 QUESTIONNAIRE DESIGN

Questionnaire was constructed so as to collect the individual as well as family information. Following information was included in the questionnaire.

Individual and household information.

-) Knowledge on STIs, HIV/AIDS and drugs use.
-) Knowledge on use of condom and other methods of family planning
-) Information on drug.
-) Group discussion and public communication.

3.6 DATA MANAGEMENT

The questionnaires, after collection has checked thoroughly and the coding were done. Then information was entered in computer using software package. Frequency, cross and mean tables and other appropriate tables were generated depending on the nature of data for the analysis. Interpretations of tables were done based on percentage and number of cases.

CHAPTER- IV

BACKGROUND CHARACTERISTICS

Background characteristic includes the socio-economic and demographic characteristics. The socio-economic and demographic characteristics include the age and sex of the respondents, caste/ethnicity, religion, family size, migration, status of agriculture land, educational and occupational status of parents. This chapter deals with the socio-economic and demographic information of the respondents.

4.1 SOCIO-DEMOGRAPHIC BACKGROUND OF RESPONDENTS

Socio-demographic backgrounds influence the concept of the respondents. Persons from different socio-demographic characteristics have different level of knowledge. Socio-demographic information includes age and sex of the respondents, caste/ethnicity, religion, family size migration, status of agriculture land, education status of parents and occupation of parents.

4.1.1 AGE AND SEX STRUCTURE

Age is considered as the major demographic component. This has relationship with other aspects of respondents. Table 3 shows the age and sex distribution of the respondents.

The age of the respondents ranges from 14 to 19 years. Nearly half of the respondents (43.3%) are aged 15 followed by aged 16 (24.0%) and the lowest percent of respondents are aged 18 (2.0%). Of the total, more than half (53.8%) are Boys and 48 out of 104 respondents (46.2%) are Girls. The age of respondents is dispersed. Though the average age of respondents is 15.5 years, the average age of Girls is slightly lower (15.4 years) than for Boys students (15.5 years).

Table 4: Distribution of Respondents by Age and Sex

Age of respondent	Sex of the respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
14 yrs	11	19.6	6	12.5	17	16.4
15 yrs	21	37.5	24	50.0	45	43.3
16 yrs	16	28.6	10	20.8	26	25.0
17+yrs	8	9.0	8	12.5	16	10.6
Total	56	100.00	48	100.0	(04	100.0
Median age	15.50		15.44		15.45	

Source: Field Survey, 2006.

4.1.2 FAMILY SIZE

Quality of life depends on size of the family. In large family it is difficult to fulfill all the needs of the members. The basic need such as education, health and other physical facility are fulfilled if the size of family is smaller. For this study, family size has been defined as the number of persons living together and sharing the common food provision.

Table 5 shows that the highest percent of respondents (27.9%) have a family size for 5 members followed by respondents with 6 member (17.3%) and 7 members (14.4%). About 18 percent of respondents have families with 10 and over family members whereas nearly 2 percent of respondents have families with only 3 members.

Table 5: Distribution of Respondents by Family Size

Family size	Sex of the respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
3	1	1.79	1	2.08	2	1.92
4	4	7.43	1	2.08	5	4.81
5	15	26.79	14	29.17	29	27.88
6	9	16.07	9	18.75	18	17.31
7	8	14.29	7	14.58	15	14.42
8	7	12.50	6	12.50	13	12.50

9	2	3.57	2	4.17	4	3.85
10 and above	10	17.86	8	16.67	18	17.31
Total	56	100.00	48	100.00	104	100.00
Median	6.75		6.79		6.77	

Source: Field Survey, 2006.

Table 5 that the median family size of study population is 6.8 percent. Girls are from slightly larger family size (6.8) compared to boys (6.8) but the difference is not pronounced significantly.

4.1.3 CASTE/ETHNICITY

Table 6 shows the distribution of respondents by caste/ethnicity. Tharu constitutes the highest percent of respondents (44.2%), followed by Chhetri (34.6%) and Brahmins (13.5%). A total Of 7 caste/ethnic groups are enumerated in this study. Three different caste/ethnic groups (Newar, Dhimal and Kanii) are merged into 'Others' which comprise only 4.8 percentage.

Table -6: Distribution of Respondents by Caste/Ethnicity

Caste/Ethnicity	Sex of the respondents				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Tharu	26	46.42	20	41.66	46	44.23
Chhetri	18	32.14	18	37.50	36	34.61
Brahman	7	12.50	7	14.58	14	13.46
Magar	1	1.78	2	4.16	3	2.88
Others	4	7.14	1	2.08	5	4.80
Total	56	100.00	48	100.00	104	100.00

Source: Field Survey, 2006.

4.1.4 RELIGIONS

The study indicates that almost all respondents (99.0%) are Hindus and only 1.0 percent is Buddhists. Among Hindu 53.4 percent are Boys and 43.6 percent are Girls. But among Buddhist, there is only one.

4.1.5 TYPES OF FAMILY

Generally, families are divided in two groups i.e. (i) Nuclear and (ii) Extended. Nuclear family is defined as the family where parents and their unmarried offspring live whereas in extended family more than two generations live together. Family size and type of family have close relationship. Generally, extended families are larger in size compared to nuclear families. Due to modernization and urbanization quality of life is possible in nuclear family compared to extended family because if the family size is smaller it is easier to manage it.

More than half of the respondents 60.6 percent are from nuclear families whereas 39.4 percent respondents are from extended families. This shows the breaking of traditional family system into new nuclear family. This is result of modernization. By gender, 66.0 percent boys are from nuclear family whereas it is 54.2 percent for girls. But opposite to it 45.8 percent girls are from extended family whereas it is 33.9 percent for boys.

Table 7: Distribution of Respondents by Type of Family

Type of family	Sex of the respondents				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Nuclear	37	66.1	26	54.2	63	60.6
Extended	19	33.9	22	45.8	35	39.4
Total	56	100.00	48	100.00	104	100.00

Source: Field Survey, 2006.

4.1.6 FAMILY EDUCATIONAL BACKGROUND

Family educational level also affects the perception of individual. Generally, individual with literate is more likely to have knowledge about different matter including STIs and HIV/AIDS compared to those with illiterate family.

Table 8 shows the educational status of family. Majority of respondents (76.92%) reported that all of their members are not literate who 10 years of age and are above. Only 23.08 percent respondents reported that all of their family members are literate. Over 35 percent of respondent's fathers have completed primary level of education followed by secondary level of education (19.23%) and SLC and above (11.38%). Compared to girls (8.32%), higher percent of boy's fathers (14.29%) have completed SLC and above level of education.

Table 8: Distribution of Respondents by Educational Status of Members

All family members literate (10 years and above)	Sex of the respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	13	23.2	11	22.9	24	23.1
No	43	76.8	37	77.8	80	76.9
Total	56	100.0	48	100.0	10	100.0
Father's educational status						
Illiterate	8	14.9	12	25.0	20	19.2
Literate (No Schooling)	6	10.7	9	18.8	15	14.4
Primary level	21	37.5	16	33.3	37	35.6
Secondary level	13	23.0	7	14.6	20	19.2
S.L.C.+	8	14.9	4	8.3	12	11.4
Total	56	100.0	48	100.0	104	100.0

Source: Field Survey, 2006

4.2 ECONOMIC CHARACTERISTICS

Economic characteristic include family occupation of father and status of agriculture land.

4.2.1 FAMILY OCCUPATION

The study area is semi urban in nature. Almost urban characteristics are found here. Family occupation determines the status of family. Table 8 shows that an overwhelmingly majority of respondents (86.5%) is from agriculture background and only other 13 percentage reported during the study are government/private sector service and business. About 11 percent reported that their major family occupation is service and about 3 percent said business.

Table 9: Distribution of Respondents by Family Occupation

Occupation	Number	Percentage
Agriculture	90	86.75
Service	11	10.57
Business	3	2.88
Total	104	100.00

Source: Field Survey, 2006.

4.2.2 PARENTS OCCUPATION

Family occupation and occupation of father therefore, has been tried to explore separately because of identifying contribution of father's occupation in family income. Difference has been observed between father's occupation and family occupation. Nearly 87 percent (Table 9) respondents reported agriculture as the major family occupation whereas. Slightly less proportion of respondents (84.62%) reported their fathers engaging in agriculture (Table 10). Similarly, 11.53 percent respondents reported government/private sector service as their father's occupation. Table 10 shows that there is contribution of other family members also in agriculture occupation.

Table10: Distribution of Respondents by Occupation of their Father

Occupation of father	Sex of the respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Agriculture	43	76.8	45	93.8	88	11.5
Government/private	9	16.1	3	6.3	12	2.9
Business	3	5.4	-	-	3	1.0
Other	1	1.8	-	-	1	
Total	56	100.0	48	100.0	104	100

Source: Field Survey, 2006

4.2.3 STATUS OF AGRICULTURAL LAND

Respondents were also asked whether they have agricultural land. Almost all respondents reported having agricultural land with only 0.96 percent not having it. Table 11 shows distribution of respondents by status of agricultural land. A follow-up question was asked to those respondents who reported having agriculture land, whether the land is sufficient for their survival. In this regard, only 13.60 percent respondents reported not sufficiency of land.

Table 11: Distribution of Respondents by Status of Agricultural Land

Own agriculture land	Respondents	
	No.	%
Yes	103	99.0
No	1	1.0
Total	104	100.0
Year and food sufficiency		
Yes	89	86.4
No	14	13.6
Total	104	100.0

Source: Field Survey, 2006.

4.3 PERCEIVED MEAN AGE AT MARRIAGE

According to the respondents, the perceived mean age at marriage is 24.3 years for Boys and 20.2 years for Girls. As a whole, there was not differentiation in the perceived mean age at marriage among the different caste groups, except for Magar Boys. For example, the perceived mean age at marriage for Boys was 23.9, 23.6, 23.0, 25.0 and 23.4 years for Tharu, Chhetry, Brahman, Magar and other. Similarly perceived mean age at marriage for Girls was 21.0, 19.9, 20.3, 20.0 and 19.6 years of Tharu, Chhetri, Brahman, Magar and other respectively (Table 12).

Table 12: Distribution of Respondents According to Perceived Mean Age at Marriage by Caste

Caste/Ethnicity	Perceived mean age at marriage for boys	Perceived mean age at marriage for girls	Total
Tharu	23.9	21.0	46
Chhettri	23.6	19.9	36
Brahman	23.0	20.3	14
Magar	25.0	20.0	3
Other	23.4	19.6	5
Total	24.3	20.2	104

Source: Field Survey, 2006

4.4 LIVING ARRANGEMENT

Table 13 shows that, more than 97 percent respondents were living in their own house at the time of interview. About 3 percent respondents were living with relatives and living in hostel. Compared to boys (1.8%) higher percent of girls (4.2%) were living with relatives.

Table 13: Distribution of Respondents by Living Arrangement

Living arrangement	Sex of the respondents				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Own house	55	98.2	46	95.9	101	97.1
Relative's house	1	1.8	2	4.2	3	2.9
Total	56	100.0	48	100.0	104	100.0

Source: Field Survey, 2006.

CHAPTER- V

KNOWLEDGE ON STIs, HIV/AIDS, DRUG AND USE OF CONDOM

Knowledge of STIs, HIV/AIDS and drug use is common in school adolescents. But this study aims identifying whether they have correct knowledge. Young people can be exposed to a wide range of attitudes and beliefs in relation to sex and sexuality. These sometimes appear contradictory and confusing. For example, some health messages emphasize the risks and dangers associated with sexual activity and some media coverage promote the idea that being sexually active. Because of sex and sexuality being sensitive subjects, young people and sex educators can have strong views on what attitudes people should hold, and what moral framework should govern people's behavior these too can sometimes seem to be at odds. Young people are very interested in the moral and cultural framework that binds sex and sexuality. They often-welcome opportunities to talk about issues where people have strong views, like abortion, sex before marriage, lesbian and gay issues and contraception and birth control. It is important to remember that talking in a balanced way about differences in opinion does not promote one set of views over another, or mean that one agrees with a particular view. Educational interventions have been managed so to provide basic information to adolescents. After ICPD (1994) each nation is giving attention to protect reproductive health of adolescents and so in our country.

The chapter presents the level of knowledge and behavior of the respondent's regarding, STIs, HIV/AIDS, drugs and use of condom.

5.1.1 LEVEL OF KNOWLEDGE ON STIS

Education status is important social factors, which plays vital role to determine the level of the knowledge on STI's. In the field study, respondents were asked whether they have heard about STIs or not ? Furthermore those who have heard about STIs were asked to name different types of STIs. Results shows that 81.7 percent students have heard about STIs and only 18.3 percent students have not heard about it among 104 students. Compare to girls (75%), higher percent of boys (87.6%), have about STIs.

Table 14: Distribution of Respondents by Knowledge on STIs

Knowledge on STIs	Sex of the respondents				Total	
	Boys		Girls		No .	%
	No.	%	No.	%		
Yes	49	87.5	36	75.00	85	81.73
No	7	12.5	12	25.00	19	18.27
Total	56	100.00	48	100.00	104	100.00
Name of the Heard of STIs*						
Syphilis	45	91.83	33	91.66	78	91.76
Gonorrhoea	36	73.46	29	80.55	65	76.47
Other	13	26.53	11	30.56	24	28.24

Source: Field Survey, 2006.

Students are found having heard about common STIs like syphilis and gonorrhoea but they were not familiar with other STIs like ghalamydia, trichomonosis, genital warts and cancroids. According to the study among the 85 students who have heard about STIs, 91.8 percent of the students have knowledge of syphilis. Similarly, 76.5 percent of the students were able to name gonorrhoea. The level of knowledge, of STIs is slightly higher among Boys students than Girls students.

5.1.2 SOURCE OF KNOWLEDGE FOR STIS

Source of information can be based on the social-cultural aspects of individual. Different common options were given to respondents to choice. Among the 85 students in this study who had heard about STIs 65.9 percent reported that teacher was the source for knowledge of STIs which is highest among proportions of respondent reporting various sources (Table 15). This is followed by ratio (51.8%), television (21.2%), newspaper and books (12.9%), parents (.11.8%) and friends (8.2%).

Table no 15: Distribution of Respondents according to sources of knowledge for STIs by sex

Sources of information	Sex of the respondents*				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Radio	28	57.1	16	44.5	44	51.8
Television	11	22.5	7	19.4	18	21.2
Newspaper	7	14.6	4	11.1	11	12.9
Friends	5	10.2	2	5.6	7	8.2
Parents	7	14.5	3	8.3	10	11.8 +
Teacher	29	59.2	27	75.0	56	65.9
Other	1	2.0	-	-	1	1.2

source:Field survey 2006

Table 15 also shows that higher percent of girls (75.0%) reported teacher as the source of knowledge for STIs which is only 9.2 percent for boys. While on the other 10.2 percent boys have heard about STIs from friends which are only 5.6 percent for girls.

5.1.3 KNOWLEDGE ON TRANSMISSION OF STIS BY MODES

Among the 85 students in study who had heard about STIs, knowledge on mode of transmission of the STIs is found high because 96.7 percent students (82) believed that STD is transmitted through unsafe sexual contact (Table 16). Similarly, more than 98 percent students know that it is not transmitted from eating together or/and living together. Only a few students didn't respond about the modes of transmission of STIs.

STIs are the communicable diseases which are transmitted through various sexual behaviors and other activities. STIs are transmitted through direct unsafe sexual intercourse, mouth contact to genitals and areas, exchange of syringes, transfusion of infected blood etc.

The transmission knowledge on STIs is higher among Boys students as 97.96 percent Boys students know that STIs are transmitted through unsafe sexual contact. But in the case of Girls

students, only 94.45 percent said so. The proportion of Girls students who do not know about STIs was quit higher than Boys. One of the strong reasons for this difference may be due to that Girls usually do not open discuss about the mode of transmission of STIs.

Table 16: Distribution of Respondents According to Mode of Transmission of STIs by Sex

Knowledge of transmission of STIs	Sex of the respondents*				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	48	98.0	34	99.4	82	96.4
No	1	2.0	2	5.6	3	3.5
Total	49	100.0	36	100.0	85	100.0
Mode of transmission of STIs**						
Unsafe sexual contact	48	100.0	34	100.00	82	100.0
Sharing infected blade/syringe	25	52.1	19	55.9	44	53.7
Blood transfusion	31	64.6	30	88.2	61	74.4
Birth from infected mother	23	47.9	18	52.9	41	50.0

Source: Field Survey, 2006.

* Note: Only those who have knowledge about STIs.

** Note : Only those who have knowledge of transmission of STIs.

Result so that 96.5 percent respondents have knowledge on mode of transmission of STIs and only 3.5 percent have not knowledge about it among 85 students. Among 82 students in this study who had knowledge on mode of transmission of STIS, all students believed that STD is transmitted through unsafe sexual contact. Similarly, 74.4 percent students know that it is transmitted through blood transfusion and more than 50 percent students know that it is transmitted through sharing infect blade/syringe or/and birth from infected mother. The transmitted knowledge on STIs is almost equal between both sexes.

Knowledge on STIs transmission is found high among Brahman more than 80 percent of them have knowledge about it and this is followed by Tharu 97.3 percent Tharu, 96.7 percent, Chhetri 96.7 and Magar 66.7 percent. These respondents know that STIs are transmitted through unsafe sexual contact. Among the different caste groups, Magar have comparatively lower knowledge than other caste groups.

Table 17: Distribution of Respondent According to Transmission Knowledge of STIs by Cast

Caste	Mode of Transmission*								Total	
	Unsafe sexual contact		Sharing infected blood/syringe		Blood transfusion		Birth From Infected mother			
	No.	%	No.	%		%	No.	%	No.	%
Tharu	36	100.0	21	58.3	29	80.6	19	52.8	36	43.9
Chhetri	29	100.0	13	42.8	20	69.0	12	41.4	29	35.4
Bralunan	11	100.0	9	8.8	9	81.8	10	90.9	11	13.4
Magar	2	100.0	-	-	1	50.0	-	-	2	2.4
Others	4	100.0	1	25.0	2	50.0	-	-	4	4.9
total	82	100.0	44	53.7	61	74.4	41	50.0	82	100.0

* Note: Only those who have knowledge about STIs.

Source: Field Survey, 2006.

Table 17 shows that all of respondents know that STIs are transmitted through unsafe sexual contact, knowledge on STIs transmission is found among Brahmin as more than 80 percent of them have knowledge about it, followed by Tharu, Chhetri and Magar. Among the different castes groups, Magar have comparatively lower knowledge than other.

5.1.4 TRANSMISSION KNOWLEDGE ON STIS BYAGE

Among the 82 students who had knowledge on more of STIs is transmission, more than 95.00 percent students in all 18-19 years age group have knowledge about all modes of transmission of STIs. But unsafe sexual contact as the major mode of transmission of STIs in known by all students in each age group. The study also shows that there is positive relationship between the knowledge of STIs and age of respondents.

Table 18 Distribution of Respondents by Knowledge on Mode of Transmission

Age group	Mode of Transmission*								Total	
	Unsafe sexual contact		Sharing infected blood/syringe		Blood transfusion		Birth From Infected mother			
	No.	%	No.	%	No.	%	No.	%	No.	%
14-15	45	100.0	21	46.7	27	60.00	17	37.8	45	54.
16-17	33	100.0	19	55.6	30	90.9	21	63.6	33	40.2
18-19	4	100.0	4	100.0	4	100.0	3	75.0	4	4.9
Total	82	100.0	44	53.7	61	74.4	41	50.0	82	100.0

Source: Field Survey, 2006

* Note : Only those who have knowledge about STIs.

5.2.1 LEVEL OF KNOWLEDGE OF HIV/AIDS

HIV/AIDS is fatal untreated disease. It was diagnose in 1983. For the first time it has caused lot of causalities worldwide. Developing countries are more affected because of it. The productive manpower especially the youths is being affected because of it. The case of HIV/AIDS is not so much higher in Nepal but the pace of growth is alarming, if not checked surely will invite disaster in the country's economic development. Respondents wee asked they have known about HIV/AIDS. Knowledge on HIV/AIDS is common among adolescents since large mechanism is devoted to increase awareness in adolescents. The national, regional and grassroots level campaigns have been launched to provide information to them. Recently, the school level campaigns have been launched to provide information to them. Recently, the school level curricula have been rearranged including information on Reproductive Health especially, about STIs re HIV/AIDS.

Table 19 shows that 99.0 percent respondent have heard about I-IIV/AIDS. Compared to boys all of lower percent of girls (97.9%) have heard of HIV/AIDS.

Table 19: Distribution of Respondents by Knowledge on HIV/AIDS

Knowledge of HIV/AIDS	Sex of the respondents				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Yes	56	100.0	47	97.9	103	99.0
No	-	-	1	2.1	1	1.0
Total	56	53.9	48	46.2	104	100.0

Source: Field Survey, 2006.

5.2.2 SOURCE OF INFORMATION

As in the sources of STIs, the sources for information on HIV/AIDS are also classified into six different options, i.e., 1 radio, 2 television, 3 newspaper, 4 friends, 5 parents and 6 teacher. Curriculum media have positive role in enhancing the information on HIV/AIDS, and communication media have also positive role in enhancing the information on HIV/AIDS. The development of mass media has increased the level of awareness among adolescents.

Table 20: Distribution of Respondents by Source of Knowledge for HIV/AIDS

Source of Knowledge	Sex of respondents*				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Radio	50	89.3	45	95.7	95	92.3
Television	28	56.0	27	53.2	55	53.4
Newspaper	13	23.2	9	19.2	32	31.1
Friends	9	16.1	6	12.8	15	14.6
Parents	11	37.5	4	8.5	15	19.6
Teacher	55	98.2	43	91.5	98	95.2

) Source: Field Survey, 2006.

) Note: Only those who have heard HIV/AIDS.

Table 20 shows that majority of respondents (95.3%) obtained knowledge of AIDS through teacher, followed by radio (92.3%), television (53.4%), newspaper (31.1%), parents (14.6%) and friends (14.6%). Nearly 99 percent Boys respondents have known about AIDS from teacher whereas it is 91.5 percent for Girls. But radio and television are the sources for higher percent of Girls respondents than Boys.

5.2.3 KNOWLEDGE ON MODES OF HIV/AIDS TRANSMISSION BY SEX

Most of the respondents reported that they have right knowledge about the modes of transmission of HIV/AIDS except infected mother to new born child. The knowledge on modes of HIV/AIDS transmission is high among Girls students. More than 97 percent Girls students believed that HIV/AIDS is transmitted through unsafe sexual contact, whereas only 83.9 percent Boys students said so. The difference between Girls and Boys is 13.9 percent. Similarly, 78.8 percent Boys students mentioned sharing blade and syringe as an important way of transmission but only 57.4 percent Girls students mentioned it. But in the case of blood transfusion as a mode of HIV/AIDS transmission the proportion of Boys students (73.2%) is found higher than Girls (57.4%). This study also indicates that 14.3 percent Boys students have knowledge of transmission of HIV/AIDS through infected mother to new born child while only 51 percent Girls have knowledge about it. About all of students have knowledge that HIV/AIDS is not transmitted from mosquito bite, spit (saliva), sharing clothes/beds, using same latrine, handshake and breast feeding?

Table 21: Distribution of Respondents According to Knowledge on Modes of HIV/AIDS Transmission by sex

Transmission variables	Sex of respondents*								Total			
	Boys				Girls				Right answer		Not know	
	Right answer		Not know		Right answer		Not know		Right answer		Not know	
	N.	%	N.	%	N.	%	N.	%	N.	%	N.	%
Unsafe sexual contact	47	83.9	9	16.1	46	97.9	1	2.1	93	90.0	10	9.7
Blood transfusion	41	73.2	15	26.8	27	57.4	20	42.6	68	66.0	35	34.0
Mosquito Bite	56	100.0	-	-	47	100.0	-	-	103	100.0	-	-
Spit (Saliva)	56	100.0	-	-	47	100.0	-	-	103	100.0	-	-
Infected mother to child	8	14.3	48	85.7	4	8.5	43	91.5	12	11.7	91	88.3
Share clothes/beds	56	100.0	-	-	47	100.0	-	-	103	100.0	-	-
Use same latrine	55	98.1		1.8	47	100.0	-	-	102	99.0	1	1.0
handshake	56	100.0	-	-	46	97.9	1	2.1	102	99.0	1	1.0
Sharing blade/syringe	44	78.8	12	21.6	27	55.4	20	42.6	71	68.9	32	31.1
Breast feeding	55	98.2	1	1.8	46	97.9		2.1	101	98.1	2	1.9
Kissing	50	98.2	6	10.7	45	97.7	2	4.3	95	92.2	8	7.8

) Source: Field Survey, 2006.

) Note : Only those who have heard HIV/AIDS

5.2.4 KNOWLEDGE ON PREVENTION OF HIV/AIDS

For the analysis of preventive knowledge of HIV/AIDS, four variables were included in the questionnaire. This study reveals that among the total respondents of 104, 80.8 percent (4) students know about the preventive knowledge and 9.2 percent are not aware about it, which is comparatively lower level of knowledge than that of HIV/AIDS transmission.

This study shows that among those who have heard of HIV/AIDS, 70.2 percent said avoid from sexual contact as a way of HIV/AIDS prevention similarly 67.9 percent.

Students believe that HIV/AIDS can be prevented through checking blood before transfusion, 67.2 percent mentioned that condom plays the significant role to prevent from HIV/AIDS and 54.7 percent said it can be prevented by not sharing syringe/blade.

Table 22: Distribution of Respondents According to Knowledge on HIV/AIDS

Knowledge on HIV/AIDS prevention	Know*		Do not know*	
	No.	%	No.	%
No sexual contact	59	70.2	25	29.8
Check blood before transfusion	57	67.9	27	32.1
Use condom	64	76.2	20	23.8
Don't share syringe/blood	46	54.8	38	45.2

Source: Field Survey, 2006.

* Note: Only those who have knowledge of HIV/AIDS prevention.

5.2.5 PREVENTIVE KNOWLEDGE OF HIV/AIDS BY SEX

This study indicates that among those Boys who have knowledge of HIV/AIDS prevention, 55.9, 57.8, 68.4 and 67.4 percent reported no sexual contact or with only one partner, use condom, checking blood before transfusion, and not to share syringes/blade respectively are method of HIV/AIDS preventions. But among those family students who have knowledge HIV/AIDS preventions, 44.1 percent believed that no sexual contact is the way of prevention from HIV/AIDS, 42.9 percent said it can be prevented using condom, 31.6 percent said blood should be checked before transfusion and 32.6 percent reported not to share syringe/blade.

This study further reveals that more Boys have knowledge about various ways of HIV/AIDS prevention compared to Girls (Table 23). The major reason behind it might be that Girls students cannot openly discuss about the way of I-IIV/AIDS transmission because of social obstacles/shyness.

Table 23: Distribution of Respondents According to Knowledge of HIV/AIDS Prevention

HIV/AIDS prevention	Sex of the respondents*			
	Boys		Girls	
	Frequency	Percent	Frequency	Percent
No sexual contact	33	55.9	26	44.1
Use condom	37	57.8	27	42.2
Check blood before transfusion	39	68.4	18	31.6
Don't share syringe/blood	31	67.4	15	32.6

Source: Field Survey, 2006.

* Note: Only those who have knowledge of HIV/AIDS prevention.

5.2.6 PREVENTIVE KNOWLEDGE ON HIV/AIDS BY AGE

This study shows that the higher age groups students have more knowledge about HIV/AIDS prevention than lower age groups students. More than 75.0 percent students in the age group 18-19 years have preventive knowledge of HIV/AIDS. Which is, more than 53 percent in the age group of 14-15 years. Among the students in the 18-19 age group who have knowledge of HIV/AIDS prevention all of students said blood should be check before transfusion and lowest percent (75.0%) favored for no sexual contact, similarly, among students in the 16-17 age group who have knowledge about HIV/AIDS prevention, highest (83.7%) and (64.5%) was observed preferring for use of condom and no sexual contact and for age group 14-15, same was observed preferring for use of condom and not to share syringe/blade.

Table 24: Distribution of Prevention Knowledge on HIV/AIDS of Respondents by Age

Prevention variables/age	Age of the respondents*					
	14-15		16-17		18-19	
	N.	%	N.	%	N.	%
No sexual contact	36	73.5	20	64.5	3	75.0
Use condom	41	83.7	20	64.5	3	75.0
Check blood before trans	38	77.6	15	48.4	4	100.0
Don't share syringe/blood	26	53.1	17	54.8	3	75.0
Total	49	100.0	31	100.0	4	100.0

Source: field survey, 2006

Note: Only those who have knowledge of HIV/AIDS prevention.

5.2.7 BEHAVIOR TOWARD HIV/AIDS PATIENTS

After finding out the knowledge on transmission and prevention of HIV/AIDS, the study is concerned about the behavior of students on HIV/AIDS patients. Behavior was analyzed by including four variables. The study reveals that 83.5 percent students are not feeling risky to handshake with HIV/AIDS infected persons. Similarly 61.2, 31.1 and 45.6 percent students did not feel risky with HIV/AIDS infected person while eating together, sleeping in the same room and using same clothes respectively. However, 16.50 percent students feel risky to handshake with HIV/AIDS patients, 38.8 percents feel risky to sleep in the same room with them and 54.4 percent feel risky using same clothes. It is found that more students are not feeling risky to handshake with HIV/AIDS infected persons then doing other activities with them.

Table 25: Distribution of Respondents According to their Perceived Behavior with HIV/AIDS Patients

Behavior variables	Respondents*			
	Not risky		Risky	
	No.	%	No.	%
Handshake	86	73.5	17	16.5
Eat together	63	61.2	40	38.8
Sleep in a room	32	31.1	71	68.9
Use same clothes	47	45.6	56	54.4

Source: Field Survey, 2006.

* Note: Only those who have heard knowledge of HIV/AIDS.

5.2.8 BEHAVIOR TOWARD HIV/AIDS PATIENTS BY SEX

This study reveals that more Boys students than Girls are not feeling risky as 85.72 percent of them said they can shake hand with HIV/AIDS infected people. Similarly, 69.74, 51.79 and 57.14 percent Boys students said that they do not feel risky eating together, sleeping in same room and using same clothes respectively with them. But only 80.85 percent Girls said they will shake hand with HIV/AIDS infected person. The difference between proportions of Boys and Girls is approximately 4.7 percent in this regard. Nearly 52 percent Girls students did not feel risky eating together with HIV/AIDS patients, 6.38 percent did not feel risky sleeping in the same room and 31.91 percent did not feel risky using same cloth with them.

Table 26: Distribution of Respondents According to their Perceived Behavior with HIV/AIDS Patients by Sex

Behavior variable	Sex of respondents*							
	Boys				Girls			
	Not risky		Risky		Not risky		Risky	
	N.	%	N.	%	N.	%	N.	%
Handshake	48	85.7	8	14.3	38	80.9	9	19.2
Eat together	39	69.7	17	30.4	24	51.1	23	48.9
Sleep in a room	29	51.8	27	48.2	3	6.4	44	93.6
Use same clothes	32	57.2	24	42.9	15	31.9	32	68.1

Source: Field Survey, 2006

Note: Only those who have heard of HIV/AIDS patients.

5.2.9 BEHAVIOR TOWARD HIV/AIDS PATIENTS BY AGE

The perceived behavior toward HIV/AIDS patients is not found different between respondents of age group 14-15 and 16-17 years. More than 80.0 percent respondents in both age groups said they can shake hands with HIV/AIDS patients. This study shows that the proper knowledge of HIV/AIDS is less among respondents of age group 14-15 years compared to age group 16-17 years. But it is higher among respondents in the age group 18-19 years as around all of them are not feeling risky to shake hand, eat together, sleep in the same room and share clothes with HIV/AIDS infected people.

Table 27: Distribution of Respondents According to their Perceived Behavior with HIV/AIDS Patients by Age Group

Variable	Age of the respondents*												Total			
	14-15				16-17				18-19				Not risky		Risky	
	Not risky		Risky		Not risky		Risky		Not risky		Risky		Not risky		Risky	
	N.	%	N.	%	N.	%	N.	%	N.	%	N.	%	N.	%	N.	%
Handshake	50	820	11	180	31	83.8	6	16.2	5	100.	-	-	86	83.5	17	16.5
Eat toget	35	57.4	26	426	23		14	37.9	5	100	-	-	63	61.2	40	38.8
Sleep in a room	16	26.2	45	73.8	12	32.4	25	67.6	4	800	1	20.0	32	31.1	71	68.9
Use same clothe	23	37.7	38	62.3	19	51.4	18	48.7	5	100	-	-	47	456	56	54.4
Total	61 (59.2)				37 (35.9)				5(4.9)				103(100.0)			

Source: Field Survey, 2006

Note: Only those who have heard of HIV/AIDS.

5.2.10 CONCEPT OF FAMILY

To understand the concept of parents a hypothetical question "Would your family accept you incase of HIV/AIDS infection?" was asked. This question keeps value because many adolescents hide the disease because of fear from the family, which ultimately helps to spread the disease. Therefore, co-operation of family is necessary.

Majority of respondents (64.1%) reported that they would be accepted even if they where infected by HIV/AIDS, whereas 35.9 percent respondents reported negative response. Compared to boys (58.4%) higher percent of girls (70.2%) reported their family would accept them.

Table 28: Distribution of Respondents According to their Perceived Attitude of Family Towards

Would family accept	Sex of respondents*				Total *	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	33	58.9	33	70.2	66	64.1
No	23	41.1	14	29.8	37	35.9
Total	56	100.0	47	100.0	103	100.0
Reason for not accepting**						
Social prestige	11	47.8	6	42.9	17	45.9
Communicable disease	7	30.4	5	35.7	12	32.4
Family Reputation	4	17.4	2	14.3	6	16.2
Others	1	4.4	1	7.1	2	5.4
Total	23	100.0	14	100.0	37	100.0

Source: Field Survey, 2006

* Note: Only those who have heard HIV/AIDS.

** Note: Only those who think will not accept their family.

5.3. LEVEL OF KNOWLEDGE ON DRUGS

In the field study, respondents were asked whatever they have heard about drug or not? They were also asked to name of drugs. The study reveals that 94.2 percent students have heard about drugs among the 104 respondents, and it is 94.6 percents among boys and percentage 93.8 percents among girls. More boys' students have knowledge about drugs than girls' students.

TABLE 29: DISTRIBUTION OF RESPONDENTS WHO HAVE HEARD ABOUT DRUG BY SEX

Heard of Drugs	Sex of respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	53	94.6	45	93.6	98	94.2
No	3	5.3	3	6.3	6	5.8
Total	56	100.0	47	100.0	103	100.0

Source: Field Survey, 2006.

5.3.1 SOURCE OF KNOWLEDGE FOR DRUG

Among the 98 students in this study who had heard about drug, 62.2 percent reported radio as the main source of knowledge for drug. Similarly, the study reveals that teacher was the source for 38.8 percent students less than 20.0 percent each reported TV, newspaper, friends and parent as the sources for drug. TV and newspaper are reported by lower proportion of respondents because of lack of availability of these facilities.

Table30: Distribution of Respondents According to Source of Knowledge for Drugs by Sex

Source of information	Sex of respondents*				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Radio	36	64.3	25	52.1	61	62.2
T.V.	7	12.5	12	25.0	19	19.4
Newspaper	6	10.7	4	8.3	10	10.2
Friends	3	5.4	3	6.3	6	6.1
Parents	6	10.7	9	18.8	15	15.3
Teacher	22	39.3	16	33.3	38	38.8

Field Survey, 2006

* Note: Only those who have heard of drugs.

5.3.2 KNOWLEDGE ON TYPE OF DRUGS

Among 98 students who had heard about drug, 85.7 percent said drug is a chemical substance, which intoxicates the users. Similarly, 7.1 percent said it is chemical substances which give relief to the users and 3.1 percent said it is a chemical substance than can be taken by all. Likewise, 5.7 percent Boys did not stage their perceived opinion about drugs. This proportion for Girls is some that less with only 2.2 percent.

Table 31: Distribution of Respondents by Knowledge on Type of Drugs

Knowledge on Drugs	Sex of respondents*				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
A chemical substance which intoxicate the User	46	86.8	38	84.4	84	85.7
A Chemical substances which give relief to the users		5.7		8.9		7.1
A chemical substances can be taken by all	1	1.9	2	4.5	3	3.1
No stated	3	5.7	1	2.2	4	4.8
Total	53	100.0	45	100.0	98	100.0
Name of the drugs						
Cannabis	43	81.1	34	79.1	77	78.6
. Heroin	17	32.1	13	30.2	30	30.6
Opium	11	20.8	6	14.0	17	17.3
Sleeping Tablet	5	9.4	4	8.9	9	9.2
Not Stated	3	5.7	1	2.3	4	4.1

Source: Field Survey, 2006.

Note: Only those who have heard of drugs.

Table 31 also shows that highest percent of respondent (78.6%) have knowledge about Cannabis, followed by Heroin (30.6%), Opium (17.3%) and sleeping tablet (9.2%), compared to girls higher percent to boys have heard about Cannabis.

5.3.3 RELATIONSHIP BETWEEN HIV/AIDS AND DRUG

Almost 90 percent respondents said there is relationship between HIV/AIDS and drug. But 10 percent respondents reported they have no idea about it. Compared to girls (87.5%) higher proportion of boys (91.6%) reported having knowledge about it.

Table 32: Distribution of Respondents by Knowledge on Relation between HIV/AIDS and Drug by Sex. Sleeping Tablet

Knowledge on relation between HIV/AIDS and drug	Sex of respondents				Total	
	Boys		Girls		No.	%
	No.	%	No.	%		
Yes	51	91.1	42	87.5	93	89.4
No	5	8.9	6	12.5	11	10.6
Total	56	100.0	48	100.0	104	100.0
Way of relation*						
Drug addicts have strong sexual desires	27	52.9	27	64.3	54	58.1
Drug addiction and prostitution are related	29	56.9	38	96.5	67	72.0
Drug contains STIs and HIV/AIDS germs	3	5.9	2	4.8	5	5.4
Drug addicts sit and live together	31	60.8	29	69.1	60	64.5
Drug addicts are unhygienic	4	3.9	1	2.4	3	3.2
Drug addicts share syringe	46	90.2	32	76.2	78	83.9

Source: Field Survey, 2006.

Note: Only those who have knowledge about relation between HIV/AIDS and drug.

5.4. KNOWLEDGE OF CONDOM

For prevention of STIs and HIV/AIDS, knowledge on condom use essential. As sex is basic need for human being, for prevention from AIDS, use of condom is most important method. This section carries information about knowledge of condom and its use.

This study reveals that out of total 93.3 percent students have heard about condom, which is 96.4 percent among Boys and 89.6 percent among Girls students.

Table 33: Distribution of Respondent in knowledge on Relation between HIV/AIDS and Drug by sex.

Heard of condom	Boys		Girls		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	54	96.4	43	89.6	97	93.3
No	2	3.6	5	10.4	7	6.7
Total	56	100.0	48	100.0	104	100.0

Source: Field Survey, 2006.

5.4.1 SOURCE OF KNOWLEDGE FOR CONDOM

Among the 97 students who have heard of condom, 74.23 percent reported radio as the main source of knowledge for condom. Similarly, 35.05, 16.49, 10.3, 11.34 and 5.15 percent student teacher, TV, newspaper, friends and parents respectively as tile sources for condom. More Boys have gained knowledge about condom from mass media than Girls.

Table 34: Distribution of Respondents According to Source of Knowledge for Condom by Sex

Source of Knowledge/sex	Boys*		Girls*		Total*	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Radio	41	75.9	31	72.1	72	74.2
TV	8	14.8	8	18.6	16	16.5
Newspaper	6	11.1	4	9.3	10	10.3
Friends	7	13.0	4	9.3	11	11.3
Parents	3	5.6	2	4.7	5	5.2
Teacher	18	33.3	16	37.2	34	35.1

Source: Field Survey, 2006

Note: Only those have heard of condom (54 Boys and 43 Girls).

5.4.2 KNOWLEDGE OF USE OF CONDOM

Among 97 students who had heard about drug, 86.6 percent students know that condom prevent STIs and HIV/AIDS and 5.4 percent know that it can prevent the conception. This study shows that 85.2 and 50 percent boys have knowledge that condom prevent STI and HIV/AIDS conception respectively. The corresponding figures for Girls are 88.4 and 39.5 percent respectively (Table 35).

Table35: Distribution of Respondents According to Knowledge on use of Condom by Sex

Variables	Boys*		Girls*		Total*	
	No.	%	No.	%	No.	%
Prevention of STI and HIV/AIDS	46	85.2	38	88.4	84	86.6
Prevent conception	27	50.0	17	39.5	44	45.4

Source: field survey2006

Note: Only those have heard of condom (54 Boys and 43 Girls).

CHAPTER -VI

GROUP DISCUSSION AND PUBLIC COMMUNITIES

6.1 PUBLIC PARTICIPATION

Discussion is an important factor in this study, which plays the vital role to determine the level of knowledge and behavior on STIs, HIV/AIDS and drug. Involvement of adolescents in different group discussions, communication and expression of opinion are important aspects of awareness development. Public participation increases confidentiality in adolescents as well as socialization is enhanced. This section deals on the communication among friends, use of communication media, and participation in awareness programs.

6.1.1 DISCUSSION WITH FRIEND

In this field study, whether respondents have ever discussed about HIV/AIDS, STIs and drug abuse with their friends were also enquired. Discussion with friends helps to exchange the knowledge. Table 35 shows that majority of the respondents (64.4%) reported they discuss with friend while 35.6 percent reported they do not discuss. Compared to girls (62.5%) higher proportion of boys (66.1%) reported having discussion with friends. This may be because boys are comparatively frank than girls. Girls hesitate to discuss about these matters. A follow-up question was asked to state the frequency of discussion with friends. Majority of respondents (26.9%) have discussed sometimes followed by 25.4 percent discussing frequently.

Table 36: Distribution of Respondents According to Discussion with Friend about STIs HIV/AIDS and Drug Use

Discussion with friend about STIs, HIV/AIDS and drug use	Sex of respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	37	66.2	30	62.5	67	64.4
No	19	33.9	18	37.5	37	35.6
Total	56	100.0	48	100.0	104	100.0
Frequency of discussion						
Many times	9	24.3	7	23.3	16	23.9
Sometimes	7	18.9	11	36.7	18	26.9
frequently	9	24.3	8	26.7	17	25.4
Rarely	12	32.4	4	13.3	16	23.9
Total	37	100.0	30	100.0	67	100.0
Reason for not discussing						
Not interested	12	63.2	9	50.0	21	56.8
Uneasy to discuss	1	5.3	4	22.2	5	13.5
Not necessary	6	31.6	5	27.9	11	29.7
Total	19	100.0	18	100.0	37	100.0

Source: Field Survey, 2006.

6.1.2 DISCUSSION WITH FRIENDS BY CASTE/ETHNICITY

Table 36 shows that almost 79 percent from Brahman caste have discussed with friends about STIs, HIV/AIDS and drugs use, followed by 69.4 percent Chhetri, 66.7percent Magar and 58.7 percent Tharu respondents. Table also tries to indicate the differential of discussion on between various caste/ethnic groups.

Table37: Distribution of Respondents According to Discussion with Friends by Caste/Ethnicity

Caste/Ethnicity	No. of respondents			
	Discussing with friends		Total	
	No.	%	No.	%
Tharu	27	58.7	46	44.2
Chhetri	25	69.4	36	34.6
Bramhan,	11	78.6	14	13.5
Magar	2	66.7	3	2.9
Other	2	40.0	5	4.8
Total	67	64.4	104	100.0

Source: Field Survey, 2006.

6.1.3 DISCUSSION WITH FRIEND BY AGE

Table 38 shows that almost 80.00 percent respondents of age group 18.2 have discussed with friend about STIs, HIV/AIDS and drugs use followed by 78.4 percent students of age group 16.2. The lowest percent of students (54.8%) involved in discussion were from age group 14-15. The study shows that as the age increases the practice of discussion about these matters also increases.

Table 38: Distribution of Respondents According to Discussion with Friends

Age	No. of respondents			
	Discussing with friends		Total	
	No.	%	No.	%
14-15	34	54.8	62	59.6
16-17	29	78.4	37	35.7
18-19	4	80.0	5	4.8
Total	67	64.4	104	100.0

Source: Field Survey, 2006.

6.2. USE OF COMMUNICATION MEDIA

Role of communication media in this time has been highly evaluated. Communication media are playing positive role in enhancing the knowledge among adolescents. The current and important message is transferred to readers through media. If the development of media is utilized with the

motive of developing health sex habits among adolescents, it will surely bring greater change among them. But now-a-days unhealthy use of media has brought a lot of problems. For example, the pornographic videos, posters, and news materials have caused bad impacts among adolescents. These types of activities in any cost should be distressed.

Respondents were asked whether they have habit of using different communication media. Questions were asked relating the three major sources of media i.e. radio, newspaper and television. Highest percent of respondents (94.2%) reported that they use to listen program related to reproductive health from radio followed by television (70.2%) and newspaper (64.4). Radio is the major source of information for adolescents. Therefore, the programs should be developed effectively through this media.

Table 39: Distribution of Respondents According to Use of Communication Media

Communication Media	No. of Respondents	Percent
Radio	98	94.2
Newspaper	67	64.4
Television	73	70.2

Source: Field Survey, 2006.

6.2.1 AWARENESS PROGRAM

Awareness program in the community has greater role for promoting reproductive health status of adolescents. Different agencies such as HMG, NGOs and INGOs are involved in community awareness programs. These agencies have various programs to address the needs of adolescents but a directive motive of implementation of such programs in grassroots level is needed. Respondents were asked whether they know about such programs were concocted in their locality.

The study shows that 46.15 percent respondents know about such awareness programs conducted in their location. Compared to girls (43.75%) higher percent of boys (48.21%) know about such awareness program.

Table 40: Distribution of Respondents According to Knowledge of Awareness Program Conducted in Locality

Any awareness program conducted in locality	Sex of respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	27	48.2	21	43.8	48	46.2
No	29	51.8	27	56.3	56	53.9
Total	56	100.0	48	100.0	104	100.0
Participation in program						
Yes	11	40.7	7	33.3	18	37.5
No	16	59.3	14	66.7	30	62.5
Total	27	100.0	21	100.0	48	100.0

Source: Field Survey, 2006.

Table 39 shows that among these who have knowledge about programs conducted in their locality, 62.5 percent have not participated in community awareness programs. Compared to girls (33.3%), higher percent of boys (40.7%) have participated in community awareness programs. It suggests that participation of adolescents in community awareness programs should be increased.

6.2.2 DISCUSSION IN FAMILY

Discussion on reproductive health matter is not common in Nepal, because of various social and cultural barriers. In our society, discussion within family on reproductive health is not encouraged. But due to change in the status of people and other development activities, the trend has been changing and discussion has started within the family. The result of this study also proves it. More than one third of respondents (38.46%) reported that they use to discuss with family members. Compared to boys (37.5%), higher percent of girls (33.6%) reported that they use to discuss these matters in their family. This shows that Girls are aware of their reproductive health.

Table 41: Distribution of Respondents According to Discussion about STIs, HIV/AIDS and Drug use in their Family

Discussion in family	Sex of respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Yes	21	37.5	19	39.6	40	38.5
No	35	62.5	29	60.4	64	61.5
Total	56	100.0	48	100.0	104	100.0

Source: Field Survey, 2006.

6.2.3 ROLE OF GOVERNMENT

The government should play important role for protecting the reproductive health of the adolescents. As Nepal has already ratified the ICPD 1994, the state is urged to implement all of the possible ways to promote the reproductive health of adolescents. On this ground, respondents were asked what public awareness program should be conducted to increase information on adolescents. About 27 percent respondents reported that curriculum should be improved. Compared to girls (89.6%), higher percent of boys (96.4%) reported that state should conduct public awareness program to increase information on adolescents.

Table 42: Distribution of Respondents According to their Perceived Opinion about Role of the State

Role of state	Sex of respondents				Total	
	Boys		Girls			
	No.	%	No.	%	No.	%
Conduct awareness	54	96.4	43	89.6	97	93.3
Improve curriculum	27	48.2	11	22.9	28	26.9

Source: Field Survey, 2006.

In fact, the course content of secondary level is not insufficient for providing information and the course needs to be updated timely so that new information can be include.

CHAPTER- VII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study focuses on the causes and prevents common and fatal disease. Common incense of spreading everywhere rapidly all over the world, fatal incense of not curing yet all. it cant be cure but can be decrease the ratio of transmission by the proper knowledge and awareness.

This study also describes the harms of use of drugs and due to the drug abuses the most of cause to transmit of HIV/AIDS and sexual disease. We have the followings major findings and conclusions.

7.1 SUMMARY

Following are the major findings of this study.

I. Background Characteristics of Respondents

) The age of the respondents ranged from 14 to 19 years, the highest percent of respondents (43.3%) were aged 15 years and the lowest (1.9%) in the age 18.

) The mean family size of the respondent is found to be 6.8 Tharu constitutes the highest percent of respondents (44.2%) and the lowest percent are from Magar (2.9%). Hindu is the major caste with 99.0 percent respondents.

) More than one-third (39.4%) respondents were from extended family. This shows that the family breakdown is rapid.

) Less than one-fourth (23.1%) reported that all members of their family are literate whereas 80.8 percent respondents have literate father. Highest percent of respondent's .father (38.6%) have completed primary level of education, followed by secondary level of education (19.2%).

) Agriculture is the major source of income for 86.5 percent of respondents followed by government/private sector service (10.6%), whereas only 84.6 percent respondent's father were engaged in agriculture, followed by governmental/private service sector (11.5%).

) Almost all respondents reported that they have agricultural land. Of those who have

agricultural land 86.4 percent reported food sufficiency.

II. Knowledge on STIs, HIV/AIDS, Drug and Use of Condom

) Nearly 82 percent respondents have knowledge about STIs and syphilis was the most commonly heard STIs with 91.8 percent and Gonorrhoea was the least heard STIs (76.5%).

) Highest percent of respondents (65.9%) got information about STIs from teacher/school curriculum, followed by radio (51.76%).

) Highest percent of respondents over 98.9 percent reported that STIs are not transferred through living together or/and eating together. More than 96 percent respondents reported that STIs are transferred through unsafe sexual intercourse.

- Almost all respondents have heard about AIDS. Compared to girls (97.9%), higher percent of boys (100%), have heard about AIDS. Majority of respondents heard about AIDS through teachers followed by radio.

) About 90 percent respondents said that AIDS is transmitted from unsafe sex, followed by 68.9 percent reporting through infected syringe/blade, whereas the lowest percent of the respondents (11.7%) reported AIDS is transmitted through infected mother to child.

) Nearly all respondents have knowledge that AIDS is not transmitted from mosquito Bites, spit (saliva), sharing clothes/blades, using same latrine and handshake.

) About 94 percent respondents have heard about drugs. Compared to boys (94.6%), lower percent of girls (93.8%) have heard about drugs.

) Highest percent of the respondents (62.2%) got information about drugs from Radio followed by teachers (38.8%).

) About 86 percent respondents said drug is a chemical substance, which intoxicates the users, whereas the lowest percent of the respondents (3.1%) reported drug is a chemical substance that can be taken by all respectively. Cannabis (*Gajha, Chares and Bhang*) was the most commonly heard drugs.

) About 99 percent respondents agreed that it is necessary to prevent from drug abuse, whereas 88.8 percent focused on public awareness for prevention.

) More than 89 percent respondents have knowledge that there is relationship between HIV/AIDS and drug and among them 83.9 percent-reported way of the relation between them as

drugs addicts share syringe/blade.

) Highest percent of the respondents (86.6%) know that use of condom during sexual intercourse can prevent AIDS and STIs.

) Majority of respondents reported that their family would accept them if they were STIs and HIV/AIDS infected. Those who reported negatively reported social prestige as the major reason.

- Majority of the respondents have information that condom is used for both purpose i.e. to avoid conception and prevent STIs and HIV/AIDS.

III. Group Discussion and Public Participation

) More than 64 percent respondents reported they use to discuss with friends about STIs, HIV/AIDS and drugs. Compared to girls, higher percent of boys use to discuss with friends.

- About 46 percent respondents reported that awareness programs were conducted in their locality and among them only 37.5 percent have participated in such programs.

) About 93 percent respondents reported that state should conduct public awareness programs to increase information about STIs, HIV/AIDS and drugs for adolescents.

) About 94 percent respondents reported that they use to listen program related to reproductive health from radio.

7.2 CONCLUSIONS

Almost all students have heard about HIV/AIDS and the average knowledge among students is high. Some misconception is also reported specially about the transmission routes of AIDS. But level of knowledge of STIs is found less among students compare to that of AIDS and condom.

The results of this study show that Boys students have more knowledge, because they can openly discuss about STIs and HIV/AIDS without any hesitation, but Girls students have less knowledge compare to Boys because of the shyness and other social obstacles. The level of knowledge of respondents about STIs and HIV/AIDS shows that higher the age, higher the proportion of respondents having knowledge.

Students have knowledge that condom can prevent the transmission of STIs and HIV/AIDS, they emphasized that in the present pandemic situation of AIDS, people should use condom to prevent the STIs and HIV/AIDS and to control the birth.

One of the major sources of information about STIs, HIV/AIDS and drug is teacher (school curriculum) among the respondents. Less than 25 percent students have received information about STIs and HIV/AIDS from parents and friends because they have also lack of knowledge about it. About 94 percent students have heard about drug and Boys students have more knowledge because they have more freedom than Girls.

7.3 RECOMMENDATIONS

This section presents some specific recommendation for the policy implication.

) Adolescents are more vulnerable to HIV/AIDS because of their instable behavior. They should be provided consistent information about reproductive health emphasizing on STIs and HIV/AIDS.

- Education plays the vital role to determine every change in society. This study recommends that detail education about reproductive health must include in the school curriculum.

) Social and cultural norms are obstacles in the society to discuss about STIs and HIV/AIDS. Therefore AIDS education should be provided according to the cultural and social background of the society.

) The major sources of information on STIs, HIV/AIDS and drug are teacher (school curriculum) and radio. Therefore, the transmission and prevention knowledge should be provided regularly with more information through radio and school curriculum should be improved on timely to prevent from STIs, HIV/AIDS and drug abuse.

) The environment should be created between Boys and Girls students and teachers to discuss about the STIs and HIV/AIDS, which is helpful to share knowledge among the students.

) The video program should be promoted to understand about the importance of knowledge on STIs, HIV/AIDS and drug abuse among students.

7.4 FURTHER RESEARCH ISSUES

School children, especially adolescents are vulnerable group for STIs, HIV/AIDS and drug abuse. A large proportion of adolescents are involved in the school. The national curriculum in the schools has tried to give information about sexual diseases and drugs but information are not adequate. Still there are many obstacles hindering the full information to adolescents. In our country, where sex education is still remained as taboo and the societies as well as families are not free of it, only the school curriculum is not sufficient for providing information to them. The social system, education planning and family background are most important aspects influencing the level of knowledge to adolescents. Therefore, it is necessary to investigate the relationship between family background, curriculum and adolescent's knowledge on STIs, HIV/AIDS and drug abuse.

REFERENCES

- Acharya, L.B., 1999, "*Knowledge on HIV/AIDS*," in Bal Kumar KC (ed.), *Population and Development in Nepal*, Vol. 1(Kathmandu: CDPS), 27-136.
- Brin, J. Gilligan, 2004, *HIV/AIDS and Working Children in Nepal* (Kathmandu: ILO).
- Bhandari, J., 2003, *World AIDS Day*, Daily Newspaper, The Rising Nepal.
- Central Bureau of Statistics (CBS), 2002, *Population Census: National Report* (Kathmandu: CBS).
- Central Bureau of Statistics (CBS), 2002, *Population Census: Mid-Western Development Region* (Kathmandu: CBS).
- CWIN (2001), *Alcohol Use in Nepal with Reference to Children* (Kathmandu: CWIN).
- Dahal, Y.B., 2003, *Knowledge and Behavior on ST/s, HIV/AIDS and Public Participation Among Secondary Level Students: A Case Study of Sanischare VDC, Morang*, An Unpublished MA Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).
- Dhital, S., 1999, *Trend of Drug Use in Nepal*, A Presentation Paper (Kathmandu: CWIN).
- Gosden, T.B., 1987, *Drug Abuse: The Truth About Today's Drug Science* (Kathmandu : ILO).
- Giri, N., 2001, *Knowledge and Attitude on STIs and HIV/AIDS among Unmarried Youth in Tulsipur Municipality of Dang District*, An Unpublished MA Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).
- International Labor Organization, 2003, *Safety Culture at Work* (Geneva: ILO).

Mahat, L.C., 2002, *Knowledge and Behavior on STIs and HIV/AIDS among Boys Seasonal Migrant: A Case Study of Selected VDC of Jumla District*, An

Unpublished MA Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).

Maskey, G., 2002, *Injecting Drug Users (IDUs) and Their Vulnerability of STIs and HIV/AIDS, A Case Study in Kathmandu Valley*, An Unpublished MA

Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).

National Centre for AIDS and STIs Control (NCASC), 2003, *Quarterly AIDS Newsletter*, Year 13. No. 50.

Roka, D.R., 2000, *Knowledge and Behavior on STIs and HIV/AIDS Among School's Adolescents, A Case Study on Khotang District*, An Unpublished MA

Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).

United Nation Children's Fund (UNICEF), 2002, *Orphans and Other Children Affected by HIV/AIDS* (Kathmandu: UNICEF).

United Nations Children's Emergency Found, 2002, *South Asia, The HIV/AIDS Epidemic* (Abuja: UNICEF).

World Health Organization (WHO), 2002, *Young People and HIV/AIDS Opportunity in Crisis* (Geneva: WHO).

Appendix: Sample of Questionnaire

Tribhuvan University
Central Department of Population Studies
Kirtipur, Kathmandu

Sample of Questionnaire

Introductina Background

District:VDC/Municipality:

Ward No. :Tole :

Respondent No. :Date of interview:

I Individual and Household Information

101. Name of the respondent:Sex 1. Boys 2. Girls

102. Age of the respondent:

103. Caste/ethnicity:

104. Religion:

105. Where do you live?

(1) Own house (2) Hostel (3) Rented room

(4) Relatives' house (5) others (specify)

106. How many members are there in your house?

107. What type of family is yours ?

- (1) Nuclear (2) Joint (3) Extended 108. 108.

What is the main source of living of your family?

- (1) Agriculture (2) Service (3) Business

(4) Others (specify)

109. Are you married? (1) Yes (2) No. ---> 112

110. What was your age at marriage?

111. What was the reason for your marriage?

112. In your opinion, what is an appropriate age of marriage for boys and girls?

Boys Girls:

113. Are all members of your family literate?

- (1) Yes --> 116 (2) No

114. How many of them are literate?

115. Is your father/mother literate?

- (1) Yes (2) No -> 118

116. What is the highest level completed by him? Father: Mother:

117. What is the main occupation of your father?

- (1) Agriculture (2) Government/Private Service
(3) Business (3) none (5) others (specify)

118. Does your household own land?

(1) Yes (2) No -> 201

119. Is the land owned by your households sufficient for your livelihood?

(1) Yes (2) No

II. Knowledge on STD and HIV/AIDS

201. Have you ever heard about any STIs?

(1) Yes (2) No -> 301

202. Name me the STIs you have heard.

203. From where did you hear first?

(1) Radio (2) Television (3) Newspaper (4) Friends

(5) Parents (6) Teachers (7) Other (specify) :

204. Do you know the way of transmitted STIs ?

(1) Yes (2) No -> 206

205. How are STIs transmitted?

(1) Unsafe sexual contact (2) Living together (3) Eating together

(4) Sharing infected syringe/blade (5) By mosquito bites

(6) Blood transfusion (7) By infected mother to the birth

(8) Don't know (9) others:

206. Have you ever heard about HIV/AIDS?

- (1) Yes (2) No --> 211

207. From where did you hear first?

- (1) Radio (2) Television (3) Newspaper

- (4) Friends.....(5) Parents (6) Teachers

- (7) Other (specify) :

208. Have you knowledge on modes of HIV/AIDS transmission?

- (1) Yes (2) No --> 211

209. Which of the following statement is true?

- (1) AIDS is transferred from Boys only.
(2) AIDS is transferred from Girls only.
(3) AIDS is transferred from neither of them.
(4) AIDS is transferred from both of them.

210. What are the other modes of transmission of the AIDS?

- (1) Unsafe sexual intercourse (2) Blood transfusion
(3) Mosquito bite (4) Spit (saliva)
(5) Sharing bed/clothes (6) Using public toilet
(7) Sharing towels/food/shaking hands (8) Brest feeding
(9) Kissing..... (10) Sharing blade and syringe (11) Other :

211. Do you know the way of prevention from STIs and HIV/AIDS?

(1) Yes(2) No -> 213

212. What are the ways of preventions?

(1) Abstinence (no sexual contact) (2) Check blood before transfusion (3) Use condom
..... (4) Don't share syringe/blade (5) Other
(specify) :

213. Have you ever suffered by any STIs ?

(1) Yes (2) No -> 215

214. What did you do after the infection?

(1) Had medical treatment (2) Informed to parents

(3) Informed to friends..... (4) Do no thing (5) Others

215. If you were suffered from any STIs, what would you do? (1) Have
medical treatment (2) Inform to parents

(3) Inform to friends (4) do nothing

(5) Don't know (6) Other (specify) :

216. If you meet any HIV/AIDS infected patient would you do the following activities?

(1) Shake hands (1) Yes (2) No

(2) Eat together (1) Yes (2) No

(3) Sleep in one bed (1) Yes (2) No

(4) Share clothes (1) Yes (2) No

217. Would you family accept if you were suffered from STIs and HIV/AIDS ?

(1) Yes -> 301 (2) No

218. Why would you family not accept you?

(1) Fear of transformation

(2) Social reputation

(3) Family reputation

(4) Other (specify) :

III. Knowledge on use of Condom

301. Have you every heard about condom?

(1) Yes

(2) No -----> 401

302. From where did you hear?

(1) Radio

(2) Television

(3) Newspaper

(4) Friend

(5) Parents

(6) Teachers

(7) Other (specify) :

303 Why do you think people use condom?

(1) Avoid conception (2) Prevention from STIs and HIV/AIDS

(3) Other (specify):

304. Would you use condom to prevent STIs and HIV/AIDS?

(1) Yes --> 306

(2)No

305. Why would you not use condom?

(1) Fear from society (2) Don't know how to use

(3) Difficult to get (4) other (specify):

306. Have you ever had any sexual relation with any one?

(1) Yes (2) No -> 401

307. with whom?

(1) Boy/girl friend (2) Prostitutes

(3) Other (specify) :

308. Did you use condom at the time of intercourse?

(1) Yes ----> 401 (2) No

309 Why did not you use condom?

(1) Didn't know (2) Was not available

(3) Didn't know how to use (4) Not necessary (5)

Other (specify):

IV. Information on Drug

401. Have you heard about drug?

(1) Yes (2) No -> 501

402. From were did you hear?

(1) Radio (2) Television (3) Newspaper

(4) Friends(5) Parents (6)
Teachers (7) Other (specify)

403 . Have you knowledge on drugs ?

(1) Yes (2) No -> 405

404 . What is drug ?

(1) A chemical substance which intoxicate the users (2) Achemical substance which give relief to the users (3) A chemical substance can be taken by all (4) Don't know

(5) Others:

405 . Have you heard the following drugs?

(1) Cannabis (i) Ganja (ii) Charesh (iii) Bhang (iv) Dhaturu

(2) Herion (i) Smak (ii) Brown sugar

(3) Opium (i) Codeine (ii) Methadine (iii) Morphine

(iv) Pethidine (v) Tidigesi

(4) Sleeping Table (i) Valium (ii) Librium (iii) Ativan

(iv) Buskam (v) Nitroson

(5) Others (i) Gum (ii)boot polish (iii) Iodex

(iv) Kerosene (v) Petrol (vi) Others

406 . How do the drug addicts use drug ?

(1) Smoking (2) Sniffing (3) Chasing

(4) Swallowing (5) Drinking (6) Injecting

407 . What are the symptoms of drug addicts?

(1) Greater sense of isolation (2) Diminished social
interaction (3) Reduced attention to personal hygiene (4) More legal difficulties

(5) Change in eating and sleeping pattern (6) Increased irritability

. (7) Reluctance to change the compulsive behavior

408 In your opinion is there necessary to prevent people from using drug?

(1) Yes 2) No -> 410

409. If yes, how ?

(1) Making strict law (2) Social discard (3) Public awareness

(4) Counseling and rehabilitation (5) Others :

410. Do you think use of drug and STIs and HIV/AIDS are related?

(1) Yes (2) No -> 501

411. Why are they related?

(1) Drug addicts have strong sexual desires

(2) Drug addiction and prostitution are related

(3) Drug addicts share syringe

(4) Drug contains STIs and HIV/AIDS germs

(5) Drug addicts sit and live together

(6) Drug addicts are unhygienic

(7) Others :

V. Group Discussion and Public Communication

501. Have you ever discussed about STIs and HIV/AIDS with your friends?

(1) Yes (2) No -->

502. How many times have you discussed?

(1) Many times (2) Sometimes (3) Rarely

(4) Frequently (5) Others (specify) :

503 Why don't you discuss with friends?

(1) Don't like (2) Feel shy (3) Not necessary

(4) Other (specify) :

504. Do you read on newspaper about the information on STIs and HIV/AIDS ?

(1) Yes -> (2) No

505. Why don't you read?

(1) Not available (2) don't like (3) Other (specify):.....

506. Do you listen the program about STIs and HIV/AIDS on radio ?

(1) Yes --> 508 (2) No

507. Why don't you listen?

(1) No available (2) Don't like (3) Other (specify) :

508. Do you watch TV for program related to STIs and HIV/AIDS?

(1) Yes --> 510 (2) No

509. Why don't you read?

(1) Not available (2) don't like (3) Other (specify):

510. Has any organization conducted awareness program in your locality?

(1) Yes (2) No

511. Have you participated on such programs?

(1) Yes (2) No

512. Have you made any discussion on such topics in family?

(1) Yes (2) No

513. Have you shared the knowledge on the topics to your friends?

(1) Yes (2) No

514. What do you think the state has to do to protect the reproductive health of the Adolescents?

(1) Conduct awareness program. 2) Improve the curriculum (3) others (specify)