

CHAPTER I

INTRODUCTION

The title of this thesis is “Knowledge on Sexually Transmitted Infections (STIs), Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)” among adolescent and youth. The basic premise for the thesis is set out the Knowledge on STI sand HIV/AIDS of adolescent and youth in the Khalanga Village Development Committee (V.D.C.), Rukum. This chapter deals with the General Background, Statement of the Problem, Objectives, Significance, Limitation and Organization of the study.

1.1 General Background

Adolescents and youth¹ is the period of Physical, Psychology and Social maturing from Childhood to Adulthood. Adolescence and youth is the age when an individual becomes integrated into the society of adults or the age when the child no longer feels that is below the level of his/her elder but equal, at least in rights. This integration into adult society has many aspects, more or less linked with puberty and maturity. It also includes very profound intellectual changes. These intellectual transformations typical of the adolescents thinking enable a person not only to achieve integration into the social relationship of adult, but also develop the phenomena of responsibility and feeling of being a part of society. (CBS, 2003)

Sexually Transmitted Infections (STIs) indicates the disease which is transmitted by sexual intercourse. A sexually transmitted infection (STIs) to person primarily through sexual contact. Now a day, the incidence of sexual transmitted infection is high and rapidly increasing in the region are unprotected sex between clients and sex worker. Needle sharing among drug injectors and unprotected sex between men. Commercial sex provides the virus.

¹ Adolescent: 10-19 years (early adolescent 10-14 years and late adolescent 15-19 years).

Youth: 15-24 years

With considerable scope for spread. Maximum countries in the world have been suffering from the great problem.

The Human Immune Virus (HIV) infection affects the immune system. The immune system is defense of a body, against infection by microorganisms (such as very small bacteria or viruses). Immune system enables the skin and mucus membranes to fight against or kill these harmful microorganisms. HIV causes AIDS. Acquired Immune Deficiency Syndrome (AIDS), a health condition, in which a person loses the efficiency of the immune system and is affected by a series of diseases. The HIV by itself is not illness and does not instantly lead to AIDS. HIV infected person can live a healthy life for many years before developing the state of AIDS.

There are a number of ways of transmission of HIV. Some of the important and prevalent are depicted below:

1. Through sexual intercourse (vaginal, anal and oral) between an infected person and his/her partner (man to woman, woman to man).
2. Through exchange of infected blood during transfusion.
3. By skin-piercing instruments e.g. sharing contaminated needles and syringes during injecting drug-use; using unspecialized needles of tattooing, ear piercing, acupuncture etc.
4. From mother to child transmission of HIV can occur during pregnancy, labor and delivery and breast feeding.

There are some ways identified as the behaviors to follow the prevention from HIV/AIDS. These are adopted safe and clean sex, avoid needles used by drug addicts and infect people, use condom, avoid multiple partners; be faithful to one partner only, avoid blood transfusion unless absolutely necessary, get a blood test done in case of doubt, HIV infected mother should not get pregnant, communicate fact about AIDS to other person and health education and women education are very important to control it.

Study on HIV/AIDS is very relevant to present day in developed and developing countries. The HIV/AIDS pandemic is one of the most serious health concerns in the world today, because of its high case fatality rate and the lack of a curative treatment or vaccine. The various aspects, problems and issues related to the spread of this disease have only just started to emerge. At this stage of its spread, it has already made an impact on human existence. It is also considered as the negative impact or burden of development efforts. Initially it has more prevalent in developed country, and afterwards its spread and consequences more severe are developing countries. The widow period, carrier stage and the stage of AIDS are the three segments of the syndrome. Since it is fatal and more related to sexual behavior, and adolescents are at the threshold of such behavior it is essential to conduct study on the knowledge of this group of people on STIs and HIV/AIDS (UNAIDS, 2010).

1.2 Statement of the Problem

Most of the research works are focused towards the Reproductive Health, (RH) Sexual Health, Family Planning (FP) method, family health and knowledge of STIs and HIV/AIDS by a number of researchers. Most of them are based on urban samples. Only limited research works are undertaken using the data from remote or rural area of Nepal. From a policy making point of view, the information of each and every part of the country should be given equal importance.

STIs and HIV/AIDS is a burning and growing problem in Nepal along with poor socio-economic and health status of the people. Most of the people are illiterate which leads them to get married at earlier age. Without having basic education on sex and health, it is always disadvantageous for the adolescents to be involved in sexual activities prematurely. Such activities are the main cause of spreading STIs and HIV/AIDS. Besides this, these are factors play vital role for the rapid spreading and transmission of HIV/AIDS.

Rukum district is rural and remote area of Nepal. Most of the people are illiterate and poor dependent in Agriculture and go to India for Daly wage work. People are backward and they could not get higher education, there is

lack of health facility and services, less access to the political, social and economic sector.

STIs related cases are increasing and found few cases of HIV/AIDS in Rukum district. Because of the returned migrated persons from India and many adolescent and youth have been identified as infected with HIV/AIDS. Lack of health facilities, lack of information about STIs and HIV/AIDS, so this research is important for this study knowledge on STIs and HIV/AIDS age group 10-24 years Khalanga VDC, Rukum. They are as follows:

-) Poor health service, infrastructure and health information system.
-) Low level of awareness towards STIs and HIV/AIDS.
-) Low coverage of mass media on STIs and HIV/AIDS prevention.

Adolescent and Youth especially of 10-24 years are believed to engage in high level of unprotected sexual activity. Consequently the further problem of unwanted pregnancy and HIV/AIDS. Such behavior also causes a major threat to the health of adolescents and youth as well as retarding their potential, education carrier and economic development.

1.3 Research Questions

The study was conducted to study the Knowledge on STIs and HIV/AIDS of Khalanga V.D.C. Rukam. This study would answer the following Questions.

-) Will be the higher socio-economic status of household associated with higher knowledge?
-) Can we expect the responsible sexual behavior of adolescents with high knowledge?
-) Is there association between access to information, knowledge and responsible sexual behavior?
-) Is level of knowledge on STIs and HIV/AIDS one of the determinant of family planning use?

1.4 Objectives of the Study

The general study is to assess the Knowledge on STIs and HIV/AIDS of Khalanga V.D.C. Rukum. The specific objectives of the study are:

-) To evaluate the socio-economic and demographic background of the household level of adolescents and youth.
-) To examine the knowledge on transmission, mode and preventive measures of STIs and HIV/AIDS among adults and youth.
-) To identify the various sources of information on STIs and HIV/AIDS.
-) To assess the sexual behavior, knowledge and use of family planning.

1.5 Significance of the Study

The adolescents and youth are most likely to start the experience and experiment with their sexuality that makes them potentially vulnerable to AIDS related risk behavior. Among them the group adolescent and youth are with high risks. This study fills in the gap to know the several behaviors including premarital sexual relation of adolescents and youths. This study aims to help the adolescents and youth to be aware of the use of family planning against STIs and HIV/AIDS, is the one hand and would be indicator to adopt coherent measures to address the problem by the family, community, schools and the government. Therefore, there is paramount importance of this study.

1.6 Limitations of the Study

This work is mostly based on primary data. This work can't cover the maximum area this topic but I hope it will be a useful referential material for others who are interested and concerned to this field.

The study is limited only 115 respondents are included in the sample from Khalanga VDC, Rukum. The findings of the study are not generalized in national level.

1.7 Organization of the Study

The presentation of the study is divided into six chapters. These are: I) Introduction II) Literature Review III) Methodology IV) Socio-economic and

Demographic Characteristics V) Knowledge on STIs and HIV/AIDS and VI) Summary, Conclusions and Recommendations.

The first chapter deal with the introduction focusing on the general background, statement of the problems, objectives of the study, significance of the study, limitation of the study and organization of the study.

The second chapter presents the review of literature relevant to STIs and HIV/AIDS with special emphasis on the study of sexual behavior. This chapter makes us more clearly on the topic of STIs and HIV/AIDS.

The third chapter deal with the research methodology begins with the selection of the study area, method of data collection, sample selection, sample size, questionnaire design and method of data analysis.

The fourth chapter presents socio-economic and Demographic characteristics analysis is divided into individual and household characteristics including age, sex, caste/ethnic composition of respondent family size, parents' education as well as occupation of household head.

The fifth chapter includes analysis of knowledge on STIs and HIV/AIDS among adolescent and youth respondents. It also includes the involvement in sexual activities and sexual partners, use of preventing method of family planning and impact of knowledge of STIs and HIV/AIDS to the sexual behavior.

Finally, the sixth chapter explains the summary of the whole study along with major conclusions and recommendations.

CHAPTER II

LITERATURE REVIEW

This chapter deals about the available on sexual behavior, sexually transmitted infection HIV/AIDS, history of more vulnerable groups of acquiring STIs like Syphilis, Gonorrhea and HIV/AIDS etc. were reviewed to generate the adequate relationship between the variables and to share the other opinion on the issued statement.

2.1 Background of HIV/AIDS

The AIDS was first reported in 1981 in United States of America. The causative organism of HIV/AIDS was identified in 1983. The HIV was diagnosed by Dr. Robber Gallo (USA) in 1984. The virus eventually became known as the HIV. There are two types of HIV:

-) HIV- 1, the most common type found world widely and
-) HIV-2, found mostly in West Africa and in a few countries in South East Asia.

The HIV infections affect the immune system. The immune system in the person's defense against infections by microorganisms (such as very small bacteria or viruses) that get pasted the skin and mucus membranes' to fight off or kill these microorganisms. A special weakness of the immune system is called Lymphocytes and Coenocytes (UNAIDS, 2010).

The HIV transmission occurs when a person is exposed to body fluids infected with virus, such as blood, semen, virginal secretions and breast milk. The primary modes of HIV transmission are 1) sexual relations with an infected person, 2) sharing hypodermic needles or accidental pricking by a needle contaminated with infected blood and 3) transfer of the virus from an infected mother to her baby during pregnancy, childbirth, breast feeding. When HIV enters the body, it infects Lymphocytes white blood cells of immune system. The virus commands the genetic material of the host cell, instruction the cell to replicate more viruses. The newly formed viruses break from the host,

destroying the cell in the process. The new viruses go on to infect and other Lymphocytes (UN, 1994).

The HIV situation in Nepal is categorized as a concentrated epidemic with the estimated prevalence among the general population being below one percent, and more than 30 percent among some groups identified as Most At-Risk Populations' (MARPs). According to the National center for AIDS and STD control (NCASC) estimates, there were about 70,000 people, including children and adults, infected by HIV in Nepal 2007. As of May 2009, a cumulative total of 13,885 HIV infections, including 2,384 cases of AIDS, have been reported in the country (NCASC, May 14, 2009). Although the reporting system of HIV/AIDS cannot actually measure the prevalence rate of infections because of under reporting and reporting delays, it does indicate because of under reporting and reporting delays, it does indicate which sub-groups of the population are most affected.

The national HIV/AIDS strategy 2006/11 has identified several MARPs and Proposes effective strategies and targeted intervention programs for these groups. The Integrated Biological and Behavioral Surveillance (IBBS) survey among these MARPs is conducted regularly as a part of the National surveillance plan to inform the development of the strategy and the National HIV/AIDS Action Plan." Men having Sex with Men" (MSM) have been identified as a core risk group because of their high risk sexual behavior with low levels of condom use and a high turnover of both male and female partners. According to Blue Diamond society, a Non-Government Organization (NGO) working with MSM in Nepal, the number of MSM in the country is on the rise (CREHPA/SACTS/FHI 2005) and low levels of awareness about HIV increase exposure to the disease whilst preventing those who are living with the virus from seeking treatment. A number of intervention strategies are underway to promote HIV/AIDS awareness at a large scale among the MSM Population.

The first round of the IBSS among MSM in Kathmandu Valley was conducted in 2004 and showed a 4.8 percent HIV prevalence among MSW and 3.6 percent among MSM (CREHPA/SATS/FHI 2005). The survey also indicated that over half of the NSWs (54%) and on in five (19%) MSM were exposed to at least

one form of STI. The second round of the IBBS conducted in 2007 showed a 3.3 percent HIV prevalence among MSM in the Kathmandu Valley, with 3.4 percent among non-MSWs and 2.9 percent among MSWs. Additionally, it was found that 19.4 percent of MSWs and 16.4 percent of non MSWs were exposed to at test on form of STIS. (New ERA/FHI, 2009).

International Conference on Population and Development (ICPD) and HIV/AIDS.

The International Conference on Population and Development (ICPD), held in Cairo in September 1994, was a milestone in the history of population and development, as well as the history of women's rights. 179 countries agreed that population and development are inextricably linked, and that empowering women, and meeting people's need for education and health, including Reproductive Health (RH), are necessary for both individual advancement and balanced development.

The AIDS pandemic is a major concern in both developed and developing countries. WHO estimates that the cumulative number of AIDS cases in the world amounted to 2.5 million persons by mid 1993 and that more than 14 million people had been infected with HIV since the pandemic began, a number that is projected to rise to between 30 million and 40 million by the end of the decade if effective prevention strategies are not pursued. As to mid 1993, about four fifths of all persons ever infected with HIV lived in developing countries where the infections was being transmitted mainly thorough heterosexual intercourse and the number of new cases was rising most rapidly among women. As a consequence, a growing number of children are becoming orphans, themselves at high risk of illness and death. In many countries, the pandemic is now spreading from urban to rural areas and between rural areas and is affecting economic and agricultural production (UNFPA, 1996).

Millennium Development Goals (MDG) and HIV/AIDS:

In 2000, leaders of 189 nations gathered at the millennium summit to discuss solutions to combat poverty, hunger, illiteracy, disease, discrimination against women and environmental degradation they agreed on a set of Millennium

Development Goals (MDGs). According HIV is a component of reproductive health. however, as resources to combat the epidemic have poured in, parallel services have evolved, with their own personnel, administrative structures and funding The continuing influx of resources presents an opportunity to gain efficiencies advance the MDG health goals, and make the ICPD vision of universal reproductive health care a reality for the millions of people living in poverty whose quality of life and very survival depend on them.

If these programmes lead to a proliferation of specialized clinics, however, funds, earmarked for HIV/AIDS have the potential to pull staff and resources away from other MDG. This could undercut efforts to strengthen and streamline health systems. It would also be a grave disservice to users. The poor typically receive only piecemeal information and service-even though they may have pressing concerns retrograding both HIV and other reproductive health issues. Moreover, sexually transmitted HIV adamancy other reproductive health problems are rooted in the same attitudes and behaviors.

A number of agreements and UN resolutions have called for an essential and comprehensive package of reproductive health and HIV/AIDS services to be made available to all service users. This recommendation was echoed by the UN Millennium Project Task force on combating AIDS. Providing an essential integrated package is both equitable and ethical. It is also a strategic is both equitable and ethical. It is also a strategic way to ensure that health systems are strengthened rather than weakened by fragmented approaches and competing Priorities (UNFPA, 2005).

Three Year Interim Plan (2007/08-2009/10) Communicable Disease Control Program (STIs and HIV/AIDS).

AIDS control requires a multi dimensional approach programs will be conducted through the engagement of Regional Health Directorates, District Public Health office, and District AIDS coordination committees' primary Health care centers, health volunteers. A semi-autonomous body will be established for the wider and effective coverage through monitoring and evaluation worlds in coordination with the concerned ministries, other

Government agencies, donor communities and NGOs. Existing Anti-Retroviral drug treatment centers will be extended and necessary medicines will be distributed free of cost to HIV/AIDS infected and Patients of sexually transmitted diseases. The national coordination system will be further strengthened and made participatory. (National Planning Commission, 2007).

Recognizing the importance of a timely response, the Governments of Nepal is committed to the prevention and control of AIDS and other STDs in Nepal through a multicultural approach. In 1988, the Government initiated the National AIDS Prevention and Control Project (NAPCP), with financial and technical support from the World Health Organization (WHO). The project aimed at preventing HIV transmission through sexual contact and blood transfusion, preventing prenatal transmission, and reducing the impact of HIV/AIDS on individuals and families. The National AIDS Coordination Committee (NACC) was established in non-governmental organizations. The NAPCP become a focal point for NACC and was responsible for coordinating HIV/AIDS prevention and control programs with the various ministries. The activities of the NAPCP were coordinated through the NACAS established in 1993. A national policy was formulated in 1995, which emphasized the importance of multi-sect oral involvement, decentralized implementation, and partnership between the public and private sectors, including local NGOs (NDHS, 2006).

2.2 World Situation on STIs and HIV/AIDS Pandemic

Although the last two decades have witnessed great progress in the prevention and treatment of HIV/AIDS, the global epidemic remains one of the greatest challenges in the field of global health. Since the disease was first identified in 1981, more than 25 million people have died of AIDS and at the end of 2008; 33.4 million people were living with HIV. With an additional 2.7 million people newly infected with HIV each year, the need to provide universal access to HIV/AIDS prevention as well as treatment, care and support to individuals, families and communities affected by the disease remains urgent. Recognizing this urgency, the international community has strengthened its commitment to combat the spread of the disease and to address the needs of people affected by

HIV and AIDS. In the Millennium Declaration that the United Nations General Assembly adopted in 2000, it made a commitment to that and reverse the spread of HIV by 2015 and in its 2006 political declaration on HIV/AIDS, the General Assembly Pledged to achieve universal access to HIV/AIDS prevention programmes, treatment, care and support by 2010. By 2009, 90 percent of governments cited the HIV/AIDS epidemic as a major concern and many had implemented a range of measures to address it. These measures include the routine screening of the blood supply for HIV. Information, Education and Communication (IEC) campaigns on the prevention and treatment of HIV/AIDS. Condom distribution programmes, the provision of free or subsidized Antiretroviral Therapy (ART) and the adoption of legislation to protect against HIV/AIDS related discrimination. Countries that have implemented such measures have succeeded in slowing the spread of HIV and have managed both to prolong the lives and to improve the quality of life people living with HIV (UNAIDS 2010).

In the context of HIV, risk is defined as the probability that person may acquire HIV infection. Certain behavior creates enhance and perpetuate of HIV such risk for example unprotected sexual partnership, lack of adherence to infection, repeated blood transfusion with shared needles and syringes. Therefore, those who have sexual relation with multiple partners have placed themselves at a high risk group for contacting with HIV/AIDS.

The epidemic of STIs in the developing countries is characterized by high incidence and prevalence high rate of complications, increasing problem of antimicrobial resistance due to inadequate treatment and increasing risk of transmission and acquiring HIV infection. The increasing urbanization and industrialization in developing world leads to migration of young men and women in search of employment in urban areas and even in other countries. This growing phenomenon results in increasing unsafe commercial sexual activities that help to spread STIs and HIV epidemic. In the context of HIV risk is defined as the probability create, enhance and perpetuate such risk for example, unprotected sex with a partner whose HIV status is not known to multiple unprotected sexual partnership. Therefore, those who have sexual

relation with multiple partners are placed themselves at a high risk group for contacting with HIV/AIDS. Risk arises from individuals engaging in risk taking behavior. They may have the lack of home information on HIV, they may be unable to be safe from negative sex and they may think that HIV/AIDS affects different social strata than their own or they have access to condoms. Religions socio cultural practices and other tradition-rigidity especially with respect to sex and reproductive health have made difficult to talk about sex in the context of Nepalese society. It is a paradox that sex is one of the commonest things in our life but still we talk least about it in our society. It is a subject that to be considered being a very personal and secret matter, whenever children ask their parents about sex and sexual organs they either ignore them or should thermo tell them utter lies.

The sexual attitude and behaviors of young adolescents in Jamaika have already been significantly shaped by socio-cultural and gender norms that send mixed message about sexuality and imposed different standards of behaviors for boys and girls. This risk of acquiring high among STIs including HIV infection is especially high among sexual partners significantly large. It is also the risk of contacting with sexually transmitted diseases is especially higher for young people who became sexually active in early age and are therefore more likely to change partners. Further more people have very poor knowledge about sex and sexuality contraception and STIs and their prevention (New Era, 2008: 75).

The HIV/AIDS is known as disease for the last two decades. This disease first came out from the USA in 1981. It was found to be more common among homosexual group whereas at the present the disease have increased among heterosexual group especially who has several sexual partners. Throughout the world, 60 percent of the AIDS patients are those people who have had heterosexual relations with many partners. HIV transmission through sexual intercourse accounts for about three quarters of all HIV infections worldwide. More then 80 percent of all HIV infection has been transmitted through sexual intercourse, in other words HIV infection is sexually transmitted diseases.

The STIs increases the chance that any, single sexual encounter will transmit the virus. In societies where STIs are widely spread and where people have many sexual partners, the risk of HIV infection is dramatically access. The majority of the worlds HIV infection have been acquired through sexual intercourse between man and women (heterosexual transmission) the proportion of HIV infection attributable to this mode of transmission continuous to grow HIV transmission through sexual intercourse between men (homosexual transmission) occurs in most part of the world. Although in the developed countries, it has become less common as the result of the adoption of safer sex practices of homosexuals men. (UNFPA, 2009).

The AIDS was first reported in 1981 in USA, the causative organisms of HIV/AIDS were identified in 1983. The pandemic nature and the magnitude of the public health problem associated with HIV. Infections were recognized much later when the proportion person infected with HIV rose vary rapidly. However considerable efforts are being made to contain the spread of HIV as the impact of HIV/AIDS seem to be very serious in a long term aspects. The HIV virus does not respect geographical boundaries. So no country of the globe is out of immune to HIV/AIDS. That is why this issue needs an issue of global thinking and intervention.

The number of people living with HIV has been rising in every region, compared to two years age, with the steepest increases occurring in East Asia, Eastern Europe and Central Asia. The number of people living with HIV in East Asia rose by almost 50 percent between 2007 and 2009, an increase that is attributable largely to China's swiftly growing epidemic. In Eastern Europe and Central Asia, there were above 40 percent people living with HIV in 2009. Accordingly that trends in Ukraine's resurgent epidemic and the ever-growing number of people living with HIV in Russian Federation (UNAIDS, 2010).

Sub-Saharan Africa remains far the worst affected region, with 254 million people living with HIV at the end of 2009, comparing to 24.4 million in 2008. Just under two thirds (64%) of all people living with HIV are in Sub-Saharan

Africa, as are more than three quarters (76%) of all women living with HIV (UNAIDS, 2010).

2.3 The HIV/AIDS Situation in Asia

National HIV infection levels in Asia are low comparing with some other continents, like Africa. But the population of many Asian nations are large that means even low national HIV prevalence, have large numbers of people living with HIV. Latest estimates show some 8.3 million people newly infected in the past year. The AIDS claimed some 540,000 lives in 2004. Among young people 15-24 years of age, 0.3 percent of women and 0.4 percent of men were living with HIV by the end of 2008. Asia is not just vast but diverse and HIV epidemic in the region shares that diversity, with the natural pace and severity of epidemic differing across the region. Overall, countries can be divided into several categories, according to the epidemics they are experiencing. While some countries were hit early (for example, Cambodia, Myanmar and Thailand), others are only now starting to experience rapidly expanding epidemic and need to mount swift, effective responses. They include Indonesia, Nepal, Vietnam and several provinces in China. In Myanmar and in parts of India and China, HIV has become well entrenched in some section of society, despite modest effects to half the virus spread. Other countries are still seeing extremely low levels of HIV prevalence, even among people at high risk of exposure to HIV, and have golden opportunity to pre-empt serious outbreaks. There include Bangladesh, East Timor, Laos, Pakistan and the Philippines (NCASC, 2009).

China, although mounting at a varied pace, HIV has spread to all of Chinas 31 provinces, autonomous regions and municipalities. In some parts such as Henan, Anhul and Shandong, HIV was already spreading a decade ago among rural people who sold blood plasma to supplement their incomes.

Elsewhere, the virus has established a more recent but firm presence among injecting drug users and to a lesser extent, sex workers and their client. Much of the current spread of HIV in China is also attributable to injecting drug use and paid sex. The HIV prevalence among drug injectors was measured at

between 18 percent and 56 percent in six cities in the southern provinces of Guangdong and Guangxi in 2008; while in Yunnan province some 21 percent of injecting drug users to their sex partners looks certain to feature more prominently in China's fast evolving epidemic. Some 47 percent of surveyed female drug injectors in Sichuan province and 21 percent in neighboring Yunnan province reported selling sex for money or drugs in the previous month, according to recent studies. Condom use was reportedly quite high but it was hardly the norm. Once HIV becomes well-established in commercial sex circuits, on wards spread of the virus could be quite rapid if current behavior trends persist. In 2008, almost one quarter of surveyed sex workers in Guangxi never used condoms and about one half used them only occasionally. In Sichuan, only around 40 percent of sex workers reported using condoms with all their clients in the previous month; to a study. Little is known about the possible role of sex between men in China's epidemic. Most new HIV infections in Asia occur when men buy sex and large number of men does so. Household based information in a number of Asian countries suggest that between 5 and 10 percent of men buy sex, which makes commercial sex a large and lucrative industry in Asia. Many sex workers especially very young women from rural areas are either coerced into the industry or join it under duress, because of the lack of other employment opportunities (NCASC, 2009)

2.4 HIV/AIDS Situation in SAARC Countries

Behavior that brings the highest risk of HIV transmission in the region are unprotected sex between clients and sex workers, needle sharing among drug injectors and unprotected sex between men. The countries which became the victim of it, they couldn't separate from the great trouble. Comparatively SAARC countries have less number of infected persons.

Though there is wide variation with south Asian region, there are many similarities. Different ethnic groups reside in this region with distinct culture but some of the characteristics are very similar. Basic development and the health indicators of the countries of this region are almost similar. All countries are basically agrarian in nature and economic status is low as well as the literacy rate. The health indicators are very much similar with high infected,

child and maternal mortality rates. The services in general are poor including reproductive health services. It is a taboo to talk about issues related to sex or sexuality. Nevertheless the social norms and values are deeply rooted in this region. The first HIV infection in SAARC countries was reported in India in 1986. This means that the endemic was introduced in the region later than other parts of the world. The infection rates in south Asia are lower than Africa but the spread of HIV is rapid. However, current trends show that this region will be severely affected very soon. For this reason the estimates of HIV in SARRC countries are often made on the basis of inadequate information (Acharya, 1999).

The virus of HIV/AIDS was reported in India in 1986 and second goes to Pakistan 1986, Sri Lanka, 1987, Nepal 1988, Bangladesh 1989 and Maldives 1991. The latest estimates show that about 5.1 million people were living with HIV in India in 2009. Serious epidemic are underway in several states. In Tamil Nadu, HIV prevalence of 50 percent has been found among sex workers while in each of Andhra Pradesh, Karnataka, Maharashtra and Nagaland, HIV prevalence measured at antenatal clinic in the Manipur cities of Imphal and Churachand has rose. Below 1 percent to over 5 percent with many of the women testing positive appearing to be the sex partners of male drug injectors. Several factors look set to sustain Manipurs epidemic, including the large proportion about 20 percent of female sex workers who inject drugs and the young ages of many injectors (UNAIDS, 2010).

The government of the India recognized the seriousness of the problem and took a series of important measures to tackle the epidemic. A high powered national AIDS committee was constituted in 1986 itself and a national AIDS control programs various preventive measure have been launching in India. To prevent HIV/AIDS in Bangladesh, a national AIDS committee (NAC) is established. NAC is advisory body to the ministry of Health and family welfare on all aspect of HIV/AIDS including legal ethical Managerial, Financial and technical issues. The Bhutanese Government is fully aware of the potential of its rapid spread. The approach towards the control and prevention of HIV/AIDS is also a broad based of the HIV virus. The strategic approaches are included to

improve surveillance, increased information, education and communication campaign about the disease and strengthened laboratory services so that timely and appropriate screening is carried out (UNFPA, 2009).

Although the reported HIV cases are very small in Maldives, Maldives is highly vulnerable to the AIDS pandemic. A sustained rapid economic growth to 7.2 percent has exposed Maldives to the outside world. HIV/AIDS prevention and control activities are given higher national priority under the National AIDS Council (NAC) program. The government of Sri Lanka established a National Task Force (NTF) in 1987 and a short term plan of action was formulated in July 1987. A multi sectoral, multidisciplinary National AIDS committee (NAC) first formed in 1988. NAC has four sub committee on laboratory services and surveillance, HIV care and counseling legal and ethical issues on HIV/AIDS and information, education and communication (IEC) functioning under it (NCASC, 2009).

2.5 STIs and HIV/AIDS Situation in Nepal

Nepal being landlocked, one of the least developed country in the world with immense problem of poverty, illiteracy, ignorance and number of young unemployed population has all the predisposing factor of increasing proportion of population being at the risk of STIs and HIV. In Nepal, the first cases of AIDS were reported in 1988. As the country being heterogeneous in terms of geography, caste and ethnicity, culture and tradition, it has multiple dimensions. Due to the lack of education and economic progress, there is lack of public awareness and health facilities in term of AIDS (UNAIDS, 2010).

The HIV/AIDS has become a major public health problem in Nepal. It has been increasing since the first case was detected in 1988 in Nepal. The HIV infected persons have been increasing rapidly in Nepal because of extensive use of commercial sex workers, high rates of sexually transmitted disease, low use of condom, drug users etc. Nepal ranks sixth amongst Asian nations in absolute numbers of HIV positive persons. Considering existing open borders with India, the threat of HIV/AIDS in Nepal is tangible because of migrant working population in metros of India, lack of job opportunities in Nepal, drug transfer

and silk route. The main identified mode of HIV transmission in Nepal is heterosexual contact, primarily commercial sex workers and their clients, Intravenous Drug Users (IVDUs) migrant workers (UNAIDS, 2010).

STIs prevalence among sex workers (SWs) is notably higher. Data from Pokhara, Kathmandu and Terai revealed the Syphilis prevalence among SWs were 18.8 percent in Terai, 19 percent in Kathmandu and 13.8 percent in Pokhara clients of sex workers (Truck drivers) were found to have 5.3 percent Syphilis. Similarly among family planning attendees, trichomoniasis was 6.0 percent, Chlamydia was 1.0 percent and HIV was 0.3 percent as per results of study conducted Adults 15 or over living with HIV - 68 thousands, Adult HIV prevalence - 0.5 percent, and AIDS deaths - 5 thousand. Cumulative number of HIV Infected approx 15 thousand. (NCASC, 2009).

**Cumulative HIV and AIDS Situation of Nepal
As of Mansir 2067 (15 December,2010)**

Total HIV infections reported	Male	Female	Total
	11,061	5,997	17,058

Cumulative HIV infection by sub-group and sex

Sub-groups	Male	Female	Total
Sex Workers(SW)	7	887	894
Injecting	2,616	61	2677*
Men having Sex with Men (MSM)	171		171
Blood or Organ Recipients	35	15	50
Client of sex worker	7,487	104	7,519
Housewives		4,467	4,467
Male Partners	30		30**
Children	660	434	1,094
Sub-group not identified	55	29	84
Total	11,061	5,997	17,058

***Mode of Transmission-IDUs or**

**** Male Partners of FSW/Female Migrant**

Cumulative HIV infection by age group and sex

Age group(Years)	Male	Female	Total
0-4	266	157	423
5-9	295	205	500
10-14	110	76	186
15-19	267	282	549
20-24	1,304	938	2,242
25-29	2,371	1,399	3,770
30-39	4,537	2,100	6,637
40-49	1,508	652	2,160
50-above	403	188	591
Total	11,061	5,997	17,058

Source: NCASC,2010 [as of 15 December 2010]

2.6 Conceptual Framework

From reviewed literatures, it is cleared that human behavior is influenced by social, economic, cultural and demographic, condition, and behavior play vital role in transmitting the STIs and HIV/AIDS. The conceived chain of relationship of STIs and HIV/AIDS with other factors including socio-economic demographic variables such as income, employment, cultural and religious norms, knowledge on STIs and HIV/AIDS prevalence of contraception, migration, place of transmission. To summarize the connection of these variables. The following conceptual framework has been mentioned.

Figure 1: Conceptual Framework for Knowledge on STIs and HIV/AIDS among Adolescent & youths

CHAPTER III

METHODOLOGY

This chapter explains about different areas/sectors such as introduction of Study Area, Methods of Data Collection, Sample Selection, Sample Size and Questionnaires Design. The Methodology is briefly interpreted along the following line.

3.1 Selection of the Study Area

Nepal is a land locked country between the two bigger Asian countries, India and China. It is one of the poor and small countries with 5 Development regions, 14 zones and 75 districts. According to the geographical feature Nepal can be divided into three ecological belts such as mountain, Hilly and Terai region. Rukum District is situated in hilly geophysical environment in Mid-Western Development Region of Rapti Zone. This research is the study of Khalanga V.D.C., ward no.5, 6 and 8. Here the term adolescent and youth refer to that person who will with in the range of age between 10-24 years.

3.2 Methods of Data Collection

This study is preliminary based on the primary data as a main source of information. Primary data will collected from the field study through surveying the age 10-24 years applying structure questionnaires. So, that they could not talk each other and could not be able to copy of next answer of another person. Then the questionnaires were distributed to the respondents. The respondents were carefully supervised during the distribution of questionnaires to minimize data errors. Self administered techniques were used to collect the information.

3.3 Sample Design

The study is based on individual information that was purposively selected. There are about 1114 adolescents and youth in Khalanga VDC ward no.5, 6 and 8 Rukum District (V.D.C .profile 2007). Among them only 115 respondents aged 10-24 years and covering 10 percent of total population.

3.4 Sampling Size

Altogether 115 adolescents and youth were interviewed as unit of the study from Khalanga VDC, Rukum. Among them 65 are male and 50 are female in the age group (10-24).

3.5 Questionnaire Design

Questionnaire constituted the major tool of this study. It was designed to solicit the necessary knowledge in STIs and HIV/AIDS, its transmission and preventive measure and some other attempt to identify the different sources of information of STIs and HIV/AIDS. This study utilized quantitative research approach to collect information from the respondents. Questionnaires are mainly constituted into three parts. There are Household Questionnaires, socio-economic condition of Household and Individual Questionnaires.

Individual Schedule was designed to collect the information on marital status, sexual behaviors of the respondents and their knowledge of STIs and HIV/AIDS. Similarly, household schedule was designed to collect the information about the socio-economic status, demographic status of the respondents such as education, occupational, caste, ethnicity, religion so on.

3.6 Method of Data Analysis

The collected information is together and analyzed in a separate chapter for interpretation. The data obtained from the field survey was processed and analyzed to interpret their implication with the help of microcomputer using SPSS. Relevant frequency and cross tables are used to describe the basic characteristics and examine the relationship between dependent and independent variables. In other words, relationship between knowledge on STIs and HIV/AIDS and level of education level of marital status were also analyzed.

3.7 Selection of the Study Variable

According to the nature of study research, the study variable categorized in to independent variable, and dependent variable.

Caste/Ethnicity: Caste/Ethnicity play important role in determining the knowledge on HIV/AIDS NEWERA, 2008 highlighted high caste/Ethnicity more knowledge than low caste on STIs and HIV/AIDS in the society. Hence selected caste/Ethnicity variable in this study. The caste/Ethnicity has been categorized Chettri, Dalit, Brahmin and magar.

Education: Education is the most important factor determining knowledge on STIs and HIV/AIDS. NCASC, 2009 focused higher level of education higher the knowledge than the persons having low level of education. Thus selected Education variable in this study.

Marital status: Married persons have higher knowledge on STIs and HIV/AIDS comparing to unmarried persons. Hence selected this variable is selected for the study.

Age/Sex: Age and sex play a vital role in determining role in determining knowledge on STIs and HIV/AIDS. Persons who are of age 20-40 years age group have higher level of knowledge than persons who are of age group 10-14 years. And male have more knowledge than female on STIs and HIV/AIDS. So this variable was also considered in this study.

Occupation: Occupation plays important role on knowledge about STIs and HIV/AIDS. Thus this variable was selected.

Hence, Independent variables affecting dependent variable and important role of Independent variable and dependent and Dependent variable in this study.

CHAPTER IV

SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Demographic and socio economic characteristics play vital role in the development of the society. This chapter presents the socio-economic and Demographic characteristics of the respondents, mainly as age and Sex, Caste/ Ethnicity. Educations, Religion, Marital status, Occupation, Cultivate land, source of Drinking water, facility at home and Housing status of Khalanga V.D.C. in Rukum district.

4.1 Age and Sex Composition of total Population

Age and Sex composition plays an important role in determining the population dynamics. The population of study area is classified into five year age group. Total population of study area is 642 out of them 358 male and 284 female. The sex ratio of the study population was 126.1 which are more than national figure (National 98.8). Table 1 shows the distribution of population according to 5 year age group. Proportion of population at age group 15-19 year is highest with 17.8 percent of the total population as where 50-54 year age group at lowest 2.2 percent.

Table 1: Distribution of Total Population of Study Area by Age and Sex

Age group	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
0-4	10	2.8	7	2.5	17	2.6
5-9	43	12.0	14	4.9	57	8.9
10-14	28	7.8	25	8.8	53	8.3
15-19	65	18.2	49	17.3	114	17.8
20-24	52	14.5	41	14.4	93	14.5
25-29	23	6.4	9	3.2	32	5.0
30-34	9	2.5	11	3.9	20	3.1
35-39	16	4.5	35	12.3	51	7.9
40-44	50	14.0	47	16.5	97	15.1
45-49	18	5.0	10	3.5	28	4.4
50-54	12	3.4	2	0.7	14	2.2
55-59	9	2.5	6	2.1	15	2.3
60-64	4	1.1	18	6.3	22	3.4
65+	19	5.3	10	3.5	29	4.5
Total	358	100.0	284	100.0	642	100.0

Source: Field Survey, 2010

Figure 2: Population Pyramid of Total Population

4.2 Caste/Ethnic Composition of Total Population

Table 2 shows that the majority of respondents 58.0 percent were from Chhetri ethnic group, which was followed by Dalit 17.0 percent, Brahmins 12.9 percent and Magar 12.1 percent. The table 2 makes us more clearly on caste and Ethnic composition of respondent.

Table 2: Distribution of Household by caste/Ethnicity by sex

Caste/Ethnicity	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Chhetri	212	59.2	160	56.4	372	58.0
Dalit*	64	17.9	45	15.8	109	17.0
Brahmin	42	11.7	41	14.4	83	12.9
Magar	40	11.2	38	13.4	78	12.1
Total	358	100.0	284	100.0	642	100.0

* Dalit (Kami, Damei, Badi and Sarki)

Sources: Field Survey, 2010

4.3 Education Status of Total Population

Education plays vital role for the development. Educational status is most important factor to determine the socio economic development of the society. Table 3 shows the distribution of population by literacy status out of 625 population 42.7 percent Illiterate, 14.4 percent informal 24.6 percent Primary, 14.1 percent Secondary and 4.2 percent, High Education. This table (table 3) is indicating the medium level of socio economic condition of Khalanga V.D.C. Rukum.

Table 3: Distribution of Household by Literacy Status of Age above 5 years by Sex

Literacy Status ²	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Illiterate	123	35.3	144	52.9	267	42.7
Informal	61	17.5	29	10.5	90	14.4
Primary	94	27.1	60	21.7	154	24.6
Secondary	53	15.2	35	12.6	88	14.1
High Education	17	4.9	9	3.2	26	4.2
Total	348	100.0	277	100.0	625	100.0

Sources: Field Survey, 2010

4.4 Marital Status of Total Population

Marriage is one of the major components of the population dynamic. It is universal in Nepal that early marriage became one major cause of poor maternal health. Women who marry too early have a high risk of teen age pregnancy. Teen age pregnancy is high risk for mother and new born baby. It is also increase maternal status. Table 4 show that the population counted for marital status was 568 from 115 households excluding those below 10 years. Among them 47.9 percent male and 55.9percent female are currently married, 41.2 percent are never married nearly 7 percent people are widow/ widower and 0.4 percent female is at divorce/separated status of the total population.

Table 4: Distribution of Total Population of Study area above age 10 years by Marital Status

Marital status ³	Sex	Total
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² Illiterate - who do not able to general read and write

Informal - able to read and write but not completed even primary education.

Primary education - which is complete primary (grade1-5) education.

Secondary education- who is complete secondary (grade6-10& Test pass) Education.

High education - Which is complete S.L.C. higher secondary and Bachelors and Master education.

³Currently married - A person who has lived as husband and wife religiously, socially, or regally at least once in their life is known as married person.

Never married - A person who has not lived as husband and wife even once in their life taken as never married.

Widow/Widower- A women has lost her husband on account of death and has not remarried she is taken as a widow. On the other hand if a man who has lost his wife die to death and has not remained is taken as widower.

Divorced - A married person who has broken up the marital relationship is taken as divorced but which should be legally.

	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Currently married	146	47.9	147	55.9	293	51.6
Never married	144	47.2	90	34.2	234	41.2
Widow/widower	15	4.9	24	9.1	39	6.9
Divorce/separated	-	-	2	0.8	2	0.4
total	305	100.0	263	100.0	568	100.0

Source: Field Survey, 2010

4.5 Occupation Status of Total Population

Occupation status of households and quality of life has positive relationship. Occupation is important factor which influence the social, economic, political, cultural and religious variables. Occupation status is also associated with the life standard. Occupation status plays vital role in promotion and protection of individual's health as well as community health.

Table 5 show occupational status 32.9 percent population are students 16.7 percent are Daily wage, 14.8 percent population are service, 10.0 percent population are Household work, 9.0 percent population are Agriculture, 8.1 percent population are dependent 7.2 percent population are Business and 1.2 percent population are pension.

Table 5: Distribution of Occupational Status of Total Population above Age 10 years by Sex

Occupation	Sex				Total	
	Male		Female		Number	Percent
	Number	percent	Number	percent		
Agriculture	26	8.5	25	9.5	51	9.0
Service	67	22.0	17	6.5	84	14.8
Business	27	8.9	14	5.3	41	7.2
Household work			57	21.7	57	10.0
Daily wage workers	55	18.0	40	15.2	95	16.7
Pension	7	2.3			7	1.2
Students	102	33.4	85	32.3	187	32.9
Dependent	21	6.9	25	9.5	46	8.1
Total	305	100.0	263	100.0	568	100.0

Source: Field Survey, 2010

4.6 Family size of the Respondent

Refer the table 6 shows that most of the respondents i.e. 63.5 percent had 6-11 Members in their family size and 36.5 percent had 3-5 members in their family.

Table 6: Distribution of Household by family size

Family Number	Frequency	Percent
3-5	42	36.5

Separated - A married person who has been living separately but they have not done divorce legally, is taken as separated.

6-11	73	63.5
Total	115	100.0

Average HH size 5.7

Source: field survey, 2010

4.7 Size of Cultivate Land Holding

Nepal is agricultural country where nearly 80 percent people are dependent in agricultural sector (CBS 2003). The size of landholding also represents the level of economic status of the population.

Table 7 shows that majority of population i.e. 46.1 percent people do not have any cultivated land, 30.4 percent have less than 10 ropani, 13.9 percent have 10-20 ropani and 9.6 have 20 and 20 above ropani cultivated land.

Table 7: Distribution of Household by Cultivated Land

Cultivated land (Ropani)	Frequency (No.)	Percent
No land	53	46.1
< 10 ropani	35	30.4
10-20 ropani	16	13.9
20+ ropani	11	9.6
Total	115	100.0

Source: Field Survey, 2010

4.8 Source of Drinking Water

Hundred percent of the people are using the pipe line Drinking Water of that study area.

4.9 Toilet Facility

Presenting the table 8 shows that most of the respondents i.e. 72.2 percent have Toilet and 27.8 percent have not Toilet facility in that study area.

Table 8: Distribution of Household by Toilet Facility

Toilet facility	Number	Percent
Yes	83	72.2
No	32	27.8
Total	115	110.0

Source: Field Survey, 2010

4.10 Availability of Physical Facilities in House

Presenting the table 9 highly 83.5 percent (i.e. 96) respondents have electricity, 37.4 percent (i.e. 43) have Telephone 46.1 percent (i.e. 53) have television and 99.1 percent (i.e. 114) have radio facility in their home.

Table 9: Distribution of House by Availability of physical facilities

Available facilities at home *	No. of frequency	Percent
Electricity	96	83.5
Telephone	43	37.4
Television	53	46.1
Radio	114	99.1

*Total may exceed 100 % because of multiple responses

Source: Field Survey, 2010

4.11 Types of House⁴

The data represent in table 10 shows that the majority population are 31.3 percent living at traditional house, 29.5 percent living at Kachhi house, 27.0 percent living at semi pakki house and 12.2 percent living at pakki house. It proves that the majority population is in middle class economic status.

Table 10: Distribution of House by Types of House

Description	No. of House hold	Percent
Traditional	36	31.3
Kachhi	34	29.5
Semi pakki	31	27.0
Pakki	14	12.2
Total	115	100.0

Source: Field Survey, 2010

⁴ Definition of house

Traditional- The house is made of grass with straw roof.

Kachhi- The house is made of stone with straw roof.

Semipakki- The house is made of stone and the roof is covered by tin.

Pakki- The house is made of stone, cement and iron.

CHAPTER V KNOWLEDGE ON STIs AND HIV/AIDS

This chapter includes knowledge toward the adolescents and youth on STIs and HIV/AIDS. In this study question were asked to the respondents to examine the Knowledge on STIs and HIV/AIDS. This chapter reveals the knowledge in different sector. In addition, it is shows respondents were weather aware or not in this topic. Thus, this topic plays vital role to know Knowledge towards STIs and HIV/AIDS.

5.1 Knowledge on STIs by sex

All the respondents had heard about sexually transmitted infections (STIs). This point carries the knowledge towards STIs. Knowledge in STIs among the adolescent and youth is very necessary in the absence of which they may involve in unsafe sex relation with their partner and suffer from various STIs. The following table (Table 11) shows the portion of the respondents who have or have no knowledge in different STIs.

Table 11: Distribution of Respondents by sex and knowledge of STIs

Knowledge on STIs	Respondents					
	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	45	69.2	28	56.0	73	63.5
No	20	30.8	22	44.0	42	36.5
Total	65	100.0	50	100.0	115	100.0

Knowledge on the types of STIs

Syphilis	36	80.0	28	96.4	63	86.3
Gonorrhea	34	75.6	28	96.4	61	83.6
Chlamydia	33	73.3	28	96.4	60	82.2
HIV/AIDS	45*	100.0*	28*	100.0*	73*	100.0*

*Total may exceed 100 % because of multiple responses

Source: Field Survey, 2010

About 63.5 percent respondents had knowledge on STIs where as 36.5 percent had no knowledge in STIs. In the research out of 115 respondents, 65 were male and 50 were female out of which, 45 males had knowledge and 20 had no knowledge. Similarly, 28 females had knowledge but 22 females had no knowledge on STIs. All of the people have knowledge of HIV/AIDS (100%) followed by 86.3 percent have knowledge about syphilis. Moreover 83.6 percent of them had knowledge of Chlamydia.

5.2 Sources of Information about STIs by Sex

The sources of information were a crucial factor for the adolescents to achieve knowledge regarding STIs and HIV/AIDS. The adolescents and youth acquire different sources of information for knowledge on STIs and HIV/AIDS. Different means of sources play vital to provide/give them information towards STIs and HIV/AIDS.

Table 12 refers that Radio, television, magazine, NGO/INGO, friends, teacher etc are the major sources of information about STIs and HIV/AIDS. Among these sources, teacher was the main sources of information as 72.6 percent

followed by friends 41.7 percent; radio 20.5 percent, television and magazine were in same position 11.0 percent. Similarly, few respondents i.e. 8.2 percent get knowledge from NGO/INGO.

Table 12: Distribution of Respondents with Different sources by Sex

Sources of information	Respondents				Total	
	Male		Female		Number	percent
	Number	Percent	Number	Percent		
Radio	8	17.8	7	25.0	15	20.5
T.V.	4	8.9	4	14.3	8	11.0
Magazine	5	11.1	3	10.7	8	11.0
NGO/INGO	4	8.9	2	7.1	6	8.2
Friends	17	37.8	13	46.4	30	41.7
Teacher	31	68.9	22	78.6	53	72.6
Total	45*	100.0*	28*	100.0*	73*	100.0*

*Total may exceed 100 % because of multiple responses

Source: Field Survey, 2010

It is revealed that, 17.8 percent, 8.9 percent, 11.1 percent 8.9 percent, 37.8 percent and 68.9 percent male respondents had got information on STIs from Radio, T.V., Magazine, NGO/INGO, Friends and Teacher respectively. Similarly 25.0 percent, 14.3 percent 10.7 percent, 7.1 percent, 46.4 percent and 78.6 percent female respondents had got information on STIs from Radio, T.V., Magazine, NGO/INGO, Friends and Teacher respectively.

5.3 Knowledge on STIs Symptom by Level of Education

The table 13 reveals the knowledge on STIs symptoms among the respondents by level of education. It sate that most of the respondents mentioned that pain on sexual organ was the main symptom if STIs 83.3 percent. Similarly Headache and Itching sexual organ were the symptoms known to 70.0 percent and 64.8 percent out of the total respondents. Few of them i.e. 38.9 and 35.2 percent thought that pain lower abdomen at sexual intercourse and white discharge were the symptoms of STIs.

Table 13: Distribution of Respondents with Symptoms of STIs by Level of Education

Symptoms	Level					Total
	Illiterate	Informal	Primary	Secondary	High education	

	N.	Per.	N.	Per.	N.	Per.	N.	Per.	N.	Per.	N.	Per.
Yes	3	27.3	9	60.0	19	82.6	27	96.4	6	100.0	64	74.0
No	8	72.8	6	40.0	4	17.4	1	3.6	0	0.0	19	26.0
Total	11	100.0	15	100.0	23	100.0	28	100.0	6	100.0	83	100.0
Pain on sexual organ	2	66.7	8	88.9	12	63.2	17	63.0	6	100.0	45	83.3
Headache	2	66.7	9	100.0	8	42.1	12	44.4	6	100.0	38	70.4
Itching sexual organ	1	33.3	3	33.3	8	42.1	10	37.0	6	100.0	35	64.8
Vomiting	-	-	2	22.2	7	36.8	6	22.2	1	16.7	28	51.9
Pain lower abdomen at sexual intercourse	-	-	1	11.1	3	15.8	9	33.3	6	100.0	21	38.9
White discharge	1	33.3	5	55.5	9	47.4	15	55.6	6	100.0	19	35.2
Tired feeling	3	100.0	9	100.0	16	84.2	20	74.1	6	100.0	30	55.6

Source: Field Survey, 2010

Tired feeling were the symptom of STIs for 100.0 percent Illiterate, Literate and High education, 84.2 percent primary and 74.1 percent secondary education level respondents very few i.e. 0 percent, 22.2 percent, 36.8 percent, 22.2 percent and 16.7 percent Illiterate, literate, primary, secondary and high education respondents respectively mentioned vomiting was the symptom of STIs. 66.6 percent respondents in Illiterate Headache was the symptom of STIs.

5.4 Knowledge on Modes of STIs Transmission by Caste/Ethnicity

Table 14 shows that the modes of STIs transmission by sex out of 68 respondents almost all i.e. 97.1 percent respondents mentioned the sexual contact with STI patient was the main cause of STIs transmission, followed by 70.0 percent stated that staying with STIs transmission, 67.1 percent mentioned the mother who has STIs to child was the mode of the transmission and 61.4 percent know that STIs transmits by using utensils of infected was the mode of transmission.

Table 14: Distribution of Respondents on Modes of STIs Transmission by Caste/Ethnicity

Cause of transmission	Caste/Ethnicity								Total	
	Chhetri		Dalit		Brahmin		Magar		N	Per.
	N	Per.	N	Per.	N	Per.	N	Per.		
Sexual contact with STIs patient	30	100.0	20	100.0	10	100.0	8	80.0	68	97.1

Taking blood	14	46.7	19	95.0	8	80.0	8	80.8	49	70.0
Mother who has STDs to her child	22	73.3	8	40.0	9	90.0	5	80.0	47	67.1
Using utensils of infected person	19	63.3	10	50.0	9	90.0	5	50.0	43	61.4

N=70 (Chhetri 30, Dalit 20, Brahmin10, Magar 10)

Source: Field Survey, 2010

Most of the respondents i.e. 100 percent Chhetri, Dalit and Brahmin and 80.0 percent Magar know sexual contact with STIs patient was the mode of transmission 46.7 percent, 90.0 percent, 80.0 percent and 80.0 percent Chhetri, Dalit, Brahmin and Magar respectively know taking blood from STIs patient as the cause of transmission. 50 percent Magar respondents know using utensils of infected person.

5.5 Methods of Preventing STIs Transmission by Respondents

Table15 shows that out of 73 respondents most of them i.e. 90.4 percent state that use of condom method of prevention STIs transmission. It is followed by 84.9 percent mentioned by sex with single partner 71.2 percent mentioned by don't sex with infected persons and 67.1 percent don't use utensils of infected persons was the method of preventing STIs transmission.

Table 15: Distribution of Respondents on Method of Preventing STIs Transmission by Respondents

Method of STIs prevention	Number	Percent
Use of condom	66	90.4
Sex with single partner	62	84.9
Don't sex with infected person	52	71.2
Don't use utensils of infected person	49	67.1
Total	73*	100.0*

*Total may exceed 100 % because of multiple responses

Source: Field Survey, 2010

5.6 Knowledge on HIV/AIDS by Hearing.

According to the table 16 almost i.e. 96.5 percent respondents had heard about HIV/AIDS only 3.5 percent respondents had not heard about HIV/AIDS.

Table 16: Distribution of Respondents by Hearing the Knowledge on HIV/AIDS

Heard about HIV/AIDS	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Yes	63	96.9	48	96.0	111	96.5
No	2	3.1	2	4.0	4	3.5
Total	65	56.5	50	43.5	115	100.0

Source: Field Survey, 2010

The above table almost all i.e. 96.9 percent out of total male respondents heard about HIV/AIDS but 3.1 percent hasn't heard about it. 96.0 percent female had heard about HIV/AIDS but 4.0 percent hasn't heard about HIV/AIDS.

5.7 Knowledge on HIV/AIDS by Different Sources

According to the table 17 out of 111 respondents, the highest portion i.e. 71.2 percent have heard about HIV/AIDS from teacher following by text book 55.9 percent and 17.1 percent mentioned radio very few i.e. 2.7 percent heard from T.V. and only 1 (i.e. 0.9 %) heard from parents.

Table17: Distribution of Respondents Knowledge on HIV/AIDS by Different Sources by sex

Sources of information	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Radio	10	15.9	9	18.8	19	17.1
T.V.	-	-	3	6.3	3	2.7
Magazine	4	6.3	3	6.3	7	6.3
Text book	30	47.6	32	66.7	62	55.9
Teacher	40	63.5	39	81.3	79	71.2
Friends	9	14.3	9	18.8	18	16.2
Parents	-	-	1	2.1	1	0.9

Source: Field Survey, 2010

Most of the male respondents i.e. 40 (71.2%) have heard about HIV/AIDS from teacher, 47.6 percent text book, 15.9 percent radio, 14.3 percent friends and 6.3 percent magazines, whereas 81.3 percent female respondents got information of HIV/AIDS from teacher followed by 66.7 percent from text book 18.8 percent from radio and friends. In the same way 6.3 percent respondent gain knowledge from T.V. and magazine and only 2.1 percent from parents.

5.8 Knowledge in ways of HIV/AIDS Transmission by Age Group

The table 18 reveals as the ways of HIV/AIDS transmission by age group. It was clear from the table 97.1 percent respondent in age group 15-19 year mentioned that it transits from sexual intercourse with infected person very few them i.e. 4.2 percent thought Breast feeding from infected mother. Respondent in age group 10-14 year mentioned that 90.9 percent sexual intercourse with infected person, 40.9 percent patient tear and 13.6 percent thought breast feeding from infected mother. Similarly respondent in age group 20-24 years mentioned that 95.1 percent sexual intercourse with infected person, 48.8 percent blood transfusion and very few i.e. 2.4 percent mosquito bite patient tear and breast feeding from infected mother said by respondents.

Table 18: Distribution of Respondents with Different Source by Age Group

Ways of HIV/AIDS transmission	Age group (year)						Total	
	10-14		15-19		20-24			
	No.	Per.	No.	Per.	No.	Per.	No.	Per.
Sexual intercourse with infected	20	90.9	47	97.1	39	95.1	106	95.5
Pricking blade	4	18.2	8	16.7	10	24.0	22	19.8
Blood transfusion	5	22.7	13	27.1	20	48.8	38	34.2
Mosquito bite	7	31.8	9	18.8	1	2.4	17	15.3
Stay together with	8	36.4	9	18.8	1	2.4	18	16.2

infected person								
Patient tear	9	40.9	5	1.4	2	4.9	16	14.4
Child from infected mother	6	27.8	10	20.8	16	39.0	32	28.8
Brest feeding infected mother	3	13.6	2	4.2	1	2.4	16	5.4

Source: Field Survey, 2010

In total 106(95.5%) of the respondents took sexual intercourse with infected person, 38(34.2%) blood transfusion and 28.8 percent thought child from infected mother are the ways of HIV/AIDS transmission. 14.4 percent patients tear and only 5.4 percent took Brest feeding from infected mother were the ways of HIV/AIDS transmission.

5.9 Knowledge on Prevention of HIV/AIDS by Level of Education

The table no.19 indicates 97.1 percent, primary, 92.3 percent informal, 90.9 percent secondary, 83.3 percent high education and 71.4 percent illiterate respondents thought the use of condom very few 14.3 percent primary respondent thought the taking tasted blood and aware about sex. 30.8 percent and 48.6 percent informal and primary respondent thought the aware about sex, 72.7 percent secondary respondent. Don't sex with infected person 100.0 percent and aware about sex and only 83.3 percent high education respondent mentioned the HIV/AIDS by level of Education.

Table 19: Distribution of Respondents to Prevent of HIV/AIDS by Level of Education

Ways of prevention of HIV/AIDS	Level of Education										Total	
	Illiterate		Informal		Primary		Secondary		High education			
	N.	Per.	N.	Per.	N.	Per.	N.	Per.	N.	Per.	N.	Per.
Use of condom	5	71.4	12	92.3	34	97.1	20	90.9	5	83.3	76	96.1
Don't involve multi partner sex intercourse	3	42.9	10	76.9	31	88.6	20	90.9	5	83.3	69	83.1
Don't sex with infected person	3	42.9	7	53.8	23	65.7	16	72.7	6	100.0	55	66.3
Don't use other's syringe	2	28.6	5	38.5	20	57.1	16	72.7	5	83.3	48	57.8
Taking tested blood	1	14.3	5	38.8	19	54.3	17	77.3	4	66.7	45	54.2
Don't child from infected person	2	28.6	6	46.2	19	54.3	17	77.3	3	50.0	47	56.6
Aware about sex	1	14.3	4	30.8	17	48.6	16	72.7	5	83.3	41	49.4

N=83 (Illiterate=7, Informal=13, Primary=35, Secondary=22 and High Education=6)
Source: Field Survey, 2010

In total, was find most of them i.e. 91.6 percent knew use of condom. It was clear that more respondents know the ways of prevention some of them were mentioned above soul of the respondents i.e. 83.1 percent had mentioned don't involve multi partner sex intercourse was one way of prevention and 49.4 percent by awareness about sex prevention of HIV/AIDS.

5.10 Knowledge about Sex by Different Sources.

In this modern age people get knowledge from many sources. The following table 20 shows friends were the main source of knowledge about sex for 71.2 percent. It is following by 65.8 percent get knowledge from teacher, 15.3 percent from magazine and 9.0 percent from Radio are the different sources from where respondents get knowledge on HIV/AIDS. Less number of respondents and 0.9 percent got knowledge from parents, sister and uncle/aunt.

Table 20: Distribution of Respondents with Different Sources by Sex

Sources of knowledge about sex	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Parents	1	1.6	-	-	1	0.9
Sister	-	-	1	2.1	1	0.9
Uncle/Aunt	1	1.6	-	-	1	0.9
Teacher	37	58.7	36	75.0	73	65.8
Friends	40	63.5	39	86.7	79	71.2
Magazine	9	14.3	8	17.8	17	15.3
Radio	5	7.9	5	11.1	10	9.0
TV	1	1.6	2	4.7	3	2.7

N=111 (Male=65, Female=48)

Source: Field Survey, 2010

The sources of knowledge was different for male and female according to the table, friends were the main sources of knowledge for male 40(63.5%) whereas 39(86.7%) female got knowledge from friends. Teacher was the second source of knowledge for male and female i.e. 58.7 percent and 75.0 percent receptively. Magazine was the third sources of knowledge for male and females 14.3 percent and 17.8 percent respectively.

5.11 Knowledge of Sexual Intercourse Sharing Behaviors

The table 21 reveals the respondents discuss behaviors about sexual intercourse with friend by sex. Highest percent of respondents i.e. 45.2 percent discuss sometimes with friends. Whereas 14.7 percent don't discuss with their friends and very few 4.3 percent and 8.7 percent discuss most of the time and usually discuss on discuss about sexual intercourse with friend.

Table 21: Distribution of Respondents with Discuss on Behaviors about Sexual Intercourse by sex

Discussion	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
No	29	44.6	19	38.0	48	41.7

Sometime	28	43.1	24	48.0	52	45.2
Most of the time	3	4.6	3	0.0	5	4.3
Usually	5	7.7	5	10.0	10	8.7
Total	65	100.0	50	100.0	115	100.0

Source: Field Survey, 2010

The table shows 44.6 percent male respondents don't discuss about sexual intercourse with friend. 41.3 percent some time discuss and 4.6 and 7.7 percent most of the time discuss and 38.0 percent never discuss about sexual intercourse from this table, we came to know that the female respondents were less discuss than male due to their shyness family background so on.

5.12 Knowledge of Sexual Experiences Sharing

By analyzing the information in table 22, we can say that highest number of respondents i.e. 78(67.8 %) not have sexual experience. Only few respondents i.e. 37(32.2 %) had sexual experience mention by the respondents.

Table 22: Distribution of Respondents by Sharing Sexual Experience by Sex

Sexual experience	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Yes	19	29.2	18	36.0	37	32.2
No	46	70.8	32	64.0	78	67.8
Total	65	100.0	50	100.0	115	100.0

Source: Field Survey, 2010

Before presenting the table 70.8 percent male and 64.0 percent female respondents have not sexual experience. But 29.2 percent male and 36.0 percent female have sexual experience mentioned by the respondents.

5.13 Use of Contraceptive Method

Table 23 shows that the highest percent of respondent i.e. 51.4 percent use of contraceptive method but 48.6 percent respondent don't use of contraceptive method and 89.5 percent respondent use temporary contraceptive method and 10.5 percent respondents use permanent contraceptive method.

Table 23: Distribution of Respondents use of Contraceptive Method by Sex

Use contraceptive method	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Yes	7	36.8	12	66.7	19	51.4
No	12	63.2	6	33.3	18	48.6
Total	19	100.0	18	100.0	37	100.0
Temporary	6	85.7	11	91.7	17	89.5
Permanent	1	14.3	1	8.3	2	10.5
Total	7	100.0	12	100.0	19	100.0

Source: Field Survey, 2010

About 63.2 percent male respondents don't use any contraceptive method.36.8 percent male use contraceptive method. Similarly 66.7 percent female respondents use contraceptive method, only 33.3 percent respondents don't use any contraceptive method. Similarly 85.7 percent male and 91.7 percent female

respondents use contraceptive method and only 14.3 percent male and 8.3 percent female respondent use permanent contraceptive method.

5.14 Knowledge of Probable Victim of HIV/AIDS (Most at Risk Population) by Sex

Table 24 shows that the highest percent of respondents (94.6%) stated unsafe sex with multi partner may cause HIV/AIDS. 51.4 percent thought commercial sexual worker and 36.9 percent through child from infected mother may be the victim of HIV/AIDS.

Table 24: Distribution of Respondents with Probable Victim of HIV/AIDS By Sex

Probable victim	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Unsafe sex with multi partner	59	93.7	46	95.8	105	94.6
Injecting drug user	20	31.7	13	27.1	33	29.7
Commercial sex worker	29	46.0	28	58.3	57	51.4
Migrant worker	9	14.3	8	16.7	17	15.3
Child from infected mother	19	30.2	22	45.8	41	36.9

Source: Field Survey, 2010

About 93.7 percent male mentioned unsafe sex with multi partner may lead to victim of HIV/AIDS followed by 95.8 percent female thought so 58.3 percent female and 46.0 percent male mentioned commercial sex worker may the victim of HIV/AIDS. Only 16.7 percent female and 14.3 percent male mentioned that migrant worker may be the victim of HIV/AIDS.

5.15 Knowledge about the Responsible for Reduction of HIV/AIDS

Table 25 shows the view of respondents persons who responsible for reduction of HIV/AIDS by level of education. The highest percent of respondents (47.0%) government is responsible. 13.9 percent mentioned all of the above (him/herself and government) said responsible for reduction of HIV/AIDS.

Table 25: Distribution of Respondents for Responsible to Reduce HIV/AIDS by level of Education

Responsible to reduce	Level of Education					Total
	Illiterate	Informal	Primary	Secondary	High	

HIV/AIDS									education			
	N	Per.	N	Per.	N	Per.	N	Per.	N	Per.	N	Per.
Person him/herself	9	60.0	12	52.2	20	46.5	10	35.7	3	50.0	54	47.0
Government	3	20.0	9	39.1	16	37.2	14	50.0	2	33.3	44	38.3
All of the above	2	13.3	2	8.7	7	16.3	4	14.3	1	16.7	16	13.9
None of the above	1	6.7	-	-	-	-	-	-	-	-	1	0.9
Total	15	100.0	23	100.	43	100.0	28	100.0	6	100.0	115	100.0

Source: Field Survey, 2010

The opinion differs from one level to another level of education 60.0 percent, 52.2 percent 46.5 percent 35.7 percent and 50.0 percent of illiterate, informal primary, secondary and high education respectively said person self responsible to reduce HIV/AIDS. Similarly 20.0 percent, 39.1 percent, 37.2 percent, 50.0 percent and 33.3 percent of illiterate, Informal, primary, secondary and high education said government is responsible for reduction of HIV/AIDS.

5.16 Knowledge on Behaviors towards AIDS Patients by Sex

It is clear from the table 26 show that highest percent of total respondents 53.2 percent mentioned lovely behavior and next to it, 26.1 percent mentioned that we should show don't know toward them very few 4.3 percent of them equal to the infected person.

Table 26: Distribution of respondents Behavior towards AIDS patients by Sex

Behave towards infected person	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Lovely	35	53.8	26	52.0	61	53.0
Hatred	8	12.32	11	22.0	19	16.5
Equal	4	6.2	1	2.0	5	4.3
Don't know	18	27.7	12	24.0	30	26.1
Total	65	100.0	50	100.0	115	100.0

Source: Field Survey, 2010

Most of the male respondents were aware of HIV/AIDS 53.0 percent mentioned that there should be lovely behavior and few i.e. 6.2 percent male mentioned that there should be equal behavior and highest number of female i.e. 52.0 percent said lovely behaviors. Similarly few number 2.0 percent female mentioned that there should be equal behaviors towards HIV/AIDS infected persons.

5.17 Knowledge of Idea Reduce HIV/AIDS by Sex

Table 27 shows that most of the respondents i.e. 82.6 percent were use of condom to reduce HIV/AIDS. 65.2 percent awareness about HIV/AIDS to reduce HIV/AIDS and very few respondents i.e. 4.3 percent transfuse only tasted blood to reduce HIV/AIDS.

Table 27: Distribution of respondent with Idea to Reduce HIV/AIDS by Sex

Idea to reduction HIV/AIDA	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		

Awareness about HIV/AIDS	43	66.2	32	64.0	75	65.2
Don't say with infected person	30	46.2	24	48.0	54	47.0
use of condom	52	80.0	43	86.0	95	82.6
Don't sex with multi partner	26	40.0	21	42.0	47	40.9
Don't use utensils of infected person	23	35.4	20	40.0	43	37.4
Expel from society	21	32.4	20	40.0	41	35.7
Transfuse only tasted blood	3	4.6	2	4.0	5	4.3
Don't know	5	7.7	1	2.0	6	5.2
Total	65*	100.0*	50*	100.0*	115*	100.0*

*Total may exceed 100 % because of multiple responses

Source: Field Survey, 2010

Above table (table 27) shows that, the view of respondents to reduce HIV/AIDS by sex according to them 80.0 percent male and 86.0 percent female stated use of condom 66.2 percent male and 64.0 percent female stated awareness about HIV/AIDS and very few 4.6 percent male and 4.0 percent female say Transfuse only tasted blood is the easiest way to reduce HIV/AIDS.

CHAPTER VI SUMMARY, CONCLUSION AND RECOMMENDATION

This chapter presents about the Summary, Conclusion and Recommendations may be assistance for the policy make as well as for the future studies.

6.1 Summary and Conclusion

This study analyzed the knowledge on STIs and HIV/AIDS. It is based on the small scale study carried out at Khalanga V.D.C, Rukum. This study is fully based on primary data. 115 respondents were selected from Khalanga V.DC, Rukum 65 was male and 50 were female with in the age group 10-24 years. . Frequency table and cross table are applied to fulfill the objectives of study.

Some of the major findings of Individual Characteristics were presented below:-

- Higher number 56.5 percent from male and 43.5 percent respondent were taken from female.
- The data were collected Khalanga V.D.C, Rukum adolescents and youth between the age group where higher number of respondents were in age group 15-19 years 42.6 percent.
- Nearly Sixty one percent respondents belonged to Chettri, 21.7 percent Dalit, 9.7 percent Brahmin and 7.8 percent ethnic group.
- Hundred (100%) percent were Hindus religion.
- Among the respondents 13.0 percent were illiterate, 20.0 percent were Informal, 37.4 percent were primary education, and 24.3 percent were secondary education and 5.2 percent high education.

Major findings of Household Characteristics:-

- Majority of the respondent's family were Illiterate (i.e. 42.7%), 14.4 percent Informal and only 0.2 percent family were high education.
- Majority of respondents family were found to be engaged age students (i.e. 32.9%), 16.7 percent Daily wage work, 14.8 percent Service, 10.0 percent Household work, 9.0 percent Agriculture, 8.1 percent Dependent, 7.2 Business and the lowest percent 1.2 percent followed pension as an occupation.
- The highest respondents 63.5 percent had mentioned 6-11 members in their family.
- Nearly 54 percent respondents were not any cultivate land.

- Hundred percent respondent drinking pipe line water.
- About 72.2 percent respondents were Toilet facility.
- More than 99 percent respondents have Radio at home followed by 83.5 percent have electricity, 46 percent have Television and 37 percent have telephone facility at home.
- About 31 percent respondents have Traditional house 30 percent have semi-pakki house, 12.2 percent have kachhi house and 27.0 percent have pakki type of house.

Major findings of Knowledge on STIs and HIV/AIDS

- Most of the respondents (63.5%) had heard about sexually transmitted infections.
- Syphilis, Gonorrhoea, HIV/AIDS, Chlamydia were familiar among respondents.
- Hundred percent, 86.3 percent, 83.6 percent and 82.2 percent respondents had heard about HIV/AIDS, Syphilis Gonorrhoea and Chlamydia respectively.
- Approximately better knowledge on STIs is seen between all levels of Education of respondents.
- Level of knowledge on STIs was higher in 20-24 year age group.
- Teacher and friends were the main sources of information about STIs and HIV/AIDS.
- All respondents had knowledge on the modes of transmission of STIs.
- Hundred percent respondents confirmed that HIV/AIDS was transmitted through the sexual contact.
- About 70 percent respondent stated that HIV/AIDS was transmitted through blood transfusion.
- About 73 percent respondents got knowledge from teacher and 41 percent got knowledge from friends.
- A few respondents said that AIDS was transmitted through patient tear, mosquito bite and syringe.
- Higher the age, higher the knowledge about modes of AIDS transmission.
- Preventive knowledge on HIV/AIDS among respondents was high.

- Nearly 90 percent of the respondents said that the use of condom is the true method of preventing AIDS transmission. About 70 percent said use only tasted blood and 67 percent said dint bear child by infected mother.
- Most of the respondent (71%) got knowledge about sex by teacher.
- About 95 percent respondent said that unsafe sex with multi partner causes one to be the victim of HIV/AIDS.
- Nearly 38 percent respondent said that the individual was responsible to reduce HIV/AIDS.
- About 45 percent respondents said that talk about sexual activities was sometime.
- About 32 percent respondents said that experienced in sex.
- About 53 percent respondent said that lovely behavior should with HIV infected person.
- Nearly 46 percent respondents said that sometimes personal problem with their parents.
- About 30 percent respondent said that currently using family planning method.

6.2 Recommendations for Policy Maker

On the basis of above analysis and result of the study, the level of knowledge on STIs and HIV/AIDS among Khalanga V.D.C Rukum adolescents and youth is good However, knowledge on STIs and HIV/AIDS is determined by demographic, social factor and economic factor.

Similarly, adolescent youth and population have been increasing rapidly in Nepal. Today's adolescents, and youth are the parents of future generation and back bone of the society and nation. Therefore adequate service, efforts and intervention must be focused on them from every side for their development.

Some recommendations for policy maker are given below:

-) Education plays vital role to determine every changes in the society. I recommend that sex education should be included in their curriculum in every school.
-) Majority of adolescents youth were reported that use of condom is the true method of preventing AIDS and STIs transmission. Therefore it is necessary to make them more knowledgeable in the context of condom users.

-) Programs should be focused to educate the parents to teach their children about sexuality and HIV/AIDS.
-) Transmission and prevention of knowledge and other information of STIs and HIV/AIDS should be provided regularly.
-) Programs must be designed to sustain over long term favor to adolescents and youth.
-) Government should make the distinct vision about awareness making, process of cure and also implementation process should be strict in health sector of government.

6.3 Area for Further Research

This study has certain boundary to fulfill the acquired aspiration. For the detail study on this topic, I would like to explore some suggestions to the new generation researcher they are:

-) I could not submit the detail view of respondents about their sexuality due to lack of time. So, I recommend to new researcher who study in this subject that each should give higher priority on the preventive measure of these diseases also provide financial support and technical support to cure them.
-) It is recommended to new researcher that the questionnaire should be filled up secretly to the responded by giving them question.
-) The religion and cultural tradition are highly affected to explore the detail view of respondents so, adult group in society should be made positive in HIV/AIDS.
-) In Nepal, the HIV/AIDS cases are raised day by day due to poverty, open conflict, low age at marriage, premarital sexual behaviors etc. So, future study should be centralized to eliminate on this predominated topics of study.

This study doesn't cover the equal respondents of male and female would be better to take the equal respondents from each age group and gender too.

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APPENDIX I

Questionnaire

Knowledge on STIs and HIV/AIDS among Adolescents and Youths (A Study of Khalanga, V.D.C., Rukum)

Section 1: Household Questionnaire

Household No.:

Name of Locality:

Name of Respondents:

Mother Tongue:

Date:

Religion

Ward No.:

Caste/Ethnicity:

S.N.	Name	Relation of the HH	Sex		Age	Education	Marital Status	Occupation
			M	F				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Code for

Relation to HH		Education		Marital Status		Occupation	
Head of the household	01	Illiterate	00	Married	01	Agriculture	01
Husband/wife	02	Literate	01	Unmarried	02	Service	02
Father/Mother	03	Primary	02	Widow	03	Business	03
Son/daughter in law	04	Lower Secondary	03	Divorced	04	Household work	04
Grand child	05	Secondary	04	Separated	05	Daily wage workers	05
Father/Mother in law	06	Higher secondary	05			Pension	06
Brother/Sister	07	Higher Education	06			Students	07
Nephew	08	Others	07			Dependent	08

Other relatives	09				Do not know	09
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Section 2: Socio-economic Condition of Household

S.N.	Questions	Opinion	Code	Skip
1	Do you have any cultivate land?	Yes No	01 02	
2	If yes, how much	Ropani	01	
3	What is the main sources of drinking water	Pipe line water Well water River Pond Others	01 02 03 04 05	
4	Do you have toilet?	Yes No	01 02	
5	Does your household have?	Electricity Telephone Television Radio	01 02 03 04	
6	What kind of your house?	Pakki Kachhi Semi-pakki Traditional	01 02 03 04	

Section 3: Individual Questionnaire

1. Respondent's Number:

2. Name:

3. Age:

4. Sex: I) Male II) Female

5. Marital Status: I) Married II) Unmarried

6	Have you heard about STIs?	Yes No	01 02	
7	If yes, what is the full form of STIs?	Specifically Tracked Disease Sexually Transmitted Infection Sexually Traced Disease Scientifically Transmitted Disease	01 02 03 04	
8	From which sources have you heard about STIs?	Radio T.V. Magazine NGO/INGO News Doctor Parents Friends Teacher Others	01 02 03 04 05 06 07 08 09 99	

9	Which STIs have you heard?	Syphilis Gonorrhea Chlamydia HIV/AIDS Others	01 02 03 04 99	
10	Do you know the symptoms of STIs?	Yes No	01 02	
11	If yes, what are the symptoms of STIs?	Pain on sexual organ Headache Itching sexual organ Vomiting Pain lower abdomen at sexual intercourse White discharge Tired feeling Others	01 02 03 04 05 06 07 99	
12	Do you know the ways of transmission of STIs?	Yes No	01 02	
13	If yes, how is it transmitted?	Sexual contact with STIs patient Taking blood from STIs patient Mother who has STD's to her child Using utensils of infected person Others	01 02 03 04 99	
14	What are the methods of preventing STIs transmission?	Use of condom Sex with single partner Don't sex with infected person Don't use utensils of infected person Others	01 02 03 04 99	
15	Have you heard about HIV/AIDS?	Yes No	01 02	
16	From which source have you heard about HIV/AIDS	Radio T.V. Magazines Text Book Teacher Friends Parents Others	01 02 03 04 05 06 07 99	
17	How does HIV/AIDS transfer?	Sexual intercourse with infected person Pricking blade Blood transfusion Mosquito bite Stay together with infected person Patient tear Child from infected mother Breast feeding from infected mother Syringe Others	01 02 03 04 05 06 07 08 09 99	
18	Do you know the ways of prevention of HIV/AIDS?	Yes No	01 02	
19	If yes, what are the ways of	Use of condom	01	

	prevention?	Don't involve multi partner sexual intercourse Don't sex with infected person Don't use other's syringe Taking tested blood Don't child from infected person Aware about sex Others	02 03 04 05 06 07 99	
20	Is the lesson of STIs included in your school course?	Yes No	01 02	
21	If yes, does your teacher explain about it?	Yes No	01 02	
22	If no, what may be the reason?	Shyness Negligence Lack of knowledge Don't know Others	01 02 03 04 99	
23	In your opinion, does the entire AIDS infected person die or some of them die or do not die?	All of them die Some of die Not die at all Don't know	01 02 03 04	
24	Where did you get the knowledge about sex and sexual intercourse?	Parents Brother Sister Uncle/Aunt Teachers Friends Magazine Radio T.V. Others	01 02 03 04 05 06 07 08 09 99	
25	Do you talk about sexual activities with your friends?	No Sometime Most of the time Usually	01 02 03 04	
26	In your opinion, is it necessary for adolescent to youth to have knowledge about HIV/AIDS?	Yes No	01 02	
27	Do you need knowledge about sex?	Yes No	01 02	
28	Have you experienced in sex?	Yes No	01 02	
29	If yes, have you suffer from STIs related diseases?	Yes No	01 02	
30	Did you use any contraceptive method?	Yes No	01 02	
31	Which method have you use?	Temporary Permanent	01 02	
32	What kind of person becomes the victim of HIV AIDS?	Unsafe sex with multi partner Injecting drug users Commercial sexual worker Migrant worker Child from infected mother	01 02 03 04 05	

		Others	99	
33	Can HIV/AIDS be treated?	Yes No Don't know	01 02 03	
34	What type of behavior should we do with HIV infected person?	Lovely Hatred Equal Don't know	01 02 03 04	
35	Who will be the more responsible person to reduce HIV/AIDS	Person him/herself Community Government NGO/INGO Non of the above All of the above	01 02 03 04 05 06	
36	What will you do to reduce HIV/AIDS?	Awareness about HIV/AIDS Don't say with infected person Use of condom Don't sex with multi partner Don't use utensils of infected person Expel from society Transfuse only tasted blood Others	01 02 03 04 05 06 07 99	
37	Do you discuss about your personal problem with your parents?	No Sometime Usually Always	01 02 03 04	
38	Have you heard of family planning	Yes No	01 02	
39	Are you currently using any family planning method	Yes No	01 02	
40	Is it easy to obtain family planning method in your locality?	Yes No	01 02	

APPENDIX II

GLOSSARY

Some important terms are used in this work. Every term is important to define the subject matter. The terms are described below.

Knowledge

According to Oxford advanced learners dictionary "Knowledge is the information, understanding and skills that you gain through education or experience. In this study knowledge refers to the understanding the causes of modes of transmission, symptoms, prevention of STIs and HIV/AIDS.

Attitude

An attitude is "ways of feeling, thinking or behaving" (oxford learners' dictionary). An attitude is a dispositional readiness to respond to certain situation, persons or objectives in a consistent manner, which has been learned and has become one's typical mode of response. In this study attitude refers to favorable or unfavorable reactions to the statement in the attitude scale provided by the researcher.

Sexuality

Sexuality is "The feeling and activities connected with a person's sexual desire" (Advanced Learner's Dictionary). In this study sexuality refers to know sexual activities to the students of higher secondary students provided by the researcher.

Immune System

The body's protecting mechanism from disease is known as immune system. It is a complex process of many organs e.g. blood, lymph gland, thymus which are important for the protection of the body from infection by recognizing diseases killing them and then remembering what they look like so that they will be able to fight with them.

STIs

STIs are group of communicable diseases which are chiefly acquired through sexual contact. Sexually transmitted infections are major cause of acute illness and morbidity.

HIV

Human Deficiency Virus (HIV), a combination of diseases caused by HIV virus, which affects the immune systems of the body or it, is a virus that produces deficiency in the immunity of a person.

AIDS

Acquired Immune Deficiency Syndrome, a fatal disease caused by HIV groups of retrovirus which affects the immune system of the body. The body has become unable to fight against infection.